Sydney South West GP Link

GP LINK Lunches | Rhianna Monahan

Dr Kenneth McCroary, Chair of Sydney South West GP Link, hosts a series of meetings with clinical/ political/regional individuals or organisations to discuss issues and solutions for GPs working in South Western Sydney.

Rhianna Monahan Ken McCroary

Ken McCroary - At Macarthur General Practice last year, I received an email from the University of East Anglia-Norwich Medical School, in the United Kingdom. Rhianna Monahan was a final year medical student hoping to do an elective in general practice medicine in Australia after finishing final exams.

She mentioned her degree program had been evenly split between clinical and academic work, having started placements from the first week of the course. This framework had given her a lot of clinical experience and she'd developed good clinical skills and reasoning.

Rhianna studied all areas of medicine in the course and, at the time of application, she was doing emergency medicine modules and advanced life-support training.

After graduation, Rhianna was planning to start work in the National Health Service (NHS)as a junior doctor in August 2023. She intends to complete the life foundation training program over two years and then apply for general practitioner training. She is interested to see how the Australian healthcare system differs to the United Kingdom's system and to see the differences in lifestyles for doctors in the two countries. She was hoping to use that knowledge to inform her choices about where and how she wanted to practice in the future.

During her studies she had a variety of hobbies including ballet and other dance classes, weight training and baking. She also worked part-time for a nursing agency at care and independent living homes.

Macarthur General Practice has a long history of training and educating medical students both from the University of NSW and the Western Sydney University. We accept students and regularly have them in the practice from years one to six. The practice is designed as a teaching practice with a multidisciplinary culture of ongoing learning and education, with a GP-led team approach with primary care nurses and allied health including onsite dietician and exercise physiology. The team was keen to participate in hosting an elective student and looked forward to welcoming Rhianna to the practice in 2023.

We were also interested in discovering more about the health systems and particularly the education delivery from other jurisdictions, and we were expecting an enlightening experience with an overseas student joining us for six weeks.
Rhianna is currently halfway through her term with us in South Western Sydney and I am pleased she joined us today to discuss the experience so far.

Ken McCroary – Rhianna, tell me about East Anglia University?

Rhianna Monahan - It is a university in Norwich, England. Its medical school started in 2008 and is one of the newer ones. The actual university has been around since the sixties and is quite large; there is 20,000 odd students.

Ken McCroary - What has the journey been like through medical school at Norwich?

Rhianna Monahan - The Norwich Medical School undergrad degree is five years. There is a course with a foundation year for students who have not done so well at school and has widening participation - that is six years. It is a mixed curriculum so you start placement from the first week; you have GP placements every year and usually do one day a week in general practice, and the other days of the week are in lectures and tutor sessions and things like that. Then you will have four-week block placements where you go to secondary care in hospitals. Throughout, it is about 50/50 academic and placement-based learning.

Ken McCroary - You would get a definite amount of hands-on experience with patients face-to-face?

Rhianna Monahan - The University of East Anglia is the most hands-on medical school in the UK, and quite proud of that fact. And certainly, it has been the best way for me to learn. Other courses in the UK are clinical, and they have a pre-clinical element where you don't see patients until your third or fourth year. That works for some people, but this method works better for me.

Ken McCroary - W**hen you were doing your onsite uni lectures and tutorials, what was the teaching methodology like? Was it more didactical or more problem-solving based or more about learning stuff?**

Rhianna Monahan - There is a real focus on problem-based learning in the sense that each week you start with a case to look at based on whatever current area of medicine you are studying. You then address learning outcomes. There is also a list of other things you want to be looking at. Most lectures are more didactic, but lecturers will add in more cases and questions and try to be more interactive, or at least the good ones do. But yes, most tutorials are very interactive.

Ken McCroary - Is it large lecture-based mainly, or do you do a lot of smaller group peer learning?

Rhianna Monahan - I would say it's about 50/50 most of the time. During the COVID lockdowns we went to a kind of mass teaching model because it was just online with one person doing a lecture. But during normal times, it is about a 50/50 mix of big, large-scale lectures and smaller group teaching.

Ken McCroary - I was going to touch on that. You are in your fifth year now, so you have gone through face-to-face and COVID and now getting back to face-to-face; it has been a bit of a roller coaster ride. How did you all cope with the transition to online learning and the changes brought about by the pandemic, particularly in the UK?

