

Brit abroad: thoughts of a British resident working in Sydney

Sarah C Armstrong

Friendly bosses, fair working conditions and positive specialty training prospects down under

It is said that there is many a true word spoken in jest, and I'm beginning to understand why. In the United Kingdom, it is joked that once a doctor has worked in Australia, there is no turning back. The reasons may seem obvious — the famous relaxed Australian attitudes, escaping the stresses of the National Health Service (NHS), a temperate climate . . . but those are only the tip of the iceberg. I am now 10 months into my Australian adventure, and it is time to take stock of the differences between the two systems of medicine. Why is practising down under so attractive to us Poms?

Back in August 2007, I was concluding my first year as a newly qualified doctor at a highly esteemed teaching hospital in Leeds in Yorkshire. Twelve months earlier, as a less sleep-deprived medical student, I had spent 2 months in Sydney on my medical elective at a central teaching hospital. The experience left a lasting impression, and as I stared bleakly out of the window into the Yorkshire drizzle, I realised I was fated to return.

Australia was to be my foreign sabbatical — a new medical experience separating my “foundation training” (intern and resident years). So here I am with my “year” rapidly running out, only to have applied for and successfully secured a further resident year at the same Sydney hospital. This will be accredited in the UK as the completion of my foundation training, which leaves me with a difficult decision. By January 2009, should I stay or should I go?

The bread and butter of my resident job in Australia doesn't differ much from what it would be in the UK. However, the terms and conditions are considerably different; paid overtime — an alien concept in the NHS that I find encourages better care and fosters goodwill within the workforce.

This brings me to the effective use of time. I cannot begin to calculate how many hours in the UK are dedicated to the art (or is it skill?) of sexing up ultrasound requests or begging for computed tomography scans from radiologists who are desperately busy and whose services are overstretched. The system in Australia is more organised, with more staff and better access to resources. This cuts out the telephone histrionics and means that, in some hospitals, imaging can be performed and reported on the same day.

Hierarchy comes into the equation as well. Consultants in the UK still resemble those in “Doctor in the House”, dressed in dark suits and followed by a quaking entourage of house officer, senior house officer and registrar. In Australia, the style is less formal but no less effective. I am on first-name terms with my boss, and am encouraged to seek advice, day or night. This is a refreshing change from the strict, intimidating chain of command back home.

I cannot neglect to mention the impact on the morale of British junior doctors of the newly devised Modernising Medical Careers (MMC) scheme, and the fallout it has generated. MMC was heralded as the educationally sound way of training junior doctors and enabling them to secure training posts that would lead to consultancies. Major flaws in the Medical Training Application Service (MTAS — the area of MMC dedicated to the national appointment of junior doctors to specialised training) were uncov-

ered last year. Criticism has focused on the system's online technical problems, the marking and weighting of applications and the lack of training posts. Fear of unemployment is high, with government figures citing 32 000 applicants for 23 000 posts.¹

The British media have been uncharacteristically sympathetic to the plight of doctors applying to the MTAS, playing on the public fear of hospitals devoid of doctors who have all emigrated to Australia as a result of a “shambolic” recruitment process. “Remedy”, an opposition group set up by doctors, reflected this fear by renaming MTAS “Moving To Australia Soon”.

By May 2007, the MTAS was unceremoniously shelved after protests from the medical community, which provoked an independent inquiry. These are still unsettling times for junior doctors.

It appears Australia prides itself on an open and systematic process for appointing junior doctors to training programs.² However, there is a growing shortage of training positions as the numbers of Australian and foreign graduates increase. A similar situation may be faced in this country if the medical community does not learn from the UK's mistakes. Australia must be wary of the blurring of political and professional agendas when it comes to allowing the government to instrumentalise the process by which junior doctors are trained.

In February 2008, the British Home Office ended its tradition of allowing doctors from Australia and other Commonwealth countries to benefit from training in the NHS.³ This medical “iron curtain” has been drawn in response to the bottleneck of home-grown and foreign graduates competing for limited positions. I hope Australia won't make the decision to follow Britain into the realms of curtailing training opportunities for foreign graduates. It breeds disillusionment and cuts short invaluable experience gained only by immersing oneself in a different medical system.

Who knows what the future holds for me? At the moment I am more than happy working in Australia, with friendly bosses, fair working conditions and positive specialty training prospects.

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