My Student Elective

An Australian in Southampton

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As a final-year student at the University of Queensland, I was most fortunate to be able to come to Britain for the Annual Scientific Meeting of the Association for the Study of Medical Education (ASME) and to undertake four weeks of orthopaedic instruction in the relatively new medical school at Southampton during October 1979. This allowed me to compare the British medical education system and Health Service with the Australian equivalents. Most of my information came from Southampton, but I also visited departments of general practice and community medicine at Guy's Hospital Medical School and had lengthy discussions with many participants at the ASME meeting, especially people from the Centre for Medical Education at Dundee.

Undergraduate and preregistration training

I was disappointed that the early medical contact that Southampton offered to its first-year students was no more than four visits to a general practitioner followed by a seminar, several visits to an antenatal clinic, the observation of a birth, and a follow-up visit to the mother and child. All Australian medical schools now provide some patient contact for first-year students either in general practice or in the teaching hospitals. I noticed, however, that medical courses last for five years in Britain, whereas they last for six in Australia. I might add that at Newcastle Medical School in New South Wales students are interviewing and examining patients in hospitals by the third term in their first year, having already completed a course in interviewing skills.

In contrast to this I was most impressed by the half-day a week spent in primary medical care by students in their first year of clinical teaching at Southampton. The inclusion of primary medical care in the core medical disciplines along with medicine, surgery, child health, psychiatry, and obstetrics allows the student to keep an appropriate perspective on the scope of these disciplines. Similarly, I admired the attempts, both at Guy's and Southampton, to encourage medical students to make decisions in the general practice setting. Obviously, these attachments require considerable time and patience from the general practitioners. So far as I am aware, although all Australian medical schools include an attachment to a general practitioner in their curricula, none has gone as far as this.

The allocation of most of the fourth year at Southampton to student projects, or study of one topic in depth, certainly ranks as one of the most interesting features of the course. Such an innovation has immense potential. If students do develop some increased ability to think critically and learn independently, then this short period of their medical careers will certainly be

of value to them and their patients throughout their practising lifetimes.

I was surprised that nearly all medical schools still impose "finals" on their senior students. At the University of Queensland we have had a system for the past nine years of term-based assessment over the final two clinical years of the course (nine eight-week terms, and one of four weeks). Although there are arguments in favour of finals rather than term-based assessment, I did sense during my stay that the finals in Britain, and the assessment system in general, tended to be more formal than in Australia and to constrict curricular developments.

The contrast of British housemen's jobs with the Australian internships is considerable. Firstly, in all States except Queensland internship posts are allocated according to academic merit at graduation—no other factors (for example, interviews) being considered. In Queensland we have a unique system whereby the Health Department sends a list of the internships available in the State to the representatives of the final year. The students in final year then run their own ballot for the hospital in which they wish to do their internship. Australian internships are attachments to a hospital rather than to individual consultants, and are almost all done within the State in which the student has attended medical school. The increasing lack of movement at graduation and for subsequent training within Australia has many obvious disadvantages when compared with the system in Britain. Furthermore, the fact that allocations in Britain and certainly in the Wessex region do not depend on exam results alone is an obvious step forward, especially since academic performance has been shown to be a poor predictor of subsequent clinical performance. Also, the fact that the consultant does have considerable responsibility in selecting his own houseman may increase the responsibility he feels towards supervising the work carried out by each houseman. In the long run this should increase the quality of training when contrasted with our impersonal attachment to a hospital and rotation through various firms as directed by the hospital administration.

Another difference is that British preregistration training is simply six months of medicine and six months of surgery, whereas Australian requirements stipulate terms in medicine, surgery, casualty, and other specialties. Thus in all Australian States attachments to a firm are never longer than 12 weeks and often are no more than eight weeks. The benefit of a longer attachment with opportunity to become a functional part of the team, rather than to come to a unit and be gone again before you have learned how everyone works, should be considerable. Possibly Australian State medical boards may direct a move back to longer attachments as we progress towards rural health services staffed by graduates with more than a year's clinical experience.

I was impressed by the way in which all preregistration posts in the Wessex region were under a planned system of regular review. In addition attempts were being made to monitor the performance of housemen and consultants who were concerned with the preregistration posts. This is far more organised than

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the present system in Queensland. I hope that our medical board may be able to follow the lead of the Postgraduate Medical Education Committee of the Faculty of Medicine at Southampton University.

Postgraduate education

Several features of the British postgraduate education system were appreciably different from the Australian. Firstly, British postgraduate education is much better organised than its haphazard Australian equivalent. While this structure obviously results from the structure of the National Health Service it certainly has much in its favour. Also the fact that registrars are provided a half-day release a week for postgraduate education shows a greater commitment to postgraduate education by the NHS administration than by Australian hospitals. I was also impressed by the day-release course provided for trainee general practitioners. The British Government has introduced regulations pertaining to a three-year training programme for graduates intending to enter general practice as principals, as set out in the National Health Service (Vocational Training) Act 1976. In contrast, although the Royal Australian College of General Practitioners has for six years been offering a four-year training programme for intending general practitioners, there have been no moves to make such training compulsory.

