

Structured clinical attachments for international medical graduates

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Clinical attachments are an opportunity for international medical graduates to gain some first-hand experience of the UK medical system and thereby improve their chances of finding employment. Unfortunately, these attachments may be hard to find and are of variable quality. This article details one deanery's approach to developing structured clinical attachments.

INTRODUCTION

Clinical attachments are well established as the means by which international medical graduates (IMGs) gain an understanding of the NHS. Such attachments also help doctors gain medical employment in the UK through local references obtained at the end of attachments (Cheerth and Berlin, 2001). Clinical attachments benefit patient care as overseas doctors with a better understanding of the NHS are likely to provide a higher quality service for patients.

There is, however, anxiety about the difficulties IMGs face in securing an attachment and about the varying quality of attachments. At present there is no system for allocating attachments. Access to attachments depends on having contacts or introductions to consultants working in the NHS. As the number of overseas doctors taking the Professional and Linguistic Board (PLAB) exam increases, the number of clinical attachments available is failing to keep pace with demand.

Other pressures on the time of overstretched consultants make them unwilling to take on the added burden of observers eager to learn, but unable to contribute to patient care. A number of trusts are now levying charges for attachments, and some consultants are taking doctors on but not offering them a worthwhile experience.

In order to address some of these problems, the London Deanery, using its

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experience of providing structured clinical attachments for refugee doctors (Ong and Gayen, 2003), embarked on a project to address some of the difficulties faced by IMGs.

SETTING UP THE PROJECT

Five trusts, one from each sector of London, agreed to participate. Two trusts were previously involved in the project of structured clinical attachments for refugee doctors. Two were new to carrying out structured clinical attachments, although they had experience of *ad hoc* individual attachments. The fifth trust had run a programme of clinical attachments for IMGs for 2 years.

In total, there were 80 places available; each of the five trusts took two cohorts of eight IMGs, with each cohort lasting 6 weeks. All of the cohorts had a project tutor responsible for organizing placements in two specialties and delivering a planned core curriculum (Table 1). The project tutors were selected as they were consultants with a record of interest in training IMGs.

The next step was to identify suitable participants. As the researchers wished to recruit IMGs as soon as they were eligible to work in the UK, they contacted the General Medical Council (GMC) and asked them to hand out letters of information about the project to all doctors who about to sit the second and final part of PLAB. If the doctors wanted to have a clinical attachment, they were invited to make contact with the overseas doctors office at the deanery once they were successful in passing PLAB 2.

The participants

While some applicants had heard of the project through the GMC, an unexpected number of applications came from doctors with PLAB 2 who had heard of the project by word of mouth, or from those who had approached participating trusts directly. Applicants were accepted for the project on a 'first come, first served' basis until a total of 80 participants had been reached. There were a number of enquiries after all the places

TABLE 1.
Core Curriculum

Core curriculum items	
Routine clinical items	History taking skills and physical examination (with consent when appropriate)
	Presentation of case
	Good prescribing practice
	Blood and infection control, interpretation of blood results, electrocardiograms and X-rays
	Treatment decisions, doctor-patient partnership, autonomy and consent
Educational and personal skills	Clinical audit project or teaching on audit skills
	How to be a member of the multidisciplinary/ward team
	Dealing with difficult patients
	Managing death and bereavement

were filled.

Of the 80 IMGs recruited, 18 attended the induction day but did not take up their attachments as they had already secured jobs, and one doctor could not be contacted despite repeated attempts. Therefore, in total 61 doctors took up the attachments, of whom 37 were male and 24 were female. Their mean age was 30 years. The doctors' countries of origin are shown in *Figure 1*. Twenty-four participants had undertaken clinical attachments before.

OUTCOME OF THE PROJECT

By the end of the project, 37 out of the 61 doctors that took up attachments gained medical employment. For 27 of these doctors this was their first clinical attachment. The 18 doctors who did not take up placements, but attended the induction day, have not been included in this figure because the focus of this paper is the possible effectiveness of structured clinical attachments.

EVALUATION BY DOCTORS

At the end of the attachments, participants were asked to fill in an evaluation questionnaire. The response rate was 82% (50/61).