Rhianna Monahan - In the UK, we were hard hit by COVID in March 2020. It was a rocky start. I was starting my rotation in respiratory medicine just as COVID hit; the people teaching us were respiratory physicians and they were preoccupied. My area of the year group had the worst experience at that point; everything was a bit haphazard to begin with. Lectures were cancelled at the last minute or didn't happen at all, or someone would put up some slides with no context. One presentation was put up with a load of slides with no text and the idea was the lecturer would talk through them all, but they never had. It was completely useless; it was just a load of pictures that meant nothing to us. We gave a lot of feedback to the university that we weren't learning anything, and they saw issues in people's attainment. That year our exams were waived so everyone was allowed to move into the following year regardless. The following year things were slightly better - that was my third year. They had gotten the hang of it and taken feedback on board and much more was done properly, but we were still online for most things. We went back to our placements in person though people were still missing bits because they would catch COVID or a household member would, but it was much better in the third year. By the time fourth year rolled around, all our restrictions were lifted and we kind of returned to as it

was before. But certainly, online teaching was more accepted at that point, and the university struggled to get us to come back in person. A lot of us had become used to online lectures and we also realised it was more efficient rather than commuting to the university, especially if financial pressures meant you struggled to travel. For those with chronic illnesses, where getting out of bed was more of an issue, why couldn't they study from home? If they were allowed to do it through the pandemic, why couldn't they continue? The university did have a battle and they tried to enforce and measure attendance. I don't believe this thinking made things better. Adults were being treated like children when most of the world was, quite rightly, discussing with their employers, "look, we want to have a kind of hybrid working.". It did have its issues and it is still being debated at the university … how things should proceed.

Ken McCroary - Those discussions, were they one-on-one with your lecturers or did you have student bodies and medical undergrad organisations? How does that work in the UK?

Rhianna Monahan - There is a student union with representatives of each year group in the medical school. The medical school will meet us through the student union, but also separately. During the pandemic there were often Q&A sessions on Zoom and things like that, where we could give our feedback. At the end of each term, we also submitted a kind of feedback survey, and the uni was supposed to act on everything in there.

Ken McCroary - One of the things we've talked about a lot is the system differences - the Australian system versus the systems you work with in the UK, and the National Health Service. Training for that service … we need to learn a little bit about what the NHS is like.

Rhianna Monahan - The purpose of the NHS was that everyone should be able to access free health care at the point of use. All health care deemed necessary is paid for by taxes, though what is necessary has changed a lot over the years and can even depend on which postcode you live in. Common things, controversial because of what is deemed necessary or not, include IVF. Depending on where you live, you might get one round of IVF or up to five cycles. That is an unfair system as there could be a discrepancy because you live on the other side of a town. Plastic surgery, for example, is not covered unless it is reconstructive. That's what it's like from a patient perspective. Obviously, it must be funded from taxes and our tax burden is quite high, but I don't think it is particularly out of line with the rest of the Western world. Because of this, it is quite an underfunded system so waiting lists are currently very long. I had surgery a few years ago and had to wait 18 months for what was a routine procedure. Certain joint replacements are taking up to six years at this point, and the general referral criteria for a knee replacement is you need to have some level of disability before you can have surgery or otherwise it is considered unnecessary, and you should go private. That would cost 6000 GBP which would be about $12,000 AUD.

Ken McCroary – Private, as in paying up front? Is there much private insurance?

Rhianna Monahan - Bupa operates in the UK. I would say the upper middle to upper classes are the people who would have insurance. I do not have insurance in the UK; I have never felt the need. But more people are considering it as an important thing to have because they are ending up in situations which can be quite dire. They need surgery or whatever, quite urgently, and they don't have private insurance to fall back on. It is becoming a big market. I think it has experienced quite exponential growth in the last five to 10 years because of the situation with the NHS.

Ken McCroary - Is there any cross subsidisation from government and the private insurance health sector?

Rhianna Monahan - The government doesn't give any money towards the private services, however, sometimes NHS hospitals will have a private wing and they will use the money brought in by the private patients to fund shortfalls in other parts of the hospital. But there is no subsidy for private work - if you want to get your knee replacement done privately that is your choice and you pay for it in full.

Ken McCroary - It is interesting hearing it from a patient's perspective. What about as a doctor in primary care - the perspective of a GP working in the NHS?

Rhianna Monahan - GPs in the NHS are quite different to GPs in Australia, in terms of autonomy, time and priorities. A GP consultation in the NHS is now fixed at eight minutes and you can have double appointments, but those would tend to be for things like procedures. Occasionally we do double appointments for things like mental health, but generally it is eight minutes. A patient is only allowed to have one problem. If you mention something else, the GP has the right to say "no, you need to make another appointment". GPs must do that because after eight minutes there is another patient booked. GPs may work from about 8am to 6pm on a full-time rotor, although most GPs are part-time on the NHS because the stress of full-time work is too much on many of them. In terms of pay, a fully qualified GP - which is two years of internship and then three years of GP training - starts on about 70,000 GBP (equivalent to about $140,000 AUD). It is decent money once you get there and, if you are a young adult without dependants, it is a nice sum. But for the amount they are working, most GPs are considering other options. Most GPs go part-time and then do something else, whether that be private work one day a week, teaching one day a week or they might do some academic research.

