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Northern Ireland Healthcare Crisis

'The second in a short series of articles in which doctors from various specialties, backgrounds and experience are asked to express their personal views on their career, and thoughts about the future, in the light of the current crisis in healthcare provision in Northern Ireland'

David J Armstrong, Editor

A Year Down Under: Perspectives from a distance

In a 2022 British Medical Association (BMA) poll, 40% of junior doctors in the UK were actively planning to leave the National Health Service (NHS) and 62% of those were planning on travelling to Australia or New Zealand to work there.[1] Two of those junior doctors were ourselves. We had completed our foundation training in Northern Ireland (NI) after starting early and stepping up with trepidation due to the coronavirus pandemic, and then spent five months working as locum doctors, to plan and finance our journey across to work in Australia for one year. Our aim was to experience a different healthcare system, to verify that what we had heard from colleagues - that the quality of life for doctors was better down-under - was true. The decision to leave was not easy, but the possibility of better pay; learning opportunities; work-life balance; and weather, convinced us to go for it.

Following a moderately unpleasant 36 hours of travel, we touched down in Perth, Western Australia (WA), where we have been working in Emergency Medicine in a tertiary hospital. Our intention is to return to further training in Northern Ireland, though we have experienced the stark differences between the health system which we left and the one we are currently working in. We hope to highlight the journey and experiences which many junior doctors choose, and provide an insight into why many choose not to return.

One of the biggest attractions to the southern hemisphere for doctors is pay. The standard hourly pay rate is twice that of the UK. In addition, there is the benefit of fortnightly payslips and salary packaging. Salary packaging involves signing up with a salary packaging company who can then deduct a portion of your gross pay on each payslip, before tax is applied, and then pay this amount back into your bank account. Ultimately this means taxes are paid on a lesser amount of salary and the idea is that this 'extra' money is used to pay for living expenses like mortgage, rent, and household bills. There is the choice to set up other perks such as car leasing and a 'meal and entertainment card' which can be used to pay for meals out and other activities. All of this combined creates the feeling that we have significantly more disposable income, simultaneously being able to save money without much sacrifice.

Some hospitals offered other enticements, such as compensation for flights and free initial accommodation, but we decided to come to Perth where a paired rota was more valuable to us. A rota on which, except for one week every two months, we work the same shifts and receive the same days off.

This was not available everywhere in Australia and to our knowledge has never been facilitated in a training post inside the UK. The ability to have a paired rota enables us to plan holidays together, organise social events and enjoy the privilege of spending significant time with each other outside of work. It cannot be overstated how important it is to have your personal life respected and facilitated, especially following two years of opposing rotas and fighting with administration for leave that lines up. Back at home, doctors are often forced to make unpleasant swaps and take on extra shifts to simply get a joint week of leave. We have heard many stories of colleagues being declined wedding leave, annual leave and last minute leave to attend funerals because they are not considered "close family". Rotas inside the UK are often produced without the 'adequate' six weeks' notice so it is difficult to plan life events further than a few months ahead.

In stark contrast, the rota in our department in Perth is very manageable. With a 40 hour week based upon 10 hour shifts, weeks are four days on, three days off. Despite an unfortunate eight day run, the rest of the rota is quite enjoyable, with an incredible six days off built in, we are able to travel and recuperate without taking annual leave. The roster is much better stocked with the number of doctors working per day noticeably more compared to the NHS. The vast majority of leave requests are usually granted and with far less stress and uncertainty than at home.

The Emergency Department (ED) we are working in is a tertiary centre and offers neurology, neurosurgical and

toxicology specialist centres. The majority of doctors we are working with are British or Irish, consultants included. It receives around 200 attendances a day, akin to some NHS hospitals,[2,3] and patients are transferred from all across Western Australia. Patient management is senior-led and all patients must be discussed with a registrar or consultant. There are obvious benefits to being senior-led, however, we had been accustomed to working more independently. The top-down approach allows for excellent learning opportunities and reduces the stress and worry you take home with you after work, but it can feel as though your clinical judgement is under-encouraged and your experience disregarded. The ED also takes much more ownership over the patients in it, similar to an acute medical ward, even following referral to a specialist team.

