The energy of slaves[1]

Increasingly, the NHS is dependent on overseas-trained health professionals

The British are past masters at harnessing the energy of their Anglo-Celtic offshoots. The names of the battles on the tombstones of returned servicemen interred in the cemetery in Halifax, Nova Scotia, are very familiar to any Australian with some knowledge of the Western Front of 1914–1918. And in the Commonwealth War Cemetery in Kraków, Poland, Australians, New Zealanders, South Africans and Canadians lie side by side, linked in death, so very far from the sunburnt country, the long white cloud, the burnt-brown veldt or the rolling prairie.

Today, Australians, New Zealanders, South Africans, and occasionally Canadians, continue to serve side by side as doctors, nurses and other health professionals in the United Kingdom's modern, dependable National Health Service. They are renowned for their energy, excellence of care, and exuberant intolerance of persisting with the old, outmoded UK approaches, justified only by "that is the way things are done here". Partly, this is a result of selection bias — those who come to the UK want to see the world, to see how things are done elsewhere, and to challenge this and themselves — and partly it is the lazy monolinguality of many native English-speakers, the air routes (and the shipping routes before them) that terminate in London, and the reciprocity of recognition of basic qualifications in the relevant professions.

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However, the greeting extended here to "foreigners", even white, English-speaking foreigners from far-flung corners of the former Empire, is paradoxically patchy. Australians are welcome to pay taxes, and even to vote. They are happily accepted as lecturers and tutors of home-grown doctors for the NHS, but those without patriality (at least one grandparent born in the UK) or "indefinite leave to remain" will have considerable difficulty obtaining a mortgage. In other words, you are free to cure our sick, pay into our public purse, teach our children and participate in our parliamentary process, but we do not guarantee that you will be allowed to own the roof over your head.

"Foreign", of course, has connotations of the unfamiliar, even the unnatural, and certainly something against which a hostile immunological response should normally be raised. Like Australia, Britain has been habitually suspicious, even untrusting, of the quality of medical degrees obtained in countries that were not part of the former British Empire. Even Commonwealth countries can be problematic if their inhabitants are not white.

On the one hand, there are reasons for having a single, demanding standard applied uniformly to all, even if that arrangement does oblige highly specialised, very experienced practitioners to go back and learn their general medicine all over again. On the other hand, in the big British cities, there are large populations of refugees and asylum-seekers, for whom the languages, cultures and endemic medical problems of their places of origin are completely unknown to practitioners trained in comfortable countries at high latitudes. Dealing with these patients is extraordinarily time-consuming, not just because of their different backgrounds, but also because of the continuing medical and psychological consequences of events surrounding their leaving their homelands and the ongoing economic, social and legal disconnection experienced after their arrival. Only recently have pilot schemes begun that allow overseas-qualified health professionals (including doctors) in these communities limited rights of practice, under supervision, to help alleviate their compatriots' burdens.

A number of people in the UK are now raising the issue of the dependence of the NHS on overseas-trained health professionals and the detrimental consequences for the source countries. Many of the suppliers of this workforce are low- to middle-income nations that can ill-afford to lose significant numbers of their graduates.

The NHS is also a source of emigrants as well as a mecca for immigrants. Remote Australia has its fair share of British graduates manning the medical frontiers — one British practitioner in rural Western Australia famously evacuated an extradural haemorrhage using a brace-and-bit borrowed from the local carpenter and guided telephonically by a neurosurgeon in Perth. But, however interesting these individuals and their experiences, they tend to be itinerants who ultimately return to the "Mother Country" (just as most Antipodeans here eventually return to their "dominions of origin"). This pattern differs sharply from the sizeable cohort whose opposition to the creation of the NHS, in the late 1940s, was sufficiently strong that they "upped stumps" and moved permanently to less socialist settings in the English-speaking world, including Australia and New Zealand.

Arguably, one result of this efflux has been a significant and lasting divide between the internal medicopolitical cultures of the NHS and the Australian healthcare system. Although acrimonious occasionally, and feeling disgruntled and downtrodden for much of the rest of the time, most of the medical profession in the UK openly supports a system that is almost always free at the point of care and in which every citizen and most residents have been nominally tied to a single general practitioner. This is the paradigm (and attitudes) that we see passed down to our British students and withstanding the test of time.

Beyond the commonality of the GP as gatekeeper to specialist services, Australia's healthcare system has long had higher levels of entrepreneurialism and market forces, and the publications of medical organisations that reach us here in the UK are forever reporting clashes with governments. A little reflection reveals that the young, pre-Thatcherite émigrés of 1948 would have been at the peak of their medical and political powers when the Whitlam government wanted to introduce Medibank in 1974. They were as trenchant in their opposition to what they saw as the intrusion of government into the sanctity of the doctor–patient relationship in Australia in the 1970s as they had been in Britain in the 1940s, perhaps kindling, or certainly entrenching, a tradition of energetic awkwardness that has bred true in every succeeding generation of Australian practitioners.

Both the UK and Australia are the more interesting, then, for the consequences of their medical slave-trades.

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1 Cohen L. The energy of slaves. London: Jonathan Cape, 1972. ❑