All of the respondents were positive about being offered attachments on contact with the deanery and said that the attachments had been successful in extending their understanding of the NHS. However, one participant stated:

'The attachment was helpful in learning the NHS system but [it] does little in terms of one's clinical capabilities especially since it's mainly at PRHO level which most of us have been through.'

Nevertheless, 98% (49/50) said the attachments had renewed their clinical skills, and that the project tutor had given them career guidance. In total, 96% (48/50) said the attachment prepared them for work. Ninety-four percent (47) said being in a cohort was more effective than being alone because of group support and learning, although one respondent argued that being in a group reduced the chance of getting a job in the department.

Other negative aspects were not being allowed hands-on work with patients, not being placed in their preferred specialty, being badly treated by some junior doctors and the need to travel a long distance to the participating trust.

EVALUATION BY TUTORS

Progress meetings were held with the project tutors when the first cohort finished their attachment and a final closure meeting was held at the London Deanery for all the tutors. The project tutors felt that the weekly sessions with the attachés worked well because it gave the opportunity for group learning based on the core curriculum and career guidance. Two of the project tutors were able

to arrange for their attachés to do short-term locums. This enabled the doctors to gain limited registration with the GMC and, subsequently, to apply for jobs demanding limited registration.

A significant hindrance to the project was the difficulty in finding consultants willing to take on the doctors on attachments. Other factors which may prevent an IMG gaining medical employment in the UK include age, lack of postgraduate qualifications (e.g. MD, MRCP) and personality problems.

Areas for future improvements to the project included increasing the number of attachés to accommodate more applicants, and increasing the length of attachment to enable the consultants to give more realistic references. There was a feeling among the project tutors that the GMC should put limits on the number of doctors taking the PLAB test as there were too many doctors passing and not moving into jobs.

COST

The total cost of the project was £32 000, or £525 per attaché. A grant of £14 000 was received from the Department of Health, and the rest was met by the London Deanery.

DISCUSSION

There is widespread concern about the purpose, educational quality and timing of clinical attachments and the difficulties IMGs face in securing attachments, including charges made by some trusts.

By working with the GMC, the researchers were able to offer clinical attachments to doctors as soon as they passed the PLAB2 examination and were eligible to work. Doctors recruited in this way did not have to depend on having a contact within the NHS or waste time searching for attachments. There is an argument for setting up a national clearing house to place job-ready IMGs on attachments.

While the evaluations were mainly positive, the criticisms need serious consideration. It is inevitable that hard-pressed clinical teams sometimes react in an unfriendly manner to observers who take up training capacity without contributing to the work. Junior doctors may resent demands made on the teach-

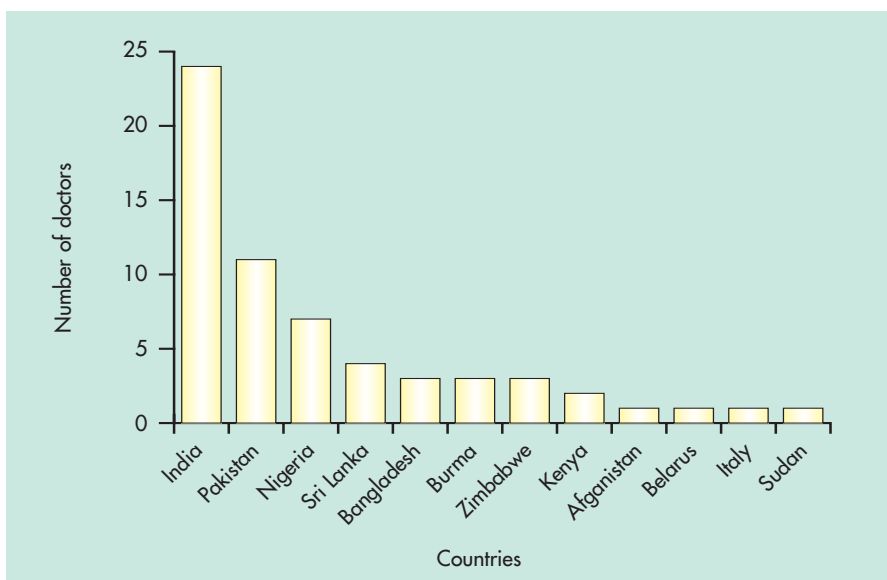


Figure 1. Participants' countries of origin

ing time available from their consultants. However, being placed in a cohort of doctors helped buffer any feelings of rejection as doctors were able to obtain intra-group support.