Practical skills are greatly encouraged whether they are ultrasound guided blocks, Biers blocks, procedural sedation, intubation or arterial lines. This is in contrast to NI where we found such opportunities scarce.

There is also a different workplace culture with regards to disruptive patients. Hospital Security plays a much bigger role in ensuring our workplace is a safe place to both work and be a patient. Those with capacity who are behaving inappropriately are quickly escorted out of the hospital while patients who lack capacity may be restrained to allow for intravenous sedation. Although this was a bit of a shock initially, this approach protects staff and other patients from being assaulted, creating a much more peaceful environment to work in. In contrast, assaults on NHS staff and patients are at an all-time high.[4]

Of course, there are some differences in prescribing practices, the most stark being antibiotics and analgesia, with ketamine and fentanyl being fairly commonplace within the ED.

In comparison to our experiences back home, we find we can offer a lot more to patients when they present to the emergency department. There is also always the option of referring or liaising with a patient's own private specialist team, if known, who then often accepts them for admission, lessening the burden on the public system.

"Teaching is sacred" is what we were told prior to commencing our job in Perth and it certainly rings true. Interns and Resident Medical Officers (RMOs - equivalent to Senior House Officers) receive 2.5 hours of teaching every Thursday which is overseen and often partially delivered by a consultant. Interns and RMOs as well as Allied Healthcare Professionals (ACPs) and registrars will deliver the teaching which includes simulation training and practical sessions. We are also advised to try to wrap up and hand over any patients to seniors, meaning we aren't contacted during teaching.

Furthermore, there are ample opportunities to get involved in audits and quality improvement and we are encouraged to use our professional or study leave to enhance our Curriculum Vitae. Happily, Professional Development Leave courses or conferences can be claimed using salary packaging.

Ultimately, all of this gives us a much improved work-life balance, and the better weather with the vast geography and wildlife provides lots of opportunities for adventure. Many of the Australian and international doctors take advantage of time off to travel either locally in WA or elsewhere in Australia or even further afield.

The grass however, isn't always greener. The greatest struggles we face are the personal pressures - the distance from family and friends. A recent BMJ article referenced a family torn apart from their divided choices to come to Australia or remain in the UK.[5]

Our choice of moving as a couple made things easier and we have been lucky enough to have family come out to visit us. Logistically, there were also teething issues. With the demand for rental properties in WA at an all-time high, we found it quite stressful to juggle work with organising and viewing rentals. We often found ourselves alongside sixty other keen applicants, who were frequently willing to offer increased weekly rent and advance payments. This is similar, if not worse, in other large cities like Brisbane, Melbourne and Sydney.

Founded in 1984, Medicare is the Australian universal health care system, covering some or all necessary healthcare costs.[6] Enrolment is mandatory, however the Australian government incentivises private health insurance with tax breaks. Public emergency departments are free to Medicare patients but a General Practitioner (GP) appointment costs around $40 or £20.[7] In terms of pressure on the health care system, in our opinion, the NHS is about 10 years further down the line when compared to the Australian public system. The NHS has a 7% vacancy rate for doctors and almost 7 million people on waiting lists; primary care is under increasing pressure often leading to an increase in ED presentations and both systems have lengthening waiting lists for public outpatient consultations.[8,9]

It seems that while the Australians are using the weaknesses of the NHS to attract doctors to strengthen the cracks in their own system, the NHS is clinging to government plans to dilute the medical workforce with non-medical clinicians.[10]

The private healthcare industry in the UK is a developing sector largely due to underfunding of the NHS and lengthening waiting lists. In the UK and within Northern Ireland patients' operations are being subsidised and completed in the private sector to improve waiting

lists. In addition, more NHS patients are now actively choosing private health insurance to access elective operations such as hip replacements, or outpatient clinic appointments.[11]

