EDUCATION IN PRACTICE

Out of programme experience: going away to bring something back: closing the loop

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ABSTRACT

In the January 2011 edition of *Frontline Gastroenterology*, I was the lead author of an article: Out of programme experience and training: going away to bring something back.¹

Since then, I have taken time out of my speciality training programme—an out of programme experience. I thought it would be of interest to trainees to read about how I organised my out of programme experience and how this time away has helped me to develop my unique selling point.

There is an increasing demand on trainees to develop their unique selling point (USP) before obtaining the Certificate of Completion of Training. This can be developed in numerous ways and I decided to embark on a clinical fellowship in advanced and transplant hepatology in Sydney, Australia, to help me develop my USP. This decision was not an easy one to make and certainly not an easy one to organise. I thought it would be of interest to trainees to read about how I organised my out of programme experience, what I did while I was abroad including clinical responsibilities, and how this time away has helped me to develop my USP.

During my initial appraisal with my educational supervisor in my ST 5 year (September 2009), I was told that I needed to develop my USP in order to maximise my job opportunities after completion of training. This would entail developing a subspeciality interest within gastroenterology or doing something that would compliment my training. A number of ideas came to mind including doing a masters of business administration in health, doing the diploma of tropical medicine and infectious diseases, taking time out to obtain a formal higher

degree (MD, MSc, PhD) or gaining clinical experience in my chosen subspeciality (hepatology in my case) that was not offered locally. I decided on the latter after numerous discussions with my senior colleagues. I wanted to gain further experience in the management of viral hepatitis, acute liver failure and learn about transplant hepatology. Having never worked outside the south west of England, I decided to pursue a clinical fellowship abroad. I had previously spent time in Australia as an elective student and decided that working in a unit there would grant me the experience I wanted as well as the chance to work in a different health system.

I managed to get the email contact details of the heads of all five transplant units in Australia and emailed them with my CV, detailing what I wanted to gain during my year there. The formal application process starts around July in Australia and so I was asked to get back in touch then. During this time I was advised to get local permission to take an out of programme experience. My out of programme experience was discussed with and agreed by my educational supervisor, training programme director, the dean and finally by the Joint Royal Colleges of Physicians Training Board. In July 2010, I had a telephone conversation with the head of the transplant unit in Sydney, New South Wales, Australia, to talk about what my job plan would include if I managed to get the post and also what I wanted to get out of my year working with them. It was emphasised that this was purely a 12-month long clinical fellowship and that I should not expect to produce numerous publications while I was there. However, there would

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likely be a project or two that I could get involved in if I so wished.

I then started the formal application process. This proved to be quite long and expensive. There were a number of organisations that I had to register with before applying for the post. I did not have to take any formal clinical or language examinations. I registered with the Royal Australasian College of Physicians, the Australian Medical Council, the Australian Health Practitioner Regulation Agency and then applied online through New South Wales Health for the post. The post was advertised as a third year training post (speciality training in Australia lasts 3 years compared to our 5 years) or post-training fellowship for local trainees. I was eligible to apply as I would have completed more than 3 years of speciality training by the start date. The visa would be organised by the hospital if I was successful in getting the post.

I had a formal telephone interview regarding the details of the post and my clinical experience to date. My training in intensive care medicine and emergency medicine served me well and I proved successful in securing the post. A trainee from Australia or New Zealand would have been given the post had it not been demonstrated that an overseas trainee would be better suited to the post. The whole application process cost me between £4000 and £5000, including a full medical examination and verification of numerous documents by a lawyer.

I started a 12-month clinical fellowship at the AW Morrow Gastroenterology and Liver Center and the Australian National Liver Transplant Unit in January 2011. This is the largest transplant unit in the southern hemisphere and performs between 60 and 70 adult transplants per year. The unit takes liver transplant patients from the state of New South Wales and the Australian Capital Territory. There are nine consultants, five liver transplant surgeons and four speciality trainees including the liver fellow. There is a large multidisciplinary team comprising dietitians, pharmacists, psychologists, specialist nurses and a drug and alcohol team. I was part of a one-in-four on-call speciality roster, which, out of hours, included being first on for upper gastrointestinal bleeds and general gastroenterology as well as liver transplants. When on call during the week (Monday–Friday), I was expected to do a normal working day from 08:30 to 17:00 hours and then be on call (non-resident) from 17:00 until 08:30 hours the next morning. The weekend on call would start on Friday at 17:00 hours and end on Monday morning at 08:30 hours, when I would start the normal working week again. I was expected to do a comprehensive ward round of all the liver transplant and general gastroenterology inpatients on Saturday and Sunday mornings. The situations that would necessitate my returning to the hospital outside of this would include upper gastrointestinal bleeds requiring endoscopies, admission for a liver

transplant and any patient with acute/subacute liver failure. General admissions and ward problems would otherwise be admitted and managed by the resident medical registrar (equivalent to a core medical training doctor in this country) with telephone advice from the speciality trainee. Patients admitted under the liver transplant team included patients being considered for or worked up for a liver transplant, those being admitted for their transplant, and any post-liver transplant patient with a complication. The weekday duties were mostly ward based, including a daily ward round with two junior doctors (core medical training and F2 equivalent) including seeing liver patients on intensive care, two formal consultant-led ward rounds per week, taking calls from other hospitals relating to patients with advanced liver disease, acute liver failure or post-transplant patient care, and dealing with outpatient issues that the specialist nurses may have, including abnormal blood results. The geography of the area and the lack of a primary care service in most rural areas meant that it was rarely just a matter of telling the patient to visit their general practitioner and have some blood tests done. I did one outpatient clinic a week for the second half of my year and a weekly endoscopy session for the whole year. This would routinely have six to eight points on it, with a mix of lower and upper endoscopy cases, and was mostly done independently. There was also a weekly x-ray and histology meeting, hepatocellular cancer multidisciplinary team, organ allocation meeting and a monthly quality and safety meeting.

My knowledge of hepatology increased significantly. I learnt about the process of organ allocation (model for end-stage liver disease and tumour model for end-stage liver disease), transplant work-up and assessment procedures, postoperative complications including recurrence of pathology—more specifically hepatitis C recurrence post transplantation, immunosuppression regimes, opportunistic infections, fulminant and sub-fulminant liver failure and treating viral hepatitis—mainly hepatitis B given the large immigrant population from Asia. In addition, I became competent in managing upper gastrointestinal bleeds independently.

My basic salary was approximately \$A100 000 for the year with overtime being paid on top of this. However, one must not forget that living in Sydney is not cheap and certainly the British pound no longer goes very far in Australia.

The advantages of doing a clinical fellowship such as this have become apparent since returning to the UK and having some time to reflect. I have gained a wealth of experience and knowledge—some of which I hope will benefit any region where I may work in the future. The satisfaction of organising a fellowship such as this, settling down in another country while having an intense and busy job, working in a different healthcare system, and making life-long contacts, is immense. However, this is not a higher degree and,

given the general restriction enforced by most deaneries of allowing trainees only one out of programme experience, you should think very carefully whether this type of post would suit you and your future lifestyle.

Competing interests None.

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REFERENCE

- 1 Valliani T, Khan M, Lockett M, *et al.* Out of programme experience and training: going away to bring something back. *Frontline Gastroenterol* 2011;2:43–4.