Psychiatrists in May and June 1989 was a landmark. The programme featured scientific sessions with British and Hungarian presenters and the delegation visited several psychiatric institutions in the capital as well as the psychiatric clinics of the Medical Universities in the cities of Szeged and Pécs. At the invitation of the Royal College a 23-head delegation of the Hungarian Psychiatric Association returned the visit in October 1991 (London and Sheffield) when the Hungarian psychiatrists participated as presenters and visitors at the autumn meeting of the College in London.

As a consequence of favourable political changes, leading Western drug factories and companies have opened offices in Hungary in the last two years, so currently all the newer antidepressants, anxiolytics and neuroleptic products are available in Hungary. The manufacturers also provide considerable assistance in the post-graduate training of psychiatrists and, recognising the fundamental role of GPs in the diagnosis and treatment of mental diseases, in the psychiatric training of general practitioners.

In recent years there has been a significant change in the system awarding scientific research grants. Formerly grants were awarded to specific persons while now, in accordance with international practice, decisions are based on such indices as a list of publications, impact factors and number of citations.

One of the most important tasks of Hungarian psychiatry is to reduce the extremely high rate of death by suicide which unfortunately makes the country a leader internationally. In the last couple of years important investigations were carried out in Hungary on the interrelation of depression and suicide. Research in Sweden also indicates that suicidal mortality can be decreased considerably with early diagnosis and modern, efficient treatment of depression.

A number of foundations and other organisations have now been established, like the Foundation for Prevention of Depression and Suicide, the Psychoeducational Foundation and the Hungarian College of Neuropsychopharmacology, with the dual purpose of providing up-to-date and efficient training to professionals and informing the population on the nature and treatment of common psychiatric diseases. Unlike in the past, in the last one and a half years several radio and TV broadcasts and newspaper articles have dealt with depression, panic and obsessive-compulsive disorder, with contributions from leading Hungarian professionals.

In spite of recent favourable trends, at present the prestige of psychiatry and psychology is quite low in the medical hierarchy. But with well planned promotions, we hope to get our right place in both the medical and social community.

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Training, manpower and employment in Australia

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Previous articles have dealt with aspects of training (Harrison, 1989) and service delivery (Andrews, 1991) in Australia. There has been no description of overall training, manpower or employment across Australia. In addition there have been important recent changes in registration and postgraduate training.

Medical services and manpower

Australia's geography and political structures have had profound effects on the organisation of medical services. Most of the interior of the country is arid or semi-arid; consequently the 16 million inhabitants are clustered along the south eastern seaboard. In spite of the impression given by films such as 'Crocodile Dundee' and the 'Man from Snowy River', Australia is one of the most urbanised countries on earth with 95% of the population located in the five state capitals.

Australia still suffers from a shortage of psychiatrists. This shortage is exacerbated by maldistribution of the available manpower. The majority of psychiatrists are located in the cities where most of the population lives, and the opportunities for private practice the greatest. This leaves large areas

of the interior with very little psychiatric cover; Western Australia, which is the same size as Western Europe, has four full-time psychiatrists working outside the main metropolitan areas.

Australia's federal constitution also has had a profound impact on health service delivery, as the country consists of six states and two territories. Although the entire population is covered for treatment in the public system by Medicare, each state has separate Departments of Health which can organise service delivery in the public health system quite differently. At present all the states are in the process of shifting the emphasis of care away from hospital to community setting; a policy that has been particularly pursued in New South Wales.

Every state has a separate medical board which registers doctors and different Mental Health Acts; that in South Australia most closely resembles current British legislation. Apart from the move to community care, psychiatric services in Australia will also be probably affected by changes in health service organisation occurring elsewhere such as the purchaser/provider split.

Training

Training in Australia is overseen by the Royal Australian and New Zealand College of Psychiatrists (the RANZCP) and has been described previously (Harrison, 1989; Timney, 1991). As in Britain, trainees are rotated through posts at six monthly intervals. Two of these must include posts in child psychiatry and liaison psychiatry. Other requirements include four hours of supervision per week (one of which must be on an individual basis), and supervised psychotherapy of a patient for a minimum of 50 sessions.

Training schemes vary considerably from state to state. In New South Wales, even though there is a centralised lecture programme, trainees are attached to small rotational schemes that centre around particular hospitals. In South Australia and Western Australia there is a unified rotational scheme that covers the whole of each state.

The duration and structure of training is rather different from the UK. The Fellowship of the Royal Australian and New Zealand College of Psychiatrists is an "exit" examination which marks the end of training. The minimum period in which training can be completed is five years, Section 1 being attempted in the third or fourth year. There is one unified training grade (registrar). There have been recent important changes in the training requirements prior to taking the examination. From December 1992, first year trainees have to present a 2,000 word case study, pass a clinical examination and receive satisfactory reports from supervisors before proceeding to the next two years of training. During this time, trainees must present an additional five case histories of between 2,000 and 8,000 words as the subspecialty attachments are completed. Trainees must also pass an examination in medical competence which previously formed part of Section 1 but has now been moved to the third year.

