International medical graduates: a tale of two scandals?

Many feel uneasy that the UK's expanding health economy is so dependant on doctors trained overseas. This applies particularly to doctors trained in countries in Asia, Africa and Eastern Europe whose health needs are so much greater than ours. The chairman of the British Medical Association (BMA) has been quoted as describing the NHS's record on recruiting staff from overseas as 'shameful' and 'a scandal' (Dunne, 2004). Putting aside the ethical issue of country of origin, the UK has a duty at least to ensure that those international medical graduates (IMGs) currently in the UK are gainfully employed. But here we fail again, this second scandal compounding the first.

In 2004, 6392 IMGs passed the Professional and Linguistic Assessment Board examination (PLAB). The five fold increase in IMGs passing PLAB over 4 years results in some junior posts attracting over 1000 applicants and IMGs spending 11 months unemployed between stopping work at home and obtaining their first post in the UK. The 870 applicants for one pre-registration house officers (PRHO) post had wasted 800 'doctor years' (Lokare and Trewby, 2004; Trewby, 2005).

The General Medical Council (GMC) publishes data on post-PLAB employment for IMGs. Their data give little indication of improvement; 57% of IMGs who passed PLAB in December 2003 obtained a post within 6 months compared to 77% 1 year earlier and for many this first post will be a locum post (GMC, 2005).

Conscious of the problems facing IMGs, the Royal College of Physicians (RCP) of London set up a working group in 2004 to look at the problems facing IMGs. The issues considered, which have been previously reported (Trewby, 2005), are discussed below.

INFORMATION ON LEVEL OF COMPETITION FOR POSTS

Here (and perhaps only here) there has been improvement. Good information on current levels of competition for posts is critical for IMGs thinking of coming to the UK and the RCP now publishes this information showing the number of applications received for different grades and specialties on the *British Medical Journal's* (*BMJ*) 'Career Focus' website (www.bmjcareers.com/juniorcomp).

The 'average doctor' will send off 227 applications if applying for a senior house office (SHO) post before obtaining a post, and 430 applications if applying for a PRHO post. Competition is greatest for posts in Wales, and posts in medicine, accident and emergency and surgery are the most sought after. The author knows of 30 advertisements in the past year that have attracted over 1000 applicants.

PROBLEMS IN SELECTION

A recent SHO advertisement in a *BMJ* 'Career Focus' specifically stated that random methods might be used for short-listing, and many trusts replying to the RCP questionnaire stated that only the first 100–200 applicants received would be considered, the remaining CVs being discarded. With such large numbers applying random methods are likely to be widely used. They are not satisfactory and will disadvantage talented UK graduates as well as IMGs.

It would be better if the marks IMGs obtained in PLAB and especially PLAB1 taken before coming to the UK could be used as an indication of merit. But the GMC is reluctant to change, arguing that PLAB is a pass/fail exam to assess minimal competencies needed to work at SHO level, not to grade candidates. The PLAB mark may or may not point to whether an IMG is a capable and caring doctor (but then nor does MB), but is preferable to the random methods currently used.

In practice, the IMG's performance in a clinical attachment often swings the balance in favour of appointment, especially if a post becomes available in the hospital where the doctor is based. However, this puts the selection barrier back from definitive job to clinical attachment and begs the question as to how one chooses candidates for clinical attachments.

Ideally, selection methods should be applied before graduates give up their jobs at home. To achieve this would require a central regulatory body for IMGs. The equivalent in the US, the National Resident Matching Programme (NRMP), has run for 52 years as a private not-for-profit corporation covering all resident programs. Linked to this would be the desirability of holding the PLAB 2 exam in the candidate's home country, to prevent candidates giving up their posts at home to take the exam in the UK (Catto, 2004). There would be financial implications for a central scheme but insignificant compared to the £1 billion or more saved to the UK taxpayer by training the 10 000 IMGs currently in training grades overseas.

