Working in England

NHS – To be or not to be

In the following article, Dr. Farshad Malekzadeh reports on the year he spent in Central England, working as a salaried General Practitioner (GP) for the National Health Service (NHS). He also highlights some of the more conspicuous differences between the healthcare systems in England and those in Austria and Germany. However, no claim is made to completeness, and the experiences described relate solely to work in general practice.

Working as a general practitioner in England is a challenge for any doctor, and even though I did not always feel up to the task, especially at the start, having only just completed my pre-registration training (becoming an expert in taking blood samples, hanging up infusion sets and writing letters – luckily, plus a few other useful skills that I was able to acquire thanks to the dedication of my fellow students and the staff at my teaching hospital), I spent a whole year working for one of Derbyshire's local health organisations, the Erewash Primary Care Trust (PCT), situated on the Nottinghamshire border.

The UK system seems complicated compared to the Austrian or German one. Since it was created in 1948, the basic principle of the NHS has been to make healthcare available free to all at the point of use, but in recent years it has had to contend with a shortage of resources. Private medical insurance and healthcare also exist, but the majority of people are not able to afford them. The whole country is covered by a network of trusts, which manage NHS services in local areas (primary care) and also in hospitals (secondary care). The General Medical Council (GMC) is the regulatory body for doctors in the UK. Other links in the chain are surgeries and their employees, and finally the patients themselves.

Unlike in Austria and Germany, there are hardly any single-handed surgeries (in other words, with just one doctor and a receptionist) and teamwork is encouraged; for example, I worked in two different surgeries, one with 13 doctors (a big one, with about 15,000 registered patients) and the other with four doctors (medium-sized, with about 6,000 patients), while a friend, also an Austrian doctor, worked as a general practitioner in a surgery with only two other doctors (small, about 3,000 patients). The working hours are flexible, but are generally divided into two and a half hour morning and evening sessions, in which you see people for 10-minute appointments; in between, you have a lunch break (in theory), do telephone consultations, make home visits, write letters, and deal with anything else that crops up. When it is your turn to be on call, you have to be at the surgery by 6.30 p.m., but, with a bit of bad luck, you can also find yourself still with another house visit to make at 6.30 p.m. – what time you finish working that day is then in the lap of the gods. However, the fact that there is no obligation to provide an out-of-hours service turned out to be a bonus.

In England, the GP is responsible for everything (including paediatric and gynaecological problems) and there is no such thing as unrestricted access to specialists (who, in the main, only work in hospitals) without the GP's blessing (and referral); and the GP also has to write a letter of referral, of course (to let the specialist know what the problem is about) – so writing letters is quite useful, after all. It then takes another two to three months for the patient to get an appointment, depending on where you send him or her. There are several options available for acute problems, depending on the degree of urgency: internal and general surgery cases can be sent straight to hospital without further ado, but for everyone else you have to contact the senior house officer or consultant at the hospital, and that's when the negotiations start: who can persuade whom?

The average surgery is usually run by a primary healthcare team consisting of doctors, practice nurses, receptionists, a practice manager, pharmacy

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advisors and pharmacy technicians, a midwife, health visitor, counsellor and district nurses, so many surgeries are almost like little hospitals.

Practice nurses take some of the workload off doctors, mainly by helping with the management of chronic diseases (asthma/COPD, hypertension, diabetes), vaccinating children and people travelling abroad, giving advice about straightforward, uncomplicated complaints (such as hay fever), as well as taking smears and blood.

In the secondary care or hospitals sector, some nurses even hold clinics of their own; for example, nurses at Ilkeston Community Hospital, the district hospital for Erewash, run a Minor Injuries Unit (with access to X-ray and plaster-of-Paris facilities) and even perform routine endoscopic procedures.

In England, there are various organisational structures for working as a GP in general practice: for example, running a practice independently, working for a PCT in a practice, or working as a PCT employee in an independent practice.

It was the chance to work as a GP for a PCT, with a secure income and none of the financial risk of setting up a practice from scratch, as well as the opportunity to gain the experience that turns an unseasoned doctor into a seasoned one, that particularly appealed to me, especially in view of the less-than-favourable situation on the labour market in Austria and Germany.

Although the pay is above the European average, the cost of living is equally high. Having said that, a family of four can maintain an average lifestyle on the pay of a salaried GP.

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