When the above requirements have been met, trainees can sit Section 1 which consists of two written papers, two clinical papers and a consultancy viva. Training is completed by a fifth year during which Section 2 must be completed; this consists of a dissertation which may be clinical research or a literature review.

Working in Australia

The diversity of country and health service delivery offers a large range of clinical experience. To make the most of working in Australia it is important to be aware of the differences between states and match individual interests with the prevailing system. In choosing a position, issues to consider are the balance between hospital and community care, as well as the disadvantages and advantages of country as opposed to city practice. In addition, British trained doctors leaving for Australia need to be clear as to whether they wish temporary work experience as part of their training or with a view to permanent settlement.

Practicalities

There are three hurdles to pass in arranging to work in Australia which vary in difficulty according to whether temporary work experience or permanent settlement are contemplated: medical registration, work permits and specialist recognition.

(a) Temporary work experience as part of training

In this situation, arrangements remain relatively straightforward. Finding out about posts available is best done through senior colleagues with contacts abroad; otherwise details can be obtained by writing to individual hospital departments or in the case of Western or South Australia where rotations are organised on a state-wide basis, the postgraduate psychiatric education subcommittee of the RANZCP.

Registration requirements for overseas trained doctors are in a state of upheaval but it appears that in the case of doctors entering on training exchanges, limited registration will be granted without the need for sitting a registration examination. Exact details should be clarified through the appropriate state medical board. A visa is obtained through the Australian High Commission on sponsorship from the prospective employer.

The optimum time for overseas experience as part of training is probably a part of a senior registrar rotation. It is usually possible to arrange a year's absence with the guarantee of a continued place on the scheme; one year of overseas experience will count as part of higher specialist training on application to the JCHPT. A letter from the Australasian college confirming completion of the post is the only documentation required. Leaving the country for a year if this is not part of a training programme, and without a guaranteed job on return, is best avoided.

(b) Permanent entry

Details of permanent positions for trained psychiatrists can be obtained through contacting prospective employers directly or the pages of the medical press. As with temporary work permits, permanent residence is arranged by the prospective employer through the Australian High Commission.

Registration for British and Irish trained doctors wishing to settle in Australia has been made considerably more difficult by changes which took effect from the beginning of 1993. From this date uniform medical registration was introduced across the whole country which is coordinated by the Australian Medical Council (AMC) in conjunction with the state medical boards. Previously primary medical degrees obtained in Britain or Ireland were recognised by all state medical boards except New South Wales. In implementing national registration, the Australian authorities have taken the opportunity to unilaterally remove recognition previously granted to British and Irish trained graduates.

Registration and specialist recognition will become increasingly linked. Overseas trained psychiatrists who wish to practise in Australia will have the option of taking the Australian Medical Council examination before applying for specialist registration or having their qualifications assessed by the College, through the AMC, for limited recognition to be granted. This would be portable throughout Australia without the need to re-apply if the individual moved to the jurisdiction of another state medical board. These exemption procedures from the examination would be available only to those with permanent residence in Australia and would include an interview as well as a detailed assessment by a subcommittee of the RANZCP (RANCP, 1992).

Psychiatrists with the MRCPsych are in a more advantageous position in that the British and Australasian Colleges have agreed a scale for the recognition of pre- and post-MRC Psych experience in meeting the training requirements of the RANZCP (Royal College of Psychiatrists, 1991). It is important to note that this procedure covering exemptions in gaining the FRANZCP is quite separate from that required for limited registration. Only when permanent residence has been obtained, registration granted and specialist recognition obtained, can an overseas specialist settle and practice.

These recent restrictions are to be regretted and psychiatrists considering such a move should carefully scrutinise both the posts and restrictions to practice before committing themselves to positions. Geographically isolated facilities which cannot attract Australian applicants may well be able to offer fast track routes into the country; once employed doctors may find themselves trapped by restrictions on the location and specialty of practice, as well as the rights to private patients.

Finally it is worth considering applying to sit the FRANZCP once in a permanent specialist post, especially given the exemptions given to doctors with the MRCPsych. Accreditation for training is given to individuals not institutions and those without the FRANZCP may find approval more difficult to obtain; this has obvious repercussions from the point of view of being allocated junior staff.

In conclusion, practising psychiatry in Australia, whether temporarily or permanently, remains possible in spite of recent changes in registration and specialist training. Salaries in the public sector are similar to the UK while the cost of living is lower. Rewards in the private sector, which forms a larger part of practice than in Britain, are greater.

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