# Travelling Fellowship

## Balancing Priorities

The last ten years have seen significant changes in healthcare structure within the United Kingdom. The current mantra promoted by the government is "Primary Care-led NHS" which has led to considerable increases in resources being offered to the primary care sector. This, together with a major change in the way that healthcare funds are contracted at the local level has caused conflict and perceptions of inequity in funding provision and service delivery.

There has also been a perceptible change in the mode of delivery of care within the community sector. It is now uncommon for Family Medical Practitioners (GPs) to offer 24-hour care for their own patients, most care out of normal working hours now being delivered through GP Co-operatives or through contracted out services. GP's are increasingly being encouraged to develop their own special interests to decrease the secondary care workload.

The decrease in working hours for hospital doctors at a time when there is a moratorium on increasing numbers of trainees has led to a dependence on "Non-Consultant Career Grade" doctors (Staff and Associate Specialist Grades, SASGs). There are a number of doctors working in positions that are not clearly defined (Trust grade, Clinical Fellows). All these doctors require Continuing Professional Development and a career structure to follow. The balance between training grade doctors and those in "non-training" grades has led to some inter-personal conflict and a sense of grievance in many cases. There is increasing dependence on locum doctors to provide cover through anti-social hours and a decreasing number of skilled doctors wishing to provide this service.

There are suggestions at governmental and senior professional level that the secondary care service would be best provided by junior Consultants who carry a greater share of the patient load, freeing their colleagues to devote more time to managerial, teaching and supportive roles.

## National Health Service (NHS) in the UK

Healthcare in the NHS in the UK is free to all at the point of delivery. Patients can only access specialist care via the General Practitioners (GPs) many of whom practise in purpose-built Health Centres.

Hospital specialists usually offer services from their hospital base. Few GPs have sessions in hospitals: Few Consultants attend Health Centres.

Hospital sites in the UK are generally larger than those in North Carolina. District General Hospitals (DGHs) typically serve populations of 250,000. Tertiary centres usually serve their own population and provide tertiary services for referrals from 10-20 DGHs. Tertiary specialists in some specialties offer outreach clinics in DGHs.

Each hospital in UK has a Postgraduate Clinical Tutor who is a full-time clinician who also has responsibility for co-ordinating and monitoring postgraduate medical education.

Health care in the U.S. is based much more on a free market system than in the U.K., and is delivered in a variety of settings. Payment is required at the point of delivery, and health insurance coverage may be either private or public. Medicare, the federally funded and administered health insurance program for persons over 65, covers approximately 18 percent of the U.S. population. Medicaid, the federally and state funded insurance program for the poor, covers an additional 15 percent of the U.S. population. Approximately 50 percent of the population has private health insurance, normally provided through one's employer.

Approximately 15 - 20 percent of the U.S. population has no health insurance, and is required to pay out-of-pocket for any health care. Realistically, many of the uninsured are unable to pay for expensive services, and thus receive care in large teaching hospitals or in other public facilities that take patients regardless of ability to pay.

Most physicians in the U.S. are in private practice, either in small single-specialty groups or in larger multi-specialty groups. Regardless of whether they are a generalist (family physician, general internist, or a general pediatrician) or a specialist, most physicians have both an office-based practice and admit patients to their local general hospital. In this way, they follow their own patients when they are admitted for in-patient care. Over the past 10 years there has been a growing trend towards hospital-employed intensivists, both in adult medicine and in pediatrics. This is still a small percentage of physicians, however, and most physicians continue to admit their own patients to the hospital.

**Access to care**

North Carolina's population is almost 30 percent ethnic minority. Approximately 22 percent of the North Carolina population is African-American, 5-6 percent Latino/Hispanic, and 2-3 percent American Indian and other underrepresented minority groups. As a result, there are particular challenges in providing equal access to health care for all ethnic and racial groups. Research clearly indicates that a more diverse health care workforce is better able to provide access to care for the entire population. A compounding problem is the fact that there are significant disparities in health status among different ethnic groups, with underrepresented minorities having higher levels of infant mortality, substantially greater incidents of chronic illnesses, and higher incidents of accidents and other forms of injuries due to violence.

