Impressions about the Health System in the United Kingdom: experience of a postgraduate course in London

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Abstract

As part of my specialized training in Internal Medicine, I was given the opportunity of attending, I was given the opportunity of attending a postgraduate course at Hammersmith Hospital in London.

This one year experience, at a highly recommended and recognized medical center, gave me the chance to understand better the British National Health System as well as the medical teaching and careers.

These are the aspects that I would like to share with you, both in their similarities and differences with our own system.

Introduction

During my training, as a resident specializing in Internal Medicine, I had the opportunity to take a training period at Hammersmith Hospital in London, where I took a Postgraduate Course in Internal Medicine lasting nine months, followed by a further three-month Clinical attachment. It is about this experience of one year of training, at a center of recognized merit and international prestige, that I shall now tell you, bearing in mind, above all, the different perspectives and approaches, whether in the form of living the profession, or in the form of facing the medical careers, a theme that is always relevant and constantly changing over the years.

Departmentalization *versus* services

Having, for the first time in my career, been part of a Department of Medicine, where different medical subspecialties (so-called units) were included, I should recognize that the department has, when confronted with a policy of existence services, clear and indisputable advantages. Firstly, when people feel that they are an integral part of a common whole, they tend to display greater availability and show a clear sense of collaboration, which translates, in practice, as better coordination between the various subspecialties, with clear benefits not only for patients, but also for the doctors involved, as the training and teaching aspect is always considered.

The training actions for young doctors of the Department are numerous and regular. Among these is a morning meeting, where cases of patients seen the night before are presented and discussed, and a complete clinical history is carried out (possible because the average number of daily admissions is rarely more than two) and appropriate complementary diagnostic exams are planned and scheduled. The evolution of these patients, hospitalized and previously presented, is also monitored.

Once a week, on a rotating basis between the different subspecialties, some theme of great clinical and scientific interest to the young doctors is also presented. This session is led by a specialist or a consultant. This morning meeting is presided over and supervised, also on a rotating basis, by a consultant of the Department, a radiologist must also be present, whose job is to emphasize and clarify the radiological and imaging alterations which, in any case, have computerized treatment, according to each case.

Besides these actions, the ward rounds are particularly important, where each week, three of the most interesting cases seen in the Department are presented and discussed, for the benefit of all the staff of the Hospital.

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There are also regular preparation sessions for the entry exams to the professional association, the M.R.C.P. (Member of the Royal College of Physicians), which I shall refer to again later, and also specific actions within each unit, which include several clinical visits each week (usually three, with the Registrar, Senior Registrar and Consultant or Head of Department), as well as various clinical and scientific sessions.

This great investment in the training of young doctors by the heads of the Department gives the trainees great motivation, and results in a high level of professional quality of the physicians, with the patients being the main beneficiaries.

Secondly, although each subspecialty is given a certain, fixed number of bets, this does not mean that if there are no beds on a particular sector on the date of admission, the patient cannot be admitted to any of the existing places, even in other subspecialties, for which the doctors of the unit must go to the other unit on a daily basis to see the patient, until they can be transferred to the respective sector. The result of this is a greater dynamization of the functioning of the Department, which is reflected in greater and better profitability.

Working hours

Another aspect to highlight is the fact that all the professionals of the hospital work "full time": Doctors in any phase of their career (with the exception of the Consultant and Head of Department, the only ones who perform their hospital activity alongside private practice), nurses, auxiliaries, secretaries of the unit, other administrative staff, etc. This enables the average waiting times for external consultancies (practically non-existent) to be decreased, with the timely delivery of auxiliary diagnostic exams, whether for inpatients or for outpatients.

It also enables more available time, whether for professional development - the Hospital has a library that houses all the medical journals, where you can consult the Medline database (with three computers for doctors' use), or carry out research, an activity that is considered extremely important for the prestige of the Hospital, and is therefore well supported.

All these factors help make the services more cost effective and improve the quality. However, I should also state that often, this is achieved at the cost of excessive overtime on the part of the doctors, as throughout the United Kingdom, their numbers are clearly insufficient in relation to the needs, the ratio of doctors to patients is the lowest in the European Community. Thus, the weekly work load is inhumanely high (at the Hammersmith Hospital, it is common to work a 110 hour week), which not only significantly increases the risks of medical error and negligence, but also negatively reflects the personal lives of the professionals; the number of divorces and the rates for suicide and early death among doctors is far higher than for the general population, and the use of psycho-stimulant drugs is widespread.