The continual demand for clinical attachments has often provoked a response from hospital consultants, as reflected by the project tutors, that the number of overseas doctors taking the PLAB test should be limited.

Placing doctors in cohorts for clinical attachments is emerging as an effective model for group learning, and support and enables the organization of additional supervision and career guidance from a project tutor responsible for the cohort.

CONCLUSION

As clinical attachments now form an essential part of the pathway for IMGs to obtain medical employment in the

UK, there is a need for more consistent quality and easier access. Structured clinical attachments in cohorts have advantages for IMGs when compared to individual *ad hoc* clinical attachments. There is an urgent need for a central allocation system to enable IMGs to access suitable attachments as soon as they are eligible to work in the UK. **HM**

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KEY POINTS

- Attachments in cohorts enabled group learning, support and career guidance.
- 60% of doctors on this project gained medical employment on completion of their attachments.
- 46% of doctors who gained employment in this project had undertaken earlier individual clinical attachments and had not been successful in gaining employment.
- IMGs have problems finding clinical attachments, which raises the need for a central allocation system.

IN THE PUBLIC'S VIEW...

The single most important factor

By the time this column appears we will have had a new government for a little more than a month. We may even know what is going to happen to the NHS, although I doubt it. We certainly didn't know before the election. All commentators seemed to agree that it was the most lacklustre, uninteresting election since the last one. There are health issues that matter, but we heard nothing of them; instead we got squabbling over irrelevant detail.

Methicillin-resistant *Staphylococcus aureus* (MRSA) has been much in the news, so the Conservatives, in their pernicious 'Are you thinking what we're thinking' campaign, asked, 'I mean, how hard is it to keep a hospital clean?' Anyone who thinks for a moment or two – although not in the way the Conservatives thought – knows how difficult. It's very difficult. There are ill, immuno-compromised patients in hospitals. Yes, we must learn better hand washing habits. There are fewer cleaners than there used to be. Now, which party was in government when that started? Higher bed occupancy makes it more

difficult to clean bed spaces between patients. But the cleanest areas of the hospital still manage to harbour unpleasant bacteria in their corners. Hospitals are dangerous places to be, it's just that sometimes it's more dangerous not to be there.

Then we had Mr Blair and the 48-hour target for GPs. Audience participation debates can be good television, but they are not good debates. The problem of GPs not allowing patients to book an appointment for more than 48 hours ahead is trivial; it is an anomaly caused by insisting on a 48-hour target, follows the law of unintended consequences, but is easily solved. How about asking Mr Blair, or any of the leaders, what is the NHS for, exactly. Why not ask them how we can all become more realistic about health-care? But it's all too difficult: better to have a circumscribed tizz.

Jeremy Paxman was equally dreadful: expecting Charles Kennedy to do instant sums and work out what a 32-year-old librarian married to a 25-year-old secretary and with two children would pay in tax under Liberal Democrat proposals.

From Jeremy Paxman's facial expressions during his interviews you might suspect all politicians have trouble with faecal continence. It's amusing, but distracting.

What of the main UK medical journals? The *British Medical Journal* had some pages of analysis, but no editorial comment. The *Lancet*, in its leading editorial, simply printed the truth: it doesn't matter what the parties think, or who the public votes for. The 'single most important factor hindering the improvement of health services [is] the catastrophic collapse in morale among doctors' (Horton, 2005). The issue of patient choice is foremost among many 'improvements' that upset doctors, and the more we get upset, the more the politicians seem to think they have got it right.

Whoever is in power now, I hope they saw that editorial. And I hope, for the sake of health care in this country that they take notice. **HM**

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