**PEP Specialist Stream – Reflective Task Example 3:**

Working in Australia as a doctor has been a long standing ambition. The chance to work in a beautiful diverse country and get immersed in a different culture, and learn about a new health care system was the dream. The process to get here was not straight forward with much duplication and unnecessary red tape. However after 10 months I finally started my new Job. I was expecting it to be different but I was shocked at how different the level of care is. In the UK everyone is treated the same regardless of financial status, ethnicity, or immigration status. Healthcare is free at the point of access. Although this leads to over/misuse (in the minority) it works well and patients get what they need (may have to wait if non urgent). Within the first few weeks I noticed how different it is here and there is definitely a two tiered system. Those with private healthcare have access to fantastic facilities and care, but those without often go without or have to travel vast distances/ wait years to get care. Unfortunately, those who are in a low socioeconomic class and/or in a regional area are disproportionately affected. I find this hard to deal with sometimes when there are desperate patients in front of me and I am helpless to help them. However I have a supportive team and have found ways to cope to avoid burnout.

After this initial shock, I have come to love my current role. It is far more varied and flexible, and I am able to spend as much or little time with patients as required and get paid for the work I do. In the NHS it was 10 minutes per patient regardless of the number or complexity problem. Additionally I am able to use minor op skills and skills learned from working in ED as quite often you are the ED doctor. Prescribing is a lot more free and less process/guideline driven. although seeking PBS authority is unnecessary and time consuming in most cases.

Like all new jobs there have been several challenges to get to grips with. The first major one was the billings system. In the UK this simply doesn't exist. The practices are paid by the government and we get a salary based on the number of 4 hour sessions we do. Here the vast majority of numbers and what can and can not be billed together is confusing. As time goes by I am getting use to the common codes and my practice manager and other colleagues are very approachable and are able to help with any queries I have. I have signed up to AusDoc and get monthly 'cheat sheets'. I am also aware of courses that I may attend to maximise my billing potential.

Moving here I was also very surprised at the extremely high rates of opiate and benzodiazepine prescribing. I am not sure if this is a nation wide, regional or [anonymised] specific issue but it is a huge problem for many of my patients. In the UK benzodiazepines are given out for short term severe psychological disturbance only. They are not routinely given for back pain or sleep. Part of my UK role was trying to wean patients of these medications and so coming here where they are requested multiple times per day has been a challenge. I am trying to re educate and wean patients off where possible, but the damage has already been done (dependence). Similarly in The UK the strongest opiate we could initiate on patients was co-codamol (panadine forte) or tramadol. Yet the ED and GPs here regularly give oxycodone and tapentadol. Becoming comfortable initiating and

monitoring this is a learning curve but the eTGL and AMC are great resources. The other doctors have been great too and the same rules apply. If you are not competent or don't think it is the right thing to prescribe we can say no. Generally the patients understand if they have been educated on the reasons and alternatives are offered e.g. weak opiates/NSAIDs/ pain clinic etc. Another challenge linked to this is brand prescribing vs generic. In the UK to avoid confusion/ drug errors 99% of medications are prescribed by drug name. Only lithium and various antiepileptic medications which come in different formulations are prescribed by brand. Historically, medications here have been prescribed by brand name. For me it makes prescribing more tricky because if a patient asks for it by brand I have to look up the medication to know what they need. Additionally initiating new medications is more difficult as combination medications and brand name make drug errors more likely (duplication). To avoid this I switch prescriptions to generic, as per RACGP guidance, and double check all medications before issuing.

The final major challenge I have come across is the lack of continuity between primary and secondary care. In the UK all medical records from secondary care are shared with the GP. Any clinic letters/pathology, Ed admissions come through the GP so we are fully aware of the patients journey and any follow up care required. If a patient is admitted to a hospital out of area or seen by an out of hours care provider, if they are registered with a GP their records will follow. If they are not registered we have a team of secretaries who can contact those departments and obtain records easily. Signed consent is not required, only informed consent. Additionally whenever a patient moves practice, their medical records automatically follow. I have found here, given the two tiered system and size of the country records are often incomplete. If medical records are required, signed consent is needed for each individual organisation. Patients do not often know addressed or names of doctors making the process time consuming. If we get a response medical records are often little more than an A4 sheet of paper. This is an institutional/national issue and something I can not fix. Now that I am aware of it I can manage patient expectations and have to treat every patient on their merits and manage their care as best I can.