Emergency, admissions, medical delay and social welfare

Due to the very efficient Primary Healthcare policy, the Emergency Service can fully assume their designated function, with obvious benefits for the population, unlike what happens in Portugal, where this function is clearly perverted by a Primary Healthcare System that is far from managing to respond adequately to the needs of the population.

Optimized operation of the Emergency Service (ES) also contributes to an effective admissions policy, with emphasis being given not only to admissions through the ES, but also those through External Clinics, which here in Portugal, has almost ceased to be a reality in recent years.

Due to this highly selective admissions policy, together with the fact that the Hammersmith Hospital has been a hospital of reference for many years (not only in the UK but also abroad), the admission time ends up being an irrelevant factor, compared with the adequate and thorough investigation of each patient. This makes it totally unviable which, unfortunately, has been happening in Portugal, in that the extreme shortage of beds often leads to early discharge which in turn, lead to readmissions due to decompensation, therefore it is questionable, in my opinion, the money-saving policy that is prevalent and the increasingly shorter average delays. However, although it does not have the same type of problems that exist in our hospitals, the average delay is obviously, throughout the UK, a relevant factor to bear in mind in the management of services.

Another aspect of fundamental importance (in a society in which the concept of family has long been seen in a different way from that which we are still accustomed to seeing in the Latin countries) is the

response of the Social Welfare Services to individual needs, with numerous support systems for patients, particularly the elderly. These may include the presence of a care working during the day and another at night, meals delivered to the patient's home, help with daily tasks and weekly shopping, payment of income support and other expenses, installation of devices to make daily life easier (ramps for wheelchair, adaptors for taps, etc.). The most important consequence is that people are kept, for as long as possible, in their own homes and within their communities, and retirement homes are considered the final stage in the process. This also means that the need for back-up hospitals or clinics is not as clearly felt as is often the case here in Portugal.

Training, evaluation and career progression

In relation to medical training, the Medical Course last six years in all. This period is followed by around two years of general training as a Junior Doctor, and a variable period as a Senior Houseman Officer - S.H.O. – which is equivalent to our Specialist Intern. During this period, the activity of the S.H.O has two fundamental components: A common component (lasting around two to three years), and a specific component for each medical specialty (lasting around 4 years).

It is important to note that in the UK, there is no assess exam to the specialty, as these differ substantially from the way in which we understand them.

Entering a given specialty depends on the candidate's interest, the needs of the service, and his acceptance by the heads of the sector, without any kind of personal favoritism. The training is priority and is seen by all as essential, therefore constant support is given, which also includes training activities like those referred to earlier, and encourage research and investigation, to which all the doctors dedicate themselves in one form or another, throughout their careers.

In the same way, there are no strict programs to fulfill, or annual assessments. If the training is, in fact, continuous, then the assessment is also done daily, by criteria not only of assiduity, interest and working ability, but above all, of competence and suitability for the job.

Likewise, there is no exit exam that is even comparable to the one we have here. Thus, to obtain the title of Specialist or Registrar, it is necessary to go through two important stages, consisting of two types of exam; the so-called M.R.C.P. part I and part II (Member of The Royal College of Physicians).

The M.R.C.P. part I consists of a written test with multiple choice questions on the Scientific Background to Medicine (recently particularly emphasis have been to Immunology and Genetics, for example). The exam takes place in two periods each year (February and October). Passing this exam does not depend on a previously determined limit of 50%; rather, it is established based on the degree of difficulty and the overall average obtained by candidates in each period.

The M.R.C.P. part II is divided into two parts: Written and clinical. The written test consists of a slide interpretation section, gray cases, and data interpretation cases.

