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Trainees' forum

An Australian exchange

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The opportunity to travel and practise one's skills in a variety of settings is an attractive aspect of the medical profession. However, in the current atmosphere of competition for jobs and structured career paths, deviation from which may mean losing one's place on the ladder, the prospects of working abroad are limited and the decision to do so often risky. One way round this is to arrange jobs on an exchange basis for a limited period. This is most convenient where the countries involved have similar teaching programmes and reciprocal arrangements for college recognition: in the case of psychiatry this includes Australia, New Zealand, USA, Canada and Hong Kong.

I was recently fortunate enough to participate in such an exchange, for a six month period, at registrar level, with a trainee from Sydney, Australia. Because it suited us to do so, both jobs were in child psychiatry but this need not necessarily have been so.

There were aspects of the arrangement which were of benefit on a personal level: the chance to travel, the challenge of a new environment and the opportunity to sample the Antipodean lifestyle to name but a few. Of particular interest were the 'transcultural' aspects of working within a system which has many similarities with our own but some marked differences (Ellard, 1979; Gelder, 1979). A brief account of some of these differences, their effect on the trainee in psychiatry, and some practical details of the exchange may be of interest to others.

Training programmes

Most of the training programmes at premembership level operate on a similar basis to those in the UK: six monthly rotations to cover a range of general psychiatry and specialist jobs. In Australia it is their College requirement that trainees complete six months of child psychiatry and a six month liaison post, few of which currently exist in the UK. It is also a College requirement that each trainee receives a minimum of four hours supervision per week, from a psychiatrist, at least one hour of which must be individual. At the end of each job the trainee completes a form from the College with comments and criticisms of the job and details of the supervision received.

Each trainee must also see a long term psychotherapy patient for a minimum of 50 sessions with regular supervision, often paid for by the trainee who has to provide proof that this requirement has been satisfied. While a similar recommendation is made by the British College (1986), it is still possible for trainees to miss out altogether on seeing psychotherapy patients.

Many of the training schemes in Sydney consist of a small number of trainees attached to a particular hospital, although lecture courses are organised centrally by the Institute of Psychiatry, usually half a day per week. Compared to many of the larger schemes in England, this arrangement seemed to be less able to provide a coordinated programme with the opportunity for peer support and tailoring of a wide variety of jobs to meet individual interests.

Trainees are eligible to sit the first part of the Australian Membership exam after three years of training, but before doing so must submit five detailed case histories of between 2,000 and 8,000 words. The exams consist of two written and two clinical tests, covering material similar to that in the British exam. In addition there is a fairly rigorous clinical exam in any aspect of general medicine. It was my impression that the Australian exam is tougher and viewed as more daunting by the trainees than the British equivalent. Many candidates meet weekly in informal study groups for several months or even years beforehand to prepare for the exam. I was lucky enough to be able to participate in one such group and found it stimulating as well as sociable.

Candidates who are successful in these exams must then wait a year to become full members of the College, this being dependent on the submission and acceptance of a dissertation, or less commonly five further case reports. Post membership training is less structured than in the UK. Trainees are eligible for senior registrar posts in their fifth year of training, and these posts are usually for one year only. Those with full membership may continue in these posts but are automatically eligible for consultant posts or at this stage can set up in private practice.

Health care

All Australian residents are entitled to public health care through the Medicare System, and hold a Medicare card and number. Medicare will pay for all

treatment within the public hospital system: it will also pay a standard rate for consultations with primary health care doctors and for specialists practising outside hospitals. Some of these doctors will charge above the Medicare rate and expect the patient to make up the difference. The patient is able to choose which doctor to consult and in the primary care system may seek treatment from more than one doctor at once.

A far higher percentage of Australian psychiatrists are practising independently of the hospital system, so-called private practice, although the implications of the term are different from the UK as some of this treatment is still funded by Medicare. In particular Medicare will pay for intensive long-term psychotherapeutic treatment if provided by a doctor.

These differences have a number of implications for the trainee. Certainly in Sydney there is far less communication with a primary health care doctor who could be expected to know the patient, have access to his notes and provide continuation of care in the community; emergency referrals have rarely been filtered by a GP. Perhaps as a reflection of this there is no involvement of the GP in compulsory detention of a patient, which in an emergency can be done by just one doctor at any stage of training. On the other hand, there seem to be more community facilities available, and in the Lower North Shore area of Sydney there is a community crisis team of nurses and social workers operating 24 hours a day, which can make direct referrals to the registrar on call and can provide intensive community support where required.

General aspects

There were a number of other areas in which the psychiatry of the two countries seemed to differ, which are personal impressions only.

There appeared to be a stronger psychotherapeutic influence in the practice of general psychiatry and there seemed to be more psychotherapy, of all types, being practised generally. Along with the use of DSM-III, this may reflect a stronger American influence. Availability of therapists is heavily influenced by the large number of 'private' psychiatrists who can see patients for psychotherapy and bill Medicare. There also seemed to be a less rigid hierarchical structure, with less emphasis on phenomenology but more discussion and questioning of diagnoses. This perhaps in addition to the more daunting exams and less structured training programs, seemed to promote a more enquiring and independent attitude amongst the trainees: the 'pioneering spirit'?!

Practical details

As mentioned, most of the rotations in Sydney operate on a six monthly basis. The change-over times are the beginning of January and mid-July, slightly before most UK jobs, but with some juggling of holidays this is not a problem.

In Sydney, if appointments are arranged on an exchange basis no additional qualifications are required (a distinct advantage as overseas graduates are normally required to sit an extra exam to practise in New South Wales), Medical Defence Union registration covers both countries with no extra fee. Registration with the New South Wales Medical Board (£40.00) requires a hospital sponsor in the state and a Certificate of Good Standing from the GMC (£20.00). The hospital sponsor will also arrange a visa through the Australian Embassy, who then simply require a GP medical and a chest X-ray. The health authority for which I work was willing to grant the absence either as unpaid leave (in which case superannuation must still be paid) or as a gap in contract with re-employment on return. Rates of pay and work conditions are roughly equivalent in the two countries and for college accreditation all that is required is a letter from the Australian College confirming completion of the appointment.

Perhaps the best way to arrange such an exchange is through one's senior colleagues with contacts abroad, but the same could probably be achieved by writing to particular departments to ask if they would be interested.

The exchange was a great success and an invaluable learning experience at the end of which I was able to return to a secure job in England with a broader perspective of psychiatry. I can highly recommend the ideas to others.

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