The Advice Zone

Got a career or related problem that needs answering? Can't find the right person to point you in the right direction? Log on to the Advice Zone (www.bmjcareers.com/advicezone) for reliable medical careers advice. You can post a question or see if one of our 300 advisers has already answered a similar question. Here is a selection of questions and answers posted on the site.

What are the chances of a non-European Union resident getting a type 1 training number in orthopaedics? Is there any chance that I could be a consultant in orthopaedics in the United Kingdom? (I am a Pakistani national.)

Dr Phil Hammond, the comedian and general practitioner, has recently written a sitcom about an Asian orthopaedic surgeon who struggled to get the top London teaching hospital job that he wanted but instead was banished to the Isle of Wight. Sadly, this does reflect the prejudice that remains in the 21st century among the medical community.

"Racism blocks the career progression of doctors from ethnic minorities and from overseas," a BMA report said (*BMJ* 2003;326:1418). It saddens me to quote such a line, but all the evidence is there that it is no doubt more difficult to get the job you want if you are from overseas. Saying that, there are plenty of senior orthopaedic surgeons in the United Kingdom who are not UK trained.

You must have the following to apply for such a post:

- General Medical Council registration
- MB BS or equivalent
- Membership of the Royal College of Physicians or fellowship of the Royal College of Surgeons, or equivalent
- Advanced trauma life support certificate
- Experience in recognised posts.

For further details approach the deanery of the region where you are interested in applying.

A consultant for whom I once worked whispered in my ear, "Don't worry about the job shortages, there's always room for the best." I took this advice to heart and spent the next few years not worrying about what other people were doing and saying, instead striving for excellence and trying hard to achieve. I would now echo those sentiments to you. Yes, it will be harder for you to get a type 1 training number and it will be harder for you to get the job you want, but not impossible.

Andy Goldberg *specialist registrar in orthopaedics*
Whittington Hospital NHS Trust

I am an overseas doctor and I have passed my Professional and Linguistic Assessments Board (PLAB) test part 2. Can I apply for a senior house officer job in the armed forces in the United Kingdom?

This will depend entirely on whether you are entitled to join the armed forces in the United Kingdom. Citizens from countries within the Commonwealth are allowed to join, and so are those who hold a UK passport or dual nationality passport.

> If you are prepared to work anywhere within the United Kingdom, there will be a good variety and range of jobs to apply for

The best way to establish this is to look on the relevant armed forces website (for example, www.rafcareers.com), telephone 0845 6055555, or go to your nearest careers advice centre. The same rules apply for the army and the navy.

You will need to go through the selection procedure and initial training as described in the articles in *BMJ Career Focus*, which can be found in the archives—for example, military psychiatry.

Mel Temple *consultant psychiatrist, squadron leader RAF*

I am interested in doing genitourinary medicine. I have two years' work experience in this field in India. What are my chances of getting a senior house officer job in this field? Can I apply for an attachment before taking my PLAB test part 2?

Once you have successfully completed the Professional and Linguistic Assessments Board (PLAB) test part 2 and registered with the General Medical Council, you can apply for senior house officer positions in either genitourinary medicine or sexual and reproductive health. If you are prepared to work anywhere within the United Kingdom, there will be a good variety and range of jobs to apply for. These are advertised in *BMJ Careers*.

It is much more difficult to get an attachment before passing the PLAB test part 2. If you are resident within the United Kingdom and are interested in doing an attachment, I suggest you approach your local genitourinary medicine department.

Alison Bigrigg *president, Faculty of Family Planning and Reproductive Health Care*

I am an overseas doctor who has completed three years of training in community health. I am interested in pursuing a career in public health in the United Kingdom. What would I need to do to get shortlisted for a specialist registrar position apart from working in a clinical post for a year (as advised by a director in public health)?

Public health as a specialty welcomes people from a wide range of backgrounds. The Faculty of Public Health sets the minimum criteria for eligibility for a specialist registrar post. Currently the criteria are:

- Registration with the General Medical Council (full or limited)
- Two years' postregistration experience (general professional training), of which at least 12 months must be in specialties involving direct patient care.

Mature entrants with a longer period of postgraduate experience are welcome.

The Faculty of Public Health website (www.fphm.org.uk) gives further details. Go to the website and then click on Training. This website also gives other useful information—for example, about examinations. Specialist registrars are appointed through open competition, so even if you meet the minimum criteria you would not automatically get a post.

Each region in England has one or more programme directors in public health, and I recommend getting in touch with those in the region(s) where you are interested in working to find out about the local training programme. Their contact details are on the Faculty of Public Health website (address above).