Ken McCroary - Do you still want to go become a general practitioner yourself?

Rhianna Monahan - Yes.

Ken McCroary - When you were planning on coming to Australia, we talked about expectations of training in the system. What were your expectations of the training and the system here?

Rhianna Monahan - I knew the system was more relaxed in terms of time and autonomy. I think doctors here are trusted and respected more and their decisions are taken more seriously. In the NHS, there are lots of criteria and specific standards you must match, and you are always expected to work within a guideline of some sort. From what I have seen so far of the Australian system, there is a bit more emphasis on using your professional judgement and experience.

Ken McCroary - Before you arrived, were you expecting it to be very similar or a little bit different?

Rhianna Monahan - I was expecting it to be different - similar medicine, but a different approach.

Ken McCroary - Different in a positive or a more negative way?

Rhianna Monahan - I think it depends. The NHS system works for what it works for. I think if we transferred to the Australian system onto the NHS, it would cause a lot of problems. We wouldn't have enough doctors to make it work, however, I do understand there is a better prevention system and a better system for patients to get better care in Australia.

Ken McCroary - W**hat about for your training here: were you expecting a similar style, similar style lectures, tutorials and face-to-face?**

Rhianna Monahan - I think I expected it was - more like the more academic degrees in the UK. But I thought the post graduate training would be like the UK, and that is pretty much what I found.

Ken McCroary - You also talked about exploring the lifestyle differences between doctors in Australia and doctors in the UK. What did you expect to find?

Rhianna Monahan - A lot of doctors moving abroad, from the UK to Australia, say there is a better lifestyle - I wanted to see if the grass was greener. There is a different lifestyle in the sense it is more relaxed in Australia. In the UK, if you go part-time at any point in your training that is seen as a big negative. It is seen as a failure, and it is not well accepted. Whereas here, it feels like most of the GP registrars are doing four days or less and

it's not considered part-time or not doing enough work as it would be in the UK. It is more of a work/life balance here, I think.

Ken McCroary – There are some underlying culture differences, too, in terms of the pressure to be full-time and the pressure they are under and not being supported.

Rhianna Monahan – Generally, UK doctors don't feel supported by the system, partially because of the renumeration and partly because the NHS culture has become toxic in the sense that if you're not burning yourself out then your patients are suffering and that is your fault. The reality is if you need to work that hard for your patients to be safe, that is not your fault; that is the fault of the people who have not trained enough doctors to keep them safe without killing themselves (from overwork). There are horror stories at the NHS, of people who get called into work for an emergency on their wedding day. It does happen and it happens quite often, doctors cancelling big life events. It is not a great system as a doctor, currently.

Ken McCroary – Can you explain what an elective term is and what you are expected to do?

Rhianna Monahan – I believe most medical schools in the UK offer the chance, at some point, to do an elective four to six weeks - and this is where you choose to do whatever you want. My medical school had two electives: one in the UK and one that could be abroad. The UK one is where you learn to practice in the NHS in a field you are interested in, and the typical abroad one was to experience life outside of the NHS and see how medicine can be approached in a different system. I have some friends currently in Great Ormond Street Hospital, a large paediatric hospital in the UK and very specialised. I also have a friend in Vietnam, and they are just doing random things.

Ken McCroary - What attracted you to do your elective in Australia?

Rhianna Monahan - I wanted to experience a system outside of the NHS and as I don't speak a language other than English, I decided it needed to be an English-speaking country. I didn't particularly want to go to America because you hear of a lot of problems in that system, and a lot of people in the NHS have been to Australia or worked here for six months. I thought while I am not connected to a job yet, it might be a good time to go and see if it is for me.

Ken McCroary - More specifically, was coming to South Western Sydney a conscious decision?

Rhianna Monahan - I wanted to go to Sydney just because it is Sydney! It is the most famous Australian city in Britain, and it seemed like there was lots to do and explore. Sydney was kind of chosen based on less of the work and more of the holiday part of it.

Ken McCroary - Sydney is a big place and there are lots of different regions in the city; working in the outer metro is a lot different to working in the inner city and the eastern suburbs. Was that important to your choices?