The slides may depict peripheral blood smears, bone or liver biopsies, bronchoalveolar washings, myelograms, eye fundus, X-ray, CAT scan, MRI, or other signs presented and relevant for pathologies. After looking at them, candidates are asked questions about each one (anomalies shown, diagnoses, etiologies, associated diseases), and are given a time limit (90 seconds) to respond. The gray cases, i.e. complete written clinical cases and questions about the relevant data, diagnostic hypothesis, differential diagnosis, presumptive diagnosis, proposed therapies, complications and prognosis. The data interpretation cases may consist of an E.C.G., arterial gasometry, analysis and their interpretation, etc. Relevant questions are asked relating to what is shown. The clinical exam is also subdivided into 2 parts: In the long case, a particular patient is assigned to each candidate, who is given 1 hour to give the full clinical history, which is then presented and discussed before a jury (3 members), followed by a theoretical interrogation, not only, but particularly relating to the case. In the short cases candidates observe various patients in the presence of jury, with clear, precise instructions on what to look for (observations of the eye fundus, auscultation, cardiac, etc), and are asked theoretical questions. There is a very short time limit for this test (15 minutes), and it is in the candidate's interest to observe as many patients as possible in the shortest space of time, as due to the difficulty and rarity of the pathologies chosen (it is emphasized that the patients always have chronic pathologies and are paid to submit to this kind of exam), their chances of passing increase with the number of patients observed. Of all the

exams, this is the most difficult one, and accounts for the most failures.

I should add that the failure rate in the M.R.C.P. part II is very high, due to the great difficulty and the high demands of this type of exam. Passing this test depends on the total percentage score obtained in both the written and the clinical parts. As for the M.R.C.P part I, this exam also takes place in two periods each year (May/June and October/November), with the clinical part being carried out approximately one month after the written part. What I believe to be important is the fact that there is a deadline for each of these exams, and each candidate can apply only when he or she feels sufficiently prepared to take them. There are, however, a maximum number of attempts for each candidate, i.e. four.

Another important factor to bear in mind is the absolute impartiality of the jury, which is made possible, firstly, by the fact that only candidate's name is known, but not where he or she works, previous professional experience (no *curriculum vitae* is presented) or any other personal information. Secondly, the place where the test is taken is drawn randomly at national level, therefore a candidate from London may have to take the tests in Newcastle, for example, and vice-versa. This ensures complete equality of conditions for all the candidates, which is not always seen here in Portugal, despite the efforts that have been made in this regard, though theoretical tests and clinics in conjunction with the *curricular exam* (the only one that was required for a long time), but which, it is seen, does not contribute to giving all the candidates equal conditions, for reasons that are outside the scope of this article.

Once these exams have been successfully completed, the doctor becomes a member of the Royal College of Physicians, and can then gain the degree of Specialist and progress in his or her career. To become a Senior Registrar, and finally, a Consultant, it is necessary not only to obtain greater professional experience, but above all, to perform substantial research work, a 3-year PhD (Doctorate) being highly appreciated, though not necessarily compulsory.

Once the M.R.C.P. exams have been passed, the only ones that any specialist in the area of medicine needs to take in the rest of his or her career, access to certain job positions is based only on the *curriculum vitae* (which is rarely longer than three pages) and in a personal interview.

There were three exams (December, March and June) all similar to part II of the M.R.C.P. those which I had to take during the Training Course I was on, for which the evaluation consisted of writing a thesis (of 4000 to 6000 words).

Another fact I consider important is the existence of working contracts with a limited time (generally three years), which may or may not be renewed, according to the competence shown, and the individuals interest. This non-existence of lifetime job positions, only possible in a country where the offer of jobs is far higher than the demand eliminates, in my opinion, certain "vices of the system" that their existence could imply, like disinterest and lack of stimulus, whether in relation to the work, or in relation to the training of younger doctors by those who should be more interested in an adequate medical training. This, however, is understandable, given the low salaries paid to those whose job includes this training function, which often means it is necessary to reconcile the hospital activity with private practice, often to the detriment of the first. In a system where doctor's salaries reflect the level of responsibility of the job function, this does not happen, since as the doctor progresses through his or career, he acquires a higher level of responsibility, salaries are adjusted accordingly, in a balanced way, enabling greater availability, accessibility and sense of responsibility on the part of those involved.

Conclusions

1) I am of the opinion that taking the practical training placement in another country, particularly within the European Community, is a unique experience, enabling a more global view of Medicine which should be accessible to all Interns of the Specialty.
2) The British Health System, though not without its faults, meets the needs, in general, of the population for whom it is designed. It is, however, a very costly system, which seems to run the risk of financial rupture in the medium term.
3) Medical training is seen as a serious form and is considered priority, which obviously ends up bring important dividends in qualitative terms.
4) However, it is thought that Careers, as they exist, will have to undergo a change, in order to adapt to the norms of the European Community, hoping that the latter knows, also, how to make the most of the many positive things about the British system, in order to improve in that which still needs to be done. ■