The University of North Carolina and the AHEC Program have a long history of special initiatives to recruit more minority students into medicine and other health care fields. In addition, the AHEC Program conducts continuing professional education programs throughout the state to better educate health care providers on issues of diversity, health disparities, and related issues. A particular challenge over the last decade have been the dramatic growth in the Hispanic and Latino population in North Carolina, requiring a significant increase in bilingual providers and interpreters in order to provide more appropriate health care for this burgeoning population. The Latino population is concentrated in both urban and rural areas. In the urban areas, the outpatient clinics operated by the teaching hospitals at both the academic health centers and the AHECs now have a high percentage of their patients who speak only Spanish.

## Service versus Education

In the NHS there is a constant tension between service and education. This is the case both for juniors in training and for the staff who train them. Each trainee is supposed to have at least 4 hours of protected time for teaching. This is stipulated by the Postgraduate Deans, who manage Postgraduate Medical Education (PGME) and hold the budget, and also by the Royal Colleges and faculties, who have set the standards for PGME. However, most juniors are in busy jobs and there are not enough doctors to allow protected time, even for the majority, in many departments. Consultants have had numerous responsibilities loaded upon them in the last few years. For some, education is just one of a long list of duties. Although teaching is an implicit part of the NHS contract for all Consultants, hospitals are often reluctant to identify the sessional time for Consultants to teach, when there are other pressures such as waiting lists and service targets to meet. This situation will be put under more pressure when the European Working Time directive (q.v.) is implemented and junior staff move to shift working in all specialties, with some of their responsibility predicted to divert to Consultants, without extra time being identified. Teaching may suffer, though attempts to realign "spoon-fed teaching" to renewed apprenticeship learning are underway, encouraged by the document "Liberating Learning" from the Conference of Postgraduate Medical Deans medical education working party (available at www.copmed.ac.uk). Despite these problems, teaching in the NHS is acknowledged to produce a high standard of medical care.

## Medical Education in the UK

Undergraduates enter medical school aged 18 and train for 5 years. Many courses are now based in problem-based learning.

After finals, the newly qualified doctor has to do a year's pre-registration house officer (PRHO) posts. At the end of this first year, the doctor can fully register with the General Medical Council (GMC).

The pluri-potential doctor may then do a series of 6 months posts in hospital as senior house officer (SHO). Few posts are linked together in programmes though GP trainees may join 2-year rotations (The NHS plans that this will change for hospital specialist posts radically over the next year). During these posts, doctors prepare for exams (depending on specialty). After 3 years or so as SHO, trainees can apply for specialist registrar posts (SpR) in their chosen career. These SpR posts generally last 5 years, at the end of which successful trainees collect a certificate of completed specialist training (CCST) which enables them to apply for Consultants posts. Most Consultants work in hospitals and stay in the same post until retirement.

During the training years, the Royal Colleges and Faculties set the standards for training and education. The Postgraduate Deans control the medical education budget and annually monitor posts that provide training. The Royal Colleges conduct an in depth inspection every 5 years. Medical education in a hospital is co-ordinated by the Postgraduate Clinical Tutor.

## Medical Education in the US

Most students enter medical school in the U.S. following completion of a four-year undergraduate degree, either a bachelor of arts or bachelor of sciences. Students come to medicine from a wide variety of fields, however, all students must complete the core set of pre-med courses in the basic sciences in order to gain admittance. Medical school is four years leading to the MD degree (or DO degree in the case of schools of osteopathy). The first two years in most medical schools are spent studying the basic medical sciences, with the third and fourth years primarily focused on clinical training.

Following receipt of the MD, graduates enter a residency program through the national residents matching program. Residency programs have a clearly defined length in the U.S., unlike the U.K., although they vary from specialty to specialty. Family medicine, general internal medicine, and general pediatrics are three-year programs, and obstetrics and gynecology is a four-year program. Other specialty training programs vary in length from three to seven years, and some surgical fellowships may be even longer.

In North Carolina, there are four schools of medicine and numerous residency programs, based at one of the four university medical centers or at one of the AHEC Centers. UNC-Chapel Hill and East Carolina University are state schools and Duke University and Wake Forest University Schools of Medicine are private schools. Five of the AHEC Centers have family medicine residency programs, four AHECs have internal medicine residency programs, three have pediatric residency programs, and four have OB/GYN residency programs. In addition, three AHECs have surgery residencies, and in Charlotte, a large academic teaching hospital, there are also programs in orthopaedics, emergency medicine, and rehabilitation medicine.