Tyneside to New Zealand

Ben Hudson MBBS, MRCGP

'You're joking. If you wear a tie everyone will laugh at you!' our receptionist told me a few days before starting work. I was at the medical centre for an introduction to the practice and had asked for some sartorial advice. My predecessor had consulted in a T-shirt on hot days, so formal dress was certainly not required at Lyttelton Health Centre where I started work three years ago. I'd arrived in New Zealand (NZ) as a fairly newly-qualified GP, having completed the UK vocational training scheme 18 months earlier and worked in an inner-city practice in Gateshead (Newcastle's neighbour on the south side of the River Tyne). Open-necked attire fits with the more informal approach here, though I have been advised to wear a tie and warned not to sink to "Kiwi sloppiness" by one English octogenarian ex-pat. Most patients call me Ben and seem to prefer me to use their first names too. My scatological vocabulary has been greatly enhanced and the casual, routine use of swearing continues to impress me.

I'd enjoyed my brief time in English general practice and had gained useful experience there, but there has been a lot to learn since moving here. The scope of practice seems broader in NZ and I've needed to brush up some clinical skills. Skin cancers are much less common in the cloudy North East of England, and most minor trauma was dealt with at the hospital, so I've needed to refresh my excision and suturing.

The principle of continuing care, with a gradually evolving and deepening knowledge of the patient (and the patient of his doctor), is alive and well. Fifteen-minute appointments help to achieve this. Compared to the usual 10-minute slots in the UK, they felt like a luxury at first, but they are easily filled, perhaps because of a different style of consulting expected by both patients and doctor. Longer consultations are certainly useful when seeing visiting seamen who attend the practice during their short periods of shore leave in Lyttelton. They are usually accompanied by an interpreter and often give hair-raising histories of accidents on board and shore-based adventures.

Beyond day-to-day work in the practice, there is plenty of opportunity to get involved in teaching and research. General practice is very well co-ordinated in Christchurch by the Pegasus group, with excellent out-of-hours cover and lots of high quality educational sessions. Support from our local hospital specialists is generally excellent and I enjoy the easy, friendly telephone access to them which seems to be the norm here but was certainly not expected in the UK. Some of the waiting times for outpatient appointments and procedures seem incredibly long though, and the depressingly regular return of referrals marked as being triaged routine, or even urgent, but with no appointment offered, is difficult. This has been a surprise since waiting times for outpatients in the NHS have become much shorter, particularly for urgent referrals, and before working here I had never encountered a referral being returned with no appointment arranged or alternative advice offered.

Getting to grips with the ACC system and its paperwork was a challenge but I now feel reasonably adept at negotiating the system. My initial surprise at being unable to prescribe some drugs without specialist approval or completing a Special Authority form has given way to an enthusiasm for Pharmac's efforts to optimise the use of the national drug budget.

One obvious disadvantage of working here is the money. The average British GP pay is now over GBP100,000 (about $250,000). However, this was achieved by the acceptance of a new contract with a strong emphasis on performance-related pay which rewards doctors for achieving measurable improvements in patients' treatment—reducing blood pressure or cholesterol, for example. This has altered the consultation for both GPs and patients, with a shift of focus towards recording and treating measurable risk factors. Critics have pointed out that this incentivised, reductionist approach obstructs thoughtful, patient-centred care and risks de-professionalising general practice to the detriment of both patient and doctor. By controlling a significant proportion of practice income in this

CORRESPONDENCE TO:
Ben Hudson
Senior Lecturer
Department of Public Health
and General Practice
University of Otago, Christchurch
PO Box 4345, Christchurch 8140
New Zealand
ben.hudson@otago.ac.nz

way, central government has acquired increased control over the way practices are run and even the way doctors practise. This reached a peak of populist appeal last December with the health minister's announcement of his plan to encourage patients to rank their GPs' competence and bedside manner on the NHS Choices website. He hopes this will do for health care what Amazon has done for the book trade. It is debatable whether this market approach is appropriate for general practice, which prides itself on the therapeutic relationship between health care professional and patient, rather than on any commercial transaction involved or ranking of quality by the consumer. It seems unlikely that such a shift in ideology will encourage a flourishing future for UK general practice, which is still run mainly as a small independent enterprise at the friendly, local bookshop level, rather than at the multi-national supermarket level.

NZ should be cautious about importing the UK model (which has also cost the UK Government much more than anticipated) without taking these factors into account.

It is a relief to be spared all that and, overall, work in NZ seems more fun, varied and satisfying than in the UK. I hope that we can protect this by resisting the temptations of performance-related pay here.

View from the edge

Emma Storr MB BS Lond., MRCGP

Time is different in New Zealand compared to the UK. There seems to be more of it in general practice, both for appointments and for paperwork. As a result, work is generally much less stressful and I actually get to eat my lunch, talk to colleagues and attend occasional midday meetings. Fifteen-minute appointments are luxurious and, with any time left over, I usually ask the patient if there are other issues they want to talk about. This is so different to practice in the UK where I was always running behind and wondering how I could 'squeeze' in the extras, before rushing out to do home visits. I never asked the patients if there were other things to be discussed. I was always trying to close the 10-minute consultation, not prolong it.

Perhaps it is not fair to compare the busy, inner-city practice in Leeds where I worked for 11 years with the mere 20 months I have spent at Student Health in Dunedin, dealing mainly with healthy, young people. My former practice was full of patients with multiple social and medical problems, many of whom did not speak English and whose health needs were very complex. I used the telephone interpreting service constantly and communication was often far from adequate. At Student Health, my role is simpler and often preventive. Contraception, sexual health counselling and screening for STIs take up many appointments, as well as treating minor injuries. These are often caused by the Dunedin students' insistence on wearing jandals all year round and stepping on the numerous broken bottles strewing the streets. There is alcohol abuse of course and a fair amount of psychological distress, but with seven counsellors on site and an in-house psychiatrist available, there is plenty of expertise to help. It is a far cry from seeing destitute refugees and the lonely, poor elderly in Yorkshire, where the problems were often overwhelming and exhausting for both the patients and the doctors.

And the downsides of general practice here? It seems very strange to have to charge patients for seeing me after working in the socialist NHS which prides itself on free access for all. It certainly influences my decision to ask patients to see me again 'to check how things are going.' I have learned to have a lower threshold for suspecting meningitis or rheumatic fever as both are much commoner here than in the UK, particularly among the Maori population. I find the fewer medicines available frustrating and the need to apply for special authority or consultant approval slightly humiliating. I hate the ACC paperwork.

Many problems are common and familiar to both New Zealand and the UK. It takes months to arrange a non-urgent ultrasound scan. ENT,

CORRESPONDENCE TO
Emma Storr
Senior Clinical Lecturer
Department of General Practice
Dunedin School of Medicine
University of Otago
PO Box 913, Dunedin
New Zealand
emma.storr@otago.ac.nz