A 2021 report by the Royal College of Ophthalmologists stated that according to NHS England data "in 2016, 11% of cataract procedures were delivered in the independent sector… by April 2021 there was almost a 50/50 split with 46% in the independent sector."[12] While the Australian healthcare system has only fairly recently introduced the publicly-funded system, UK healthcare has always been dominated by the public NHS. If the under-funding of the NHS continues, it is likely that the UK landscape will start to mirror the two-tiered system we see in Australia. The general public needs to be made aware of this to allow for informed public and ultimately, patient choice regarding incremental and ungoverned privatisation of the NHS.[13]

If we could transport our entire lives, including family, to Australia, would we? Possibly.

We have learned and experienced a lot from our time away. Work doesn't have to leave you physically, emotionally and mentally exhausted. You shouldn't have to feel that you can't give your best for patients because you are stretched too thin. You shouldn't feel that work seeps into your personal life, so you can't enjoy your time off. We are professionals, have worked hard to get where we are and deserve to take pride in our work.

Of course, this is our experience and our journey. From afar we have witnessed the collapse of General Practices, the toppling of District General Hospitals and the discontent among doctors at every level. We both believe firmly in the NHS and it's free-at-the-point-of-service core principle. We would like to see it strengthened and re-established in the global sphere as one of the best healthcare systems in the world and something we can all take pride in once again. On the anniversary of 75 years of the NHS we see a system starved of funding, starved of staffing and starved of passion. We hope a future exists where this can be reignited, however there has to be a realisation of the cost required to defend and protect this institution as well as the many people that rely on, and work within it.

The NHS is being deprived of many highly qualified doctors who were trained in the UK/NI, but are now leaving our healthcare system because the system is not fit to retain them. We believe unless there is a radical change to pay and training which reflects the value of the profession then doctors will leave and the NHS will be lost.

"The NHS will last as long as there are folk left with the faith to fight for it." - Aneurin Bevan (NHS founder).

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First Impressions – Week One as a doctor in 2023

After graduating from Queen's University Belfast in July 2023, I have taken up a post as a Foundation Year 1 doctor. I am a first-generation medical professional and began medical school straight after my A-Levels.

What does the "crisis" mean to me? Well, the pandemic wreaked havoc on my Medical School experience by revolutionizing the delivery of training. I found myself plunged into clinical placements that were overwhelmed by the management of patients with COVID, reducing my exposure to so-called "routine" care. However, I took up part-time work as a Healthcare Assistant through the Workforce Appeal which supplemented my learning extensively. As I look back now, it's highly unlikely that I would have taken this role only for the crisis that was unfolding.

In final year of Medicine, I had the pleasure of holding the office of President of QUB GP-Society, an experience which gave me incredible insight into the clockwork of Primary Care. It has been proven time and time again that Primary Care is one of the most cost-effective ways to provide Healthcare to a growing and ageing population and the current situation in local General Practice is disheartening to say the least. Increased expectation and restricted funding are a recipe for disaster. A lack of workforce planning means my future career pathway is forecast to get even worse before it recovers. Despite my first-hand experience of the effect of increased workload, I remain steadfast in my passion to join the GP workforce when the time comes.

As I write, I have just finished my first week of FY1. The pressures in hospital are equally evident, not to mention the waiting lists of patients waiting to receive elective care. The greatest impact is an unsustainable workload, coupled with an underappreciated healthcare workforce. The balance of professionalism to put patients first and professionalism to understand one's own breaking point is difficult to achieve. How can any medical professional reach the end of their shift and walk away leaving jobs incomplete? Yet we all have a responsibility to look after our own health and wellbeing for the good of our patients.

I am very much at the early stages of learning how to be a doctor. I know it's a long road. However, when I speak to some of my colleagues, there is fear for the future. There is little hope for resolution; a heartbreaking reality. My friends and family have always described me as an optimist. Now I wonder if I am simply ignorant to the facts.