British postgraduate education and training is helped by the vast flow of patients through NHS hospitals. Unfortunately, in Australia almost all general practice and more than half the specialist care are done in private practice and are thus inaccessible to the trainees in the various specialties. This creates considerable difficulty at both graduate and undergraduate levels in many specialties, but especially in obstetrics and gynaecology.

Finally, I was aware that there was far less concern about an oversupply of medical graduates in Britain than there is at present in Australia, where the effects of oversupply are already being felt.

Other observations which may be of interest include the fact that British health services are obviously under different geographic pressures from those in Australia. In Queensland a graduate in his second postgraduate year could well be in a town with but one other doctor and the nearest regional or base hospital 600 km away. Our rural general practitioners all excise skin lesions; the vast majority perform appendicectomies and herniorrhaphies; and most attend 20 or more confinements

a year. The geography of the State thus places unique pressures on our medical training; sixth-year students may travel up to 2000 km to do their surgery term in a provincial city hospital.

Another point I want to mention is to do with British cultural heritage. In a nation where many medical schools have histories which go back far beyond the foundation of almost all the Australian medical schools, I did at times feel that the tradition and history may have hindered progress or at least slowed it to a pace which is slower than the pace of change in most Australian medical schools. There may be many reasons for this, but I did feel that the British schools I came in contact with throughout my stay were less inclined to change than our own. Furthermore, the role of students in medical schools and in the Association for the Study of Medical Education appeared to be far less than in Australia. The University of Queensland Medical Faculty has had a student on its faculty executive since 1970. All Australian medical schools have strong student representations on faculty boards, and our own medical faculty encourages student participation in the design and construction of the medical course within the various teaching departments. Also the Australasian and New Zealand Association for Medical Education has had student representation on its executive committee since 1974, and actively encourages student attendance and participation in its annual conference. I was unable to find any medical school in Britain that was using senior students like the University of Queensland, where they are employed as tutors in anatomy, medical sociology, and social and preventive medicine.

In conclusion, I must emphasise that I was particularly impressed during my stay by the developments in teaching general practice or primary medical care at undergraduate, preregistration, and postgraduate levels. This stood out to me as the most dynamic area of education and training in Britain, while postgraduate education in general impressed me by its organisation and structure.

I am indebted to Dr J Macaffrey, department of surgery, University of Queensland, and Mr S K Wood, orthopaedic unit, Southampton General Hospital, who co-ordinated and facilitated my visit to Britain. Also I am most grateful to those who gave of their time to discuss educational matters with me: I would especially like to thank Dr Moore, postgraduate dean, and Professor Howell, dean, faculty of medicine, University of Southampton; Professor Higgins and Professor Anderson, Guy's Hospital Medical School; the staff at the Centre for Medical Education, Dundee; and the staff in primary medical care at Southampton.

What might be the cause of lymphoedema of the legs in a young woman developing over three years? What treatment can you suggest?

It is first of all important to establish that the patient does indeed suffer from lymphoedema. After the doctor has taken a full clinical history and done a clinical examination he may suspect lymphoedema but other diseases that increase tissue fluids must be considered and eliminated by appropriate investigations. Venous oedema may also usually be identified leaving lymphoedema as the likely diagnosis, but in difficult cases phlebography may be indicated. The definitive investigation for lymphoedema is direct contact x-ray lymphography, which can show the lymphatic defect and indicate if the lesion is that of primary (idiopathic) lymphoedema or secondary to some disease affecting lymphatic vessels or lymph nodes. Lymphoedema in a young woman developing over three years is probably primary lymphoedema, due to hypoplasia of lymph vessels or an abnormality of the lymph nodes as a primary congenital defect. There has usually been an incident at the onset of the oedema that unmasks the complaint, such as a sprain of the ankle, an insect bite, infection, or some other traumatic incident. The actual lymphatic defect can be established only by lymphography, which is indicated in the moderate to severe case.

Mild lymphoedema should be treated by conservative measures, such as elastic support to the leg. Sigvaris elastic stockings provide good support, but such treatment often conflicts with the cosmetic needs of an attractive young woman. Nevertheless, good support for

most of the time—the stockings may be of below knee fitting—is essential for true lymphoedema. The response to diuretics should be tried but is usually ineffective. Foot infections with tinea should be treated and the feet subsequently maintained infection-free. There are now effective mechanical aids to eliminate fluid from the feet. Among those tested recently is the Lympha Press machine.* This is an air-compression stocking device that produces an effective peristaltic compressive effect on the treated limb and helps to eliminate oedema. A course of treatment given at intervals will help to keep lymphoedema at a minimum.

*The Lympha Press machine may be obtained from: Laboratories for Applied Biology Ltd, 91 Amherst Park, London N16 5DR.

What is the treatment of choice for otosclerosis?

The choice of treatment for otosclerosis depends on various factors, including the age of the patient, general physical health, whether or not they have completed their family, and occupation. Surgery should be reserved for the patient with moderate to severe impairment of hearing and good cochlear function. It is less likely to achieve satisfactory results in the patient over 60 years of age, or in the very young patient, in whom the disease may be very active. A hearing aid will nearly always give excellent hearing in this disease, and the choice of treatment should be left to the patient.