I have found the e learning modules to be very beneficial and far more helpful than the other aspects of the PEP course. Within England different cities and towns and even boroughs within each city have different health needs. The module looking at the health needs of the local population has been very useful. I expected most people here to be very fit and healthy due to the climate and access to outdoor activities. Here in [anonymised], I was shocked to see extremely high rates of obesity CVD and diabetes (much higher than the national average and the worse in [anonymised] on some metrics). The module helped me realise the importance of preventative care and utilising health checks. It also corrected the incorrect stereotype I had. I am much more aware of the prevalence and actively screen for this and offer lifestyle advise at every given opportunity.

Prior to starting work in Australia, I had never thought about aboriginal health. It is a neglected part of history that needs to be taught and I was truly shocked and ashamed of the atrocities that occurred. The modules were well thought out and explained the history in a sensitive manner that shows why there are such health inadequacies between first nation people and 'Australian citizens'. The key learning point for me was there is a gap and we as GP's need to be alert to the types of illnesses this population is at risk of. I now actively ask my aboriginal patients about their mental health and follow them up if they miss a health check.

The last major learning point I took from the modules was around schedule 8 drugs. These would be akin to the UK schedule 2 drugs also known as controlled drugs. Whilst the rules are broadly similar it was very good to be guided through the differences, laws and practicalities of prescribing these drugs in [anonymised]. The key thing I ensure I do for every request is to check Q script before

prescribing. This ensures patients are not doctor shopping and drug seeking, thereby protecting the patient from overdose, me as a prescriber and the wider population by preventing opiate drugs entering the street market.

Looking to the future I have identified several areas that I would like to expand my knowledge on and develop an interest in.

Australia has a very high incidence/prevalence of skin cancer. Whilst in the UK, we get taught how to recognise skin cancers, the management is left to dermatologists. As such I feel that this is a weak area for me and something that is vitally important to become proficient in. Whilst I am able to do excisions/biopsies etc I would like to be much more confident in making diagnosis and using a dermatoscope. I have bought a dermatoscope and have done some e learning and am currently looking at enrolling on a course to further develop these skills.

Another passion of mine is elderly care. I initially wanted to be a geriatrician, but the training was not conducive to a good work life balance so I retrained as a GP. Historically in both the UK and Australia primary care in residential aged care facilities is poorly done. I aim to try and improve the care received by residents locally by setting up regular weekly visits to care homes to build those relationships with residents and staff ultimately improving their physical/medical and mental health. I am doing this in conjunction with a nurse who is passionate about chronic disease and if the pilot is successful will look to expand. I hope doing this expands my knowledge of elderly care medicine as well as improves health outcomes in this population.

Throughout my medical career so far, I have had the opportunity to teach medical students and junior doctors. This is something I really enjoy and hope to expand on and ultimately be able to teach GP registrars. I recently attended an ALS course at the [anonymised] base hospital where I was fortunate to meet the head of medical education at University of [anonymised]. She was very keen on getting volunteers to help mentor students. on completion of the PEP program and once I have fellowship I will contact her with the aim of gaining some education experience here before enrolling on a PGdip in medical education. I hope once I have achieved this I will then be able to start teaching registrars.

My final aim is to gain the ability to help manage drug dependancy and addiction, particularly with respect to opiate substitution therapy. This was a challenging part of my role in the UK but I really enjoyed. I found that this cohort of patients were not  only quite often psychologically damaged but often have severe chronic disease making them a medical challenge. To help expand my knowledge in drug misuse, I am enrolled on a medicinal cannabis course for the [anonymised] as this is unfamiliar to me and I have been asked about a lot. I have also made contact with the local OST team and hope to observe them and complete the required course to be able to prescribe OST myself (current practice permitting).

In summary, coming to Australia to work has been a lifelong ambition. It has been tougher than expected but the support and modules have helped me fit in and get unto speed quickly. For a UK trained GP graduate I feel the PEP program is not required, but the modules have been useful. I am enjoying my role and aim expand my working practice and knowledge to help the needs of the local population.