Scenes from Postgraduate Life

A better deal for overseas doctors?

Overseas doctors have been a mainstay of the British hospital scene for over 20 years. In 1984, 46% of registrars and 38% of senior house officers (SHOs) had been born overseas: these were, however, the lowest rates recorded in the last 15 years, and the downward trend was aggravated by the introduction of the Professional and Linguistic Assessments Board (PLAB) test in 1975 and by the 5-year regulation for limited registration imposed in 1979. The change in the immigration rules in 1985, which restricted the number of years an overseas graduate could spend in training in the United Kingdom to four, will no doubt have a similar effect. It is too early to say what sort of eventual impact this decline will have on hospital staffing but it is certain that if the government-backed initiative Achieving a Balance is implemented there will be a striking reduction in the numbers of British doctors in the training grades, and presumably plenty of scope for doctors from overseas.

Talking about overseas doctors one tends to assume that they mostly come from Middle Eastern, African and Asian countries. There are, of course, doctors from the European Economic Community, and the latest initiatives from the three main Royal Colleges (see below) suggest that there might be quite a demand from the ‘old Commonwealth’. In the past, many doctors from less advantaged countries have had to put up with poor training and poor prospects in this country, eager as the hospital service was (and is) for pairs of hands. This may have been dictated to some extent by a free-for-all system which allowed anyone (irrespective of suitability for specialist training) to come to the UK. In addition, the talents of the bright high flyers, who wanted to pass their specialist examinations and go home, were hidden by the large numbers of more average doctors. Nevertheless, there are now appreciable numbers of ageing doctors in SHO and registrar grades – 989 and 521 respectively in the 1984 census – with no hope of advancement, for whom a solution will have to be found. They have served the hospitals well and I hope that places will be found for them in the intermediate ‘specialist’ grade, where their knowledge of the hospital could be put to good use in the sort of post, for example, which used to be called resident surgical or medical officer or resident obstetrician.

Will things be any better in the future? Two things suggest they might. Firstly, there is a major bottleneck in the registrar grade in virtually all specialties, and present numbers would have to be cut by half or more in the popular ones in order to produce a realistic career progression for British graduates. The Joint Planning Advisory Committee (JPAC) is about to tackle the registrar problem. If numbers are reduced (some say by as many as 2,000) as they must be, they will not be replaced by more than a handful of additional SHOs. Ideally the work will be increasingly done by consultants but it will take time (and money) to make up the numbers. In the meantime, posts to be lost will have been approved for training and should be suitable for overseas graduates who wish to come to Britain for further education. Indeed Achieving a Balance has suggested that there will be two types of registrar shared between those in the career grades in this country and graduates from abroad. A proposal that they be called Regional and District registrars respectively has been widely criticised and it is hoped that the two types of post will be indistinguishable and interchangeable. It is equally important — and indeed absolutely vital — that posts for overseas graduates should not be regarded as pairs of hands. If they are in danger of becoming so then colleges will have to step in quickly to disapprove them for training.

The second prospect for change goes back to Sir David Innes Williams’s scheme for overseas doctors, first mooted in 1983, and eventually given limited backing by the Department of Health and Social Security (DHSS) for pilot schemes by the three main clinical royal colleges. The Obstetricians had already been placing overseas graduates in chosen training posts, supervised administratively by their own director of postgraduate training. The Surgeons have recently produced a detailed document outlining their own scheme (which will cover general surgery and orthopaedics), put together after extensive consultation throughout the Regions during which they identified 80 posts in surgery and 40 in orthopaedics. The Physicians,
too, know of consultants who are willing to take overseas graduates and they are able to assist in placing applicants through their Hans Sloane Fellow.

It is instructive to look at the Surgeons’ document because it highlights the scheme in action. Anyone wishing to come to the UK for training will need to be sponsored by a senior consultant in his or her own country known to the college, and such sponsorship must be supported by the institution where the doctor works. In addition, the individual should have given some evidence of wishing to pursue a career in surgery, for example by passing a local Mastership of Surgery or Part I of the F.R.C.S. examination. If accepted for training the doctor will be sponsored by someone in this country acceptable to the college – not necessarily a surgeon but often the person for whom the overseas graduate is to work. Dual sponsorship means that the doctor will be exempt from the PLAB examination. (These schemes are not meant to stop people abroad coming under their own initiative, but the latter will usually have to take PLAB and compete for posts.)

Once accepted the doctor comes to the UK for an interview by the college; a post will already have been earmarked, and he or she can start as soon as preliminaries have been completed. Interviews are not competitive, and this has caused some disquiet, but the college has promised that selection will be rigorous. Most graduates will start as SHOs and will have to complete three months’ probation. Thereafter the major part of training will be as registrars, with periods in both district and teaching hospitals. Doctors can, of course, take the F.R.C.S. if they wish and if they are eligible on account of their previous posts (some overseas hospitals are approved) but they don’t have to; a diploma or certificate of satisfactory completion of training will be issued before the doctor returns to his or her own country.

In all respects the posts will be comparable to those held by our own graduates, and sponsored doctors will be expected to work according to the regulations of the National Health Service (NHS). This is an important point because it means that countries which are prepared to support their doctors with scholarships or grants will have to pay the money to an institution in the UK because the doctor will receive a salary from the NHS. This could have two benefits: the doctor will not be able to plead special treatment by reason of his or her country’s sponsorship and sponsored doctors from poorer countries will not be at a financial disadvantage.

The success of these schemes will depend crucially on the selection of high quality graduates. If the first few are successful in getting what they want from the system, not only will the NHS have benefitted, but they will return to their countries as future leaders of their own medical services and as ambassadors for British medicine. Numbers need to be built up slowly, but the development of schemes should not be regarded with too much complacency. They must be in place and working effectively well before the expected run down of registrar posts, otherwise proper postgraduate training will be lost once more in an unseemly rush for pairs of hands.

Alex Paton
Regional Postgraduate Dean
British Postgraduate Medical Federation
33 Millman Street
London WC1N 3EJ, UK.

References

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A. Paton

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doi: 10.1136/pgmj.64.747.87

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