Rhianna Monahan - I did think going further out would potentially mean more was done in the surgery. I know in the UK the more rural a surgery is, the less likely they are to be referring for this, that and the other, because services are not close and your patients can't get to wherever if you are rural. Obviously, this (SWS) is not particularly rural, but it more suburban so more things get done inhouse, I think.

Ken McCroary - You have been here for a while and what have you learnt?

Rhianna Monahan – I've learnt a lot about the Australian system. I've learnt a lot about dermatology and skin cancer because they aren't a big issue in the UK. Whenever someone in the UK gets skin cancer, we always look at the history of living abroad or people using tanning beds. I have learnt a lot more about preventative healthcare, diet and lifestyle and diabetes control. We do all of that in the UK, but there is less of a focus on it.

We tend to have secondary prevention, not primary prevention. Because of funding in the NHS, a lot of primary prevention is not indicated. It is only when a person already has had the heart attack, already had the stroke, that we can do anything, which is unfortunate.

Ken McCroary - Prevention is considered unnecessary, is that what you are saying?

Rhianna Monahan - It is not considered unnecessary; there is less time for it. If you have 20 people coming through the door today with an MI and you don't have time to see the person with raised cholesterol, who do you chose? You need to see the person with acute MI, not the person whose LDL is high. It's the person who is going to die that you need to sort out first. That's primarily an issue with the founding of the NHS as a point of use. Things are free because it became a system based on "we have a problem, let's sort it out now", and preventative health care with the NHS, which was founded in the fifties, wasn't really a thing. The NHS was built for coughs, colds and emergencies; it wasn't built for preventative healthcare, long-term health, chronic conditions and elderly populations. The primary issue, now, is that to do a switch into that kind of health care is going to take a lot of funding and structural change.

Ken McCroary - What other things have you found different? You have spent time with the registrars, and you've met our local medical students and had discussions with them. In terms of learning - the undergraduate learning, the post graduate GP training and what you have seen here with us - what has been the most markedly different for you?

Rhianna Monahan - When I've spoken to some of the medical students and the registrars, there is less trust in juniors here, I think, and I don't think that's a bad thing. In the UK, as soon as you're qualified and on the first day of actual work, you can be left because there is less oversight and less seniors around. A higher standard is expected of us at an earlier stage, even though we don't necessarily have enough experience to be taking that on. Once I graduate in a couple of months, I could be left to look after the entire inpatient population of the hospital at night. There will also be two registrars on hand at the hospital, but they will be in A&E all night. The rest of the hospital, who may be stable but are all hospital patients and theoretically could crash at any time, will be my responsibility. While I will be able to call for help, help might not come. That doesn't seem like as much a thing here, that you would be just left in that situation without senior support. In the last few years of my training, we were given a lot more responsibility in the NHS. In my final placements, I was often doing parts of the ward round on my own such as writing up the notes. I would flash the notes in front of a senior and they would read them over and say "yes that's fine, done, don't need to see that patient", and that patient might not be seen by a doctor for that day or maybe two or three days if they were stable. Obviously, if I had any concerns at all I would immediately be saying "I don't like this at all; please, can you see this patient", but yes, I feel in the Australian system patients will be seen by a doctor. A medical student is an accessory to the team.

Ken McCroary - W**hat about in general practice in Australia, in terms of the differences in training and experience?**

Rhianna Monahan - Obviously, you see less patients here because of time, but in terms of training I get more out of it when there is only eight minutes for a consultation. There is not enough time for a med student to do much; you just sit in a corner. In some placements, the GP will sit in a corner and you will run the consultation, so you get to learn but there is no time for of teaching. So, it is definitely a better environment to learn in for the student.

Ken McCroary - We are set up as a teaching-based practice – we don't reflect every practice – so there is that extra time we put aside for the training. You mentioned you are still interested in being a general practitioner in the UK, despite the NHS and its shortfalls. Where did that interest in being a GP come from and why do you want to be a GP?

Rhianna Monahan - When I went to med school I was interested in paediatrics and psychiatry. I still have an interest in paediatrics and milder psychiatry. I have learnt inpatient psychiatry is not my thing – it was very high

pressure in the NHS. I enjoy those topics still, but there was no topic or area of the body that I wanted to do for the rest of my life and I would have gotten quite bored. For someone who wanted variety, I felt something generalist was the way to go. In the UK general practice is very intense with a quick turnover and lots of variety all the time. There is also initial diagnostics and initial investigations - I enjoy those parts of medicine and I enjoy the figuring-out part of medicine. The diagnostics is more fun for me.

Ken McCroary - One of the things important in general practice and health care is keeping your balance right: keeping people healthy while avoiding burnout yourself. I know you have a bit of a mixture with your interests, so do you constantly work hard to balance your study and your health? Or is it something you do get supported to do?