Joyce Carter *consultant in public health medicine*
Central Liverpool Primary Care Trust

19 June 2004

THIS WEEK

According to GMC statistics, 90% of overseas doctors find their first job within a year after passing the exam of the Professional and Linguistic Assessments Board (p 254). That is certainly not the impression expressed in this special issue.

Fifty two overseas doctors at the West Midlands induction course summarise the problems they experienced (p 243), and we have a round up of the 50 plus responses that overseas doctors sent to a recent article, *Misinformation, poverty, and overseas doctors* by a BBC journalist (p 274).

Opposing opinions is a theme in itself in this issue. For example, Modernising Medical Careers will help overseas doctors (p 256), will not help overseas doctors (p 244), and our section on clinical attachments shows that there are no firm rules about how to organise one (p 262-5).

But the full range of information, views, and advice should give overseas doctors insight into what working in the United Kingdom is really like and their choices of progressing their career here. There is currently no clear answer to the problems overseas doctors experience, but the next 32 pages may help. There is also some extra material on the web including some advice from the overseas doctors whose photographs appear in this issue.

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What do overseas doctors think?

Career Focus *asked* Mohamed Arafa, *to report back from the overseas doctors recently attending the West Midlands induction course*

What do you get if you ask 52 overseas doctors (four from Europe, five from Middle East, and 43 from the Indian subcontinent) what they think the problems are at every stage they go through?

Problems before the Professional and Linguistic Assessments Board (PLAB) test

(1) Lack of information about the NHS before coming to the United Kingdom.
- Structure of NHS
- Postgraduate training
- Access to career information and guidance
- Advice about studying for PLAB.

(2) Inaccurate or ambiguous information about shortage of doctors in the United Kingdom leading to unrealistic expectations. There has been a recent increase of adverts published in local newspapers in India and Europe, encouraging doctors to come to the United Kingdom where there is supposedly a medical workforce crisis. However, these adverts did not indicate that these opportunities are available only for fully trained doctors in certain specialties—for example, psychiatry, histopathology, and general practice.

Problems during studying for PLAB

(1) Lack of information about PLAB (contents, recommended books, etc).
(2) Lack of courses (approved or run by the General Medical Council) aimed at helping the overseas doctors to pass PLAB.
(3) PLAB part 2 can be taken only in the United Kingdom. It is a financial burden. Overseas doctors have to fund the examination fees, travel expenses from their own country, and living expenses in the United Kingdom.

Problems after passing PLAB

(1) Extreme difficulty in getting a clinical attachment.
(2) Some trusts (mainly in London) charge £150 for processing applications for clinical attachments.
(3) Poor job prospects (many shared their horror stories).
- Some applied for over 400 jobs but still were unsuccessful
- Some applied for a job and when there was no response telephoned human resources to be told the job was either given to an internal candidate or the interview was held before the closing date as there were too many applicants
- Great difficulty in trying to speak to the contact (either consultant or human resources) given in the advert to find out more about the post
- Each trust uses a different application form and asks for five to 10 copies
- The trusts send the application forms by second class post, which usually arrives too near to the closing date to make it worth while applying.

(4) Many have been unemployed in the United Kingdom for six, and some for more than 12, months.

Mohamed Arafa *associate postgraduate dean and consultant orthopaedic surgeon*
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Overseas doctors in the UK: Setting the scene

Peter Trewby *discusses the current problems facing overseas doctors in the United Kingdom*

Over the past few years, the situation concerning overseas doctors finding their first job in the United Kingdom has deteriorated. More overseas centres have opened for the part 1 PLAB exam and a purpose built centre for the part 2 PLAB exam opened in 2003 now offers 10 000 places per year, up from 1300 in 2000.[1]

Articles and advertisements, many sponsored by the British Council and Department of Health, have appeared in Indian newspapers encouraging doctors to seek employment in the United Kingdom.

It is not surprising that the number of applicants for senior house officer (SHO) and preregistration house officer (PRHO) has risen rapidly, and vacant PRHO posts are now attracting over 1000 applicants, the vast majority from non-EU countries.

Wasted skills

A survey of 800 applicants for one PRHO post showed that those applying had already spent on average 11 months out of work.[2] Extrapolating to those applying for PRHO posts today shows that 1000 doctor years are currently wasted in futilely filling in application forms, waiting for clinical attachments, and hoping for job interviews.

