GENERAL SURGERY

Elective report
David Kitchen

Objective 1. What common general surgical conditions are seen in Autralia? Are these the same as those encountered in the UK or are there differences in their distribution.

From my experiences so far during my time attached to an upper GI firm at the QEH, on the whole the type of patients encountered are similar to those that I have typically encountered in similar hospitals in the UK. Lots of people with gallbladder issues as well as acute pancreatitis. However, one notable difference has been in the number of patients who have had pancreatic cancer. I had previously not encountered a single patient with this in the UK, but have seen 4 or 5 in my first three weeks attached to the team at the QEH. 10.4 per 100,000 in Australia (2008 figures) compared with 13.2 in the UK (2008 firgures). One of the reasons for me seeing more cases compared to my experience in the UK is likely to due to being placed in a tertiary referral centre at the QEH, with many patients being sent from places such as Mount Gambier, which is 434 km away and even further in some cases. For cases like this it is obvious that with such extensive and complicated surgery and post-operative recovery periods it makes sense to have those done in larger centres with more expertise. So although in my experience the type of cases that presented were broadly similar to those that I had seen in the UK, the biggest difference, namely the increased number of pancreatic cancer cases I believe relate more to hospital type than anything else and indeed the raw statistics for cases per 100,000 are actually less than in the UK!

Objective 2. Is healthcare delivery the same in Australia as the UK? If not what are the differences and how does this affect patient care?

The system in Australia to a large extent is extremely similar to that in the UK. Hospital care is covered by taxes with the actual healthcare for the individual as an in-patient being free. This is covered by the Medicare levy system, which is broadly similar to the national insurance contribution in the UK. The main differences I have encountered in terms of the logistical differences when managing patients in Australia has centred around the great distances that individuals can be from the nearest hospital and certainly from the nearest specialist centre. As mentioned previously many of the patients that I encountered during my stay where from places that were 450km or more away, to put this into perspective that is the same as travelling from central London to Newcastle in England simply because that is the nearest major hospital. This means that when you are dealing with surgical patients you have to take into account what kind of assistance they are going to need on leaving hospital as the services available to them may be very different to those available to people living in close proximity to the hospital which is more often than not the case in the UK. This was the biggest and most notable difference and meant that services that I have certainly never come into contact with in the UK such as rural liaison are an essential point of contact when discharging patients from hospital care in

Australia are not required in surgical teams that I have been involved with in the UK.

Objective 3. Are waiting times for elective surgical procedures comparable to the UK?

In the Australia figures from 2010-2011 showed that the median time spent waiting for an elective procedure was 36 days. Although I was unable to get a median figure for the UK by comparing broadly across specialities in the UK the waiting time for a knee replacement was 99.2 days in 2011 compared to approximately 64 days for orthopaedic procedures in Australia. On the whole in terms of my experience on the wards there seemed to be little difference from what I had seen in the UK compared to what I saw in Australia in terms of how long patients were expected to wait for operations. I did have limited exposure to clinics which in my experience in the UK is where most operations in the UK get scheduled from. Seeing as the majority of patients that I saw be scheduled for surgery were initially admitted as emergency admissions this could be the reason for the prompt organising and undertaking of the surgery that I witnessed during my time in Australia. I would like to have a greater look at whether these figures can do genuinely show a decreased waiting time in Australia, but from my limited experience this did seem to be the case.

Objective 4. What type of professional development scheme do doctors follow in Australia; do you think you would be better suited to that system or that in the UK?

In Australia the first year on graduating from medical school is spent as an 'intern'. This is very similar to the foundation year 1 doctor role in the UK, in that a lot of your time is spent ensuring scans are ordered and bloods taken with the role predominantly being based around a desk in the ward and dealing with logistical aspects of patient care. Then on completion of your intern year, you become an RMO, this seems to be very similar to the SHO (senior house officer) level in the UK with a lesser emphasis on the ward based activities that are expected of the intern and also the opportunity to gain more exposure to different aspects of care, in the case of surgical firms this would include things like access to theatres. On the whole the structure from graduating medical school to becoming a consultant in Australia is broadly similar. From what I have gathered there seems to be an increasing amount of procedures undertaken by the more junior staff and the consultants being available if procedures were expected to be more difficult or if required by the junior staff for assistance. This allows the individual to gain a lot more hands on practical experience when compared to my exposure to similar firms in the UK. This leads me to believe that the actual practical skills of individuals with similar amounts of time in the field are more likely to be higher in Australia seeing as they will have been able to undertake more procedures themselves. On the other hand however, by having less consultant guided operations this means that the actual teaching of techniques may not be as high as in situations where you are predominantly operating with the consultant in charge of care for the patient. Having considered all of this however, I feel that once you have gained your supervisor's

trust at being able to carry out a procedure and feeling able to call of them if needed, that the Australian system would allow you to more quickly develop your practical skills as a surgeon and that I would find this approach more appealing in the long run.