Sadly, in the short-to-medium term there is little prospect of a central regulatory authority. Instead, as a holding measure, the RCP working group with the Academy of Royal colleges has published a 'Black Box', warning of the current situation with regard to job opportunities in the UK. It is hoped this factual warning which has been

widely publicized will allow IMGs to be better informed on job prospects before coming to the UK (Warning to all overseas doctors, 2005).

DESIGNATED POSTS FOR IMGS?

Some argue IMGs are too experienced to apply for PRHO posts but many do apply and in 2002 IMGs made up 14% of PRHO posts (Trewby, 2005). PRHO posts are an excellent introduction to the NHS. They give IMGs an advantage when applying for SHO positions and give first-hand bedside experience which remains the strength of UK medical education. Flexibility in delivery of the additional formal teaching required should allow PRHO posts (and Foundation Year 1 posts) to be educationally sound starting posts even for more experienced IMGs.

Trust posts (at both PRHO and SHO level) have mushroomed in recent years. Many are outside the umbrella of the colleges and postgraduate deans, but often are of the same standard as recognized posts and rotate with them. Increasingly, IMGs are appointed to these posts and more may be appointed from 2005 when foundation posts will subsume most SHO and PRHO posts into 2-year training programmes.

It is disappointing that IMGs, who fill 30% of all training grades, receive so little attention in published discussions on foundation posts. The pragmatic approach is to accept the likely further increase in trust posts so as to maintain ward-based clinical services but to regulate them and designate them as stand-alone or linked posts tailored specifically for the educational needs of IMGs.

The increased UK medical school output may further squeeze the number of posts available for IMGs making it even more important to monitor the competition for posts to prevent the number of unemployed IMGs rising further.

CLINICAL ATTACHMENTS

Clinical attachments both pre- and post-PLAB are essential for introducing IMGs to the NHS but are very difficult to obtain. Many consultants view clinical attachments as a drain on departments but they do give consultants an opportunity to judge the suitability of the graduate for locum or definitive posts in their own hospital.

With the current number of IMGs passing PLAB, access to clinical attachments must be improved. A contentious issue is whether post-PLAB clinical attachments should be offered fixed-term honorary SHO posts. If offered, GMC registration would follow and allow the doctor to be assessed in the workplace. Although seen by some as exploitive many feel that trusts should set up trial schemes. The posts would be supernumerary and time limited, and the benefit to the SHO would be that the post would provide more training and experience than clinical assistant posts currently do.

The service commitment, especially at the beginning of the post, would be little more than that necessary to assess competence and application. The advantage to trust and deaneries would be that SHOs could be fully assessed in the workplace and placed according to ability. Extrapolating from the RCP 2003 census, around 3000 consultants have a regular on-call medical commitment (Federation of the Royal College of Physicians of the UK, 2003). Even if all newly registered IMGs did a medical rather than surgical attachment each consultant need only have two clinical attachments per year.

CONCLUSIONS

In the short term, publicizing lengths of unemployment and levels of competition for junior posts will give a realistic view of current job prospects in the UK. In the long term, and presently but a pipe dream, consideration should be given to a central body to assist IMGs from the time they consider coming to the UK through to appointment to first post. IMGs constitute 1/3 of the medical workforce. It is wrong that proportionally so little is given to this group when so much is given to foundation posts principally for the benefit of UK graduates.

There is a need for an individual response from consultants as well. Consultants can make a difference by taking a more altruistic view of clinical attachments and encouraging our trusts and deaneries to do likewise. Easy access to this vital introductory stage to the NHS would make a huge difference to IMGs.

It is a sad day for the NHS when the chairman of the BMA has to speak so critically of our dealings with IMGs. But he is right. We fall short of the mark. HM

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KEY POINTS

- There has been a five-fold increase in the number of international medical graduates passing the Professional and Linguistic Assessment Board examination exam in the past 4 years.
- The result is an unprecedented number of applicants for junior doctor posts with many attracting over 1000 applicants.
- There is a need for a more focused institutional response from the Department of Health, the colleges and deaneries.
- There is also a need for a personal response from individual clinicians to increase the number of clinical attachment posts.