Rhianna Monahan - I have to work on it. I've had health problems in the past and I continue to have some. I am no good if I am not healthy myself. I try and put aside time to attend any appointments I need, but I also try to put aside time to go to the gym and do things to relax myself. I make a conscious effort to do these things and try and recognise I am more likely to get things done tomorrow if I take care of myself today.

Ken McCroary - You joined us for one of our events with GP Link our Breaking Down the Silos with GPs and non-GP Specialists, and you mentioned you found the Aboriginal and Torres Strait Islander presentation interesting and different. Do you want to expand on that?

Rhianna Monahan - We do not have Aboriginal and Torres Strait Islanders and, if we do, I haven't met any. There is not an Indigenous population in the UK in any particular sense. We have a varied ethnic mixture … I don't know the exact percentage, but there is a sizable minority now of non-white and there are race discrepancies in the UK. But the bigger discrepancy is wealth. There is a famous graph that shows the London Tube map and all the stops along one line. Your life expectancy from each stop goes down one year; between the middle of this line and the end of this train line there is a seven-year difference in life expectancy. That is more of a wealth thing. People in minority ethnic groups are slightly more likely to be in lower socio-economic classes in the UK, but it is not as stark as it is in Australia. I was interested partly because when I spoke to the person doing the talk, they said there was not really a genetic component to this. A lot of the discrepancies we see in ethnic minorities in the UK, in terms of their health outcomes, are primarily genetic. South East Asians are more likely to develop diabetes as there is a genetic link and a cultural link in terms of food. It is not necessarily to do with any kind of socio-economic problem. White males tend to develop heart disease and things in the UK because it is a socio-cultural thing - the food they eat, the diet they have and the way they live their lives. But there is a socio-economic focus in the Aboriginal and Torres Strait Islander health, so that was interesting. Obviously, I don't know anything about the history or the specific issues with that community because it is not taught in the UK. It is interesting to see that kind of alternative issues in medicine, but also the alternative community-led approach the Tharawal Medical Centre was taking - what does that community want from health care and how can we serve them, rather than giving them all of this medication and lifestyle advice that might not be applicable to them?

Ken McCroary - Your term is nearly halfway through now, isn't it? How do you think it is going and would you recommend it?

Rhianna Monahan - I think it has gone very well; I would recommend it to other students in the UK. It has been expensive … I do get some funding from various things in the UK but, even so, it is a lot of money, and it is a long time away from my family. But it has been an interesting placement and I have learned a lot, not just in terms of the medicine but as this is the first time travelling on my own I've had to do some growing up as well.

Ken McCroary - You are doing tremendously, and I hope I see you abandoning the NHS and coming back here in the future. Thanks for talking to us today. On reflection within the practice, I asked the team members for their comments.

As a registered nurse Jess, what was it like having a student from the UK in the practice?

Jess – Rewarding. I think we both learnt a lot from the experience because she could explore the health care system in the UK with me and I could explore the healthcare system in Australia with her. It was rewarding on both sides of the coin.

Ken McCroary - What do you think the practice has learnt?

Jess - The practice has learnt the teaching methods and needs of students are quite similar across the world. The UK and Australia have similar teaching techniques and what Rhianna learns is similar, I suppose, across both countries.

Ken McCroary – Keersten, as a GP registrar and from your perspective, what has it been like having a student from the UK in the practice?

Keersten - I think there has been a few factors: the first one, obviously, is how interesting it is to have someone from a different healthcare system and having that different perspective and how things run differently here compared to in the UK. So, hearing about that has been interesting, the good and the bad. And then, just generally, having a medical student - they are always good at making you learn more because they bring their own knowledge to the table and make you question things more than you would normally.

Ken McCroary - What do you reckon the practice has learnt?

Keersten - That leans towards that first part I was speaking about in the last question, in the way that different healthcare systems work and what we can learn from them to improve - seeing what things we can take into our practice and add in, making things more streamlined and making things more efficient. And working out that if we do have more resources, what are the best ways to use them.

Ken McCroary – Jacob, as a senior registrar, what's it been like having a student from the UK in the practice?

Jacob - It has been fantastic. Rhianna is knowledgeable and understands a lot about medicine. They have a very good education system over there. It is good for me, too, as it keeps me on my toes. She asks me a lot of questions. It is always a beneficial experience teaching, so that is helpful for me as well as her. She is learning from us as well; she is learning about our system and the way we do things here.

Ken McCroary - What do you think the practice has learnt?

Jacob – We've learnt having a student from overseas is beneficial to us.

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