Anglo-Australian exchange in general practice

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SUMMARY. An exchange visit was arranged between the two partners in our practice in Chagford, Devon and two partners in a practice in Canberra, Australia.

This enabled us to experience a completely different type of practice and financial system with the opportunity of working closely with other colleagues, while maintaining continuity of treatment for our own patients, since only one partner was exchanged at a time.

We also benefited from seeing new patients with new diseases, and felt that our patients probably benefited from seeing a new doctor. We returned to the practice refreshed and stimulated and our patients appeared to have been similarly stimulated by the impact of a different culture.

Introduction

IN June 1976 Dr Peter Fitt wrote asking if we would be interested in an exchange visit with him and his partner. After discussion it became clear that the advantages outweighed the disadvantages both for our practice and our private lives.

We had both been in general practice for over 12 years and felt stale both professionally and in our management of the practice. We felt that the visit would give us a chance to work under a different system and try out new methods in another practice without imposing changes on ours which might not work.

It was agreed that Dr Marsh would go to Canberra for the months of April, May, June, and July 1977 in exchange with Dr Fitt, and that Dr Rhodes would go for the months of August, September, October and November 1977 in exchange with Dr Wilson. There was to be a two-week period between the exchanges, to give the departing doctor time to hand over to the returning partner.

It was inevitably a hectic year: the resident doctor found his workload heavier, as he was acting as host and adviser to his 'new partner'. The exchange was helped by the fact that one partner from each practice were friends and had worked together before.

Temporary registration in Australia was simple and relatively cheap, but unnecessarily difficult and expensive in England, even though one of the visitors had previously trained, qualified, and registered there.

The practice

The two British doctors work as a two-man partnership in a rural practice in Devon, based in a health centre with full ancillary help, including an attached district nurse, and a health visitor and chiropodist each working one day a week.

We went to work in a health centre in the Scullin suburb of Canberra, served by four general practitioners—two partnerships of two, who shared off-duty arrangements but otherwise worked independently—and one doctor from outside the health centre. The centre had full secretarial help, all the secretaries being registered nurses, one full-time physiotherapist, seven attached community nurses, and two counsellors (social workers). Two gynaecologists, one paediatrician, one dietitian, two surgeons, and one physician each spent one session a week in the health centre seeing patients referred from sources both inside and outside the centre. The chiropodist gave two sessions a month, and there was one session of family planning each week. The health centre was government controlled and the facilities in the Australian capital territories were better than in many parts of Australia.

Workload

The work was very different since there were few elderly people in Canberra, and the majority of the wage

earners were in the Public Service. There was a high proportion of children, and home visits worked out at fewer than one per day.

The consultations were found to be relaxed, since each patient was allowed 15 minutes. However, sitting in an office from 9.00 hours to 17.30 hours, with one and a half hours for lunch, made it seem a long day, and it took some time to adjust to it. Each doctor saw an average of 140 patients each week compared with 88 in the Devon practice (70 in the surgery and 18 visits).

Dr Marsh and Dr Wilson had a weekly session with sixth forms at Hawker College for general discussion, which they enjoyed and found interesting, if challenging.

As one might expect in a country with an outdoor culture, the Australian patients were more health orientated, but no less disease orientated than British patients. We felt that some who came to the health centre were ill enough to have justified a home visit, but in fact no time was set aside for home visits during the day. However, requests for consultation after hours for non-urgent conditions were frequent, in spite of the fees being higher. Possibly this was because the health centre was a new venture and patients had the mistaken impression that a doctor was in attendance at all times.

Patients paid $8·20 (£5·38) for each consultation, $7·10 (£4·44) of which was rapidly refunded through Medibank. This was true of nearly all medical costs incurred. The rate of exchange was then approximately $1·60 to the pound.

Examples of other fees are as follows:

Standard consultation after hours	$12·60	(£7·88)
Standard home visit—		
five to 25 minutes	$12·00	(£7·50)
Standard home visit after hours	$16·80	(£10·50)
ECG tracing and report	$15·00	(£9·38)
Venesection	$ 5·60	(£3·50)
Repair of wound, not face or neck	$16·80	(£10·50)

If an Australian doctor prescribes a product which is not in the *Pharmaceutical Benefits* (equivalent to the *British National Formulary*), the patient bears the full cost of the drug, whereas he pays a set fee of $2 (£1·25) for every item in the *Benefits*.

The intrusion of money into the consultation was not great, since the staff were largely responsible for collecting fees, much of the receptionists' time being taken up by this. We could not but be impressed by the standard of living of the general practitioners in Australia who, by fixing the fees for the coming year, have kept a much more independent position. Consultation with the Government occurs, but the Government has direct control only over the amount of the fee that is refunded to the patient by Medibank. On the other hand, we were aware of the danger of letting money intrude into practice management and decisions. At a weekend on call, or at night, collecting the fee was embarrassing. Presumably one gets used to it! The fees did not appear to reduce the number of patients seen with trivial complaints. Private certificates were frequently requested, even to justify the patient taking an hour off work to attend the surgery.

Prescribing

It was necessary to obtain permission from the Health Commission to prescribe certain drugs; for example, clofibrate, (when evidence of failure of lipids to fall on the low-fat diet was required) and griseofulvin (when proof of fungal infection was required); also repeat prescriptions of such drugs as beta-blockers. We found the available products restrictive, but the system quite workable, and one which must save the country a lot of money. Change to a similar system in this country could boost the facilities generally in the National Health Service.

Registration

The practice used an A4 size folder, and wrote précis of reports and letters in the notes, rather than allow them to become too bulky.

It confirmed our opinion that a change from the present FP5 and FP6 was highly desirable. However, the fact that patients do not register with a doctor and can see any general practitioner on request made the notes much less comprehensive. Patients tended to seek further opinions until they obtained the advice they wanted. We much preferred our system of registration. Many patients of different nationalities were seen, some needing to bring an interpreter, having recently arrived in the country. At weekends many people went direct to a casualty department for treatment.

Access to other opinions

The availability of specialist opinion, face to face, in the centre, and with a minimum of delay on the telephone, also greatly reduced the strain of responsibility. To have nearly every patient seen within 24 hours when the case was even potentially urgent was in marked contrast to the situation in Britain, where a patient often has to wait four weeks for a specialist opinion, even if neoplasm is likely. Our Australian colleagues acknowledged the value of the domiciliary consultation, although the younger population in Canberra reduced the need, and felt the presence of a small general hospital in the UK to be a great advantage. Being able to refer a patient for counselling with a minimum of delay also helped markedly to reduce the workload and the fact that patients also had direct access to the counsellors no doubt reduced it still further. Patients often had direct access to a specialist, once under his care, for problems such as a post-operative wound infection.

The pattern of illness was similar to our practice in the UK, if one allows for the difference in the average age of the population.