I truly believe medicine is a vocation. I distinctly remember in my first week of medical school being told, "if wealth or fame are your goals, leave now." Even amid the current crisis, the passion and enthusiasm of a new generation of healthcare professionals will ring clear above the doom and gloom. Our patients are our priority, and the powers that be must take responsibility for the necessary decisions to be made.

Tim Neill

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The view from ICU - and from an Associate Specialist

SAS stands for Specialist, Associate Specialist and Speciality doctors. We are doctors who are not consultants, GPs or part of a recognised training programme, and may be employed on a number of different contracts. These include the nationally negotiated contracts, which are currently the "Specialty Doctor" and "Specialist." Older historical national contracts, which include the "Staff Grade" and "Associate Specialist." These grades are known collectively as SAS.

The closure of the Associate Specialist posts meant that there was no formal way of recognising experienced specialty doctors capable of working autonomously. This formed the basis of a new contract for SAS and a new Specialist post was introduced in 2021. SAS doctors are a diverse group with Speciality doctors requiring a minimum of 4 years postgraduate experience and Specialists 12 years.

SAS posts have traditionally been looked at as "just for service", but there has been a growing acknowledgment of the contribution that SAS doctors make to the NHS and to the fact that all doctors need support and development to provide the best service they can for their patients. BMA NISASC, though its work over the last number of years has been successful in getting SAS leads appointed in each trust. In addition, Trust Management has recognised the importance of opening management positions to SAS doctors as a matter of course. These actions mean that although there is still work to do, we are now on par with the other devolved UK nations with respect to SAS development.

Choosing a career as a SAS doctor should be a viable career choice. I chose SAS after passing my Royal College of Physicians Membership exams, as I wanted to continue the direct patient facing aspect of my staff grade job in RICU. I have always felt supported to pursue my career on my own terms and at my own

pace in this role, developing my own area of expertise with tracheostomies, high spinal cord injuries and more recently with ICU follow up clinics.

Like all my colleagues in primary and secondary care, I faced many challenges over the last 3 years. When reports started coming through from China and then Italy, concern began to grow about what this pandemic would mean for ICU care. This included the training of non-ICU staff to look after ventilators and prone patients. We had to plan for massive upscaling in beds, oxygen delivery and ventilators as well as devise new infection control measures. We worried about how we would cope if we had to nurse our colleagues or our own families and made preparations in case we ourselves succumbed to COVID. Those of us with school age children also had home schooling to deal with.

We got through it, in no small part due to the camaraderie and teamwork, as well as the successful implementation of vaccines but having come through all of that, staff are exhausted and burnt out, and are now also dealing with the aftermath of COVID.

The current crisis facing the NHS, especially in Northern Ireland is worse than anything I have seen before even during the pandemic. Excluding Scotland, Northern Ireland comprises 3% of UK population but 96% of all UK patients waiting over one year for treatment[1]. In 2016, people in Northern Ireland were nearly three times as likely to be waiting for planned care as those in England, and the situation has deteriorated since: they are now nearly four times as likely[2]. The infrastructure around service delivery is years behind where we need to be. The pandemic has exposed the systemic failures that decades of underinvestment and cuts have inflicted on the NHS and social care. The NHS was running on goodwill long before COVID, but this is not sustainable anymore. Doctors are leaving NHS to work in Ireland, New Zealand and Australia, taking up non-clinical posts or even early retirement.

We need our politicians back in government to work with us in taking action to ensure that our health service remains safe and sustainable. We cannot keep trying to fix a leaking bucket by pouring more water in – staff need fair pay for the work they do, and we need enough staff to run services safely.

SAS doctors need parity of esteem. They need to be employed on the right contract for their job and their expertise. They should be encouraged to take up roles in leadership, teaching and research. The expectation should be that they will be supported in progression to specialist post or to specialist registration via portfolio pathway if they wish to do so. They should not be referred to as "other" or "middle grade", nor should their opinion and expertise be overlooked because they are not on the Specialist Register. Workforce planning needs to include SAS doctors, with Trusts being encouraged and incentivised to recruit speciality doctors, to offer SAS contract to doctors working long-term non-standard contracts and to appoint specialist posts.

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