Medical skills expensively acquired in home countries are wasted. Applicants for one PRHO post had applied for an average of over 260 posts without success, and many had suffered financial and personal hardship during this time.[2]

As regulations currently stand, overseas doctors find it difficult to obtain locum posts as registration is only granted after a post has been obtained and the papers take too long to process. This will change when registration becomes automatic after PLAB. Also, because of Home Office regulations doctors cannot obtain alternative employment either. Many doctors are experienced, with part 1 of the membership of the Royal College of Physicians (MRCP) or equivalent, and should not be applying for PRHO posts. They are advised that they are unlikely to obtain an SHO post against current competition without having done a PRHO post first.

Author: Peter Trewby

Invaluable service commitment

Overseas doctors make up 33% of UK SHO posts and 14% of PRHO posts and give invaluable service commitment to the NHS while working in training grades.[1] In many district general hospitals more than two thirds of junior doctors have trained overseas. It surprising that, despite the their numerical importance in service provision in UK hospitals, no mechanism is in place for regulating the number of doctors taking PLAB, no attempt is made to match these numbers to likely training vacancies, and no central mechanism exists for arranging clinical attachments.

Even with the expansion of the output of medical schools in the United Kingdom by 2000 per year (to a total of 5400) by 2008[3] it is likely that we will still depend on overseas doctors to meet the extra demands caused by enforcement of the European Working Time Directive as well as doctors' career breaks and part time working associated with rising numbers of women doctors.

Foundation programmes

The two year foundation programmes to be introduced in the United Kingdom in 2004-5 are likely to disadvantage overseas doctors further. These programmes will be aimed at newly qualified graduates and offer rotations equivalent to PRHO and first year SHO posts so as to build up transferable core skills across different medical fields.[4] The posts would be unsuitable for most overseas graduates as most already have three or more years' experience after graduation.[2]

If PRHO posts were subsumed within these rotations, specific standalone posts might be needed for overseas graduates. It is really not clear how overseas graduates will be accommodated within the foundation year programmes (see interview with Steve Field, p 256).[4] Nor is it yet clear how the influx of doctors from new EU countries will affect applications for posts in the United Kingdom nor to what extent they will deplete medical services from their home countries.

What can we do?

Information

The number of applicants for PRHO and SHO posts with trends over time would be a helpful barometer of the number of overseas doctors looking for training posts. Such information could be posted on overseas doctor web sites and on the websites of the General Medical Council, British Council, and royal colleges and published in *BMJ Careers*, which is the first port of call for doctors applying for posts in the United Kingdom. This information could be easily obtained and disseminated.

Changes to PLAB

Restricting the number of PLAB sittings may not be a satisfactory solution as it could lead to longer waiting lists for PLAB, with doctors missing training opportunities early in their careers. Raising the pass mark for PLAB would mean restructuring the exam to allow it to grade knowledge and skills rather than be a pass or fail exam. Capping the numbers passing PLAB may have disadvantages, but many considered it preferable to doctors coming to the UK, passing PLAB and being unable to find employment. Restricting or raising the pass mark of PLAB part 1 would cause less hardship than altering part 2, which is more expensive and has to be sat in the UK (see interview with Graeme Catto, p 254).

Managed clinical attachments

This is a theme currently being explored by the Department of Health and Conference of Postgraduate Deans (COPMeD) (see article by Alan Rich and Cynthia Marvin on p 264). However, until such a scheme is established along with a central register of hospitals and consultants willing to take on clinical attachments established, the current unfair and piecemeal situation is likely to continue.

GMC registration changes

Proposals from the GMC to allow registration to follow PLAB automatically (see interview with Amanda Watson, p 255) would allow doctors on clinical attachments to act more as locums than observers and allow them to demonstrate their skills and competencies.

Geographical zoning

Trusts have their own problems with such large numbers of applicants. Conventional criteria or person specifications cannot be used to grade such numbers all of whom fulfil the criteria for PRHO posts. Shortlisting is arbitrary, with patronage playing a part: doctors who are lucky enough to obtain clinical attachments are often favoured in their own hospital. Doctors spend time and money filling in and posting CVs. Each trust has different requirements, some requiring up to eight copies of CVs. A central electronic repository for CVs would save on duplicating and postage.

Currently most applicants apply for all or most jobs, which is reflected in the increase in applicants for PRHO and SHO posts across the United Kingdom. A geographical zoning system might need to be imposed by the deaneries. It would certainly help reduce the number of applicants per trust by directing applicants to one or two regions chosen by them or chosen arbitrarily so as to distribute applicants evenly.

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INFORMATION

An updated quick guide to working in the United Kingdom

Jo Constable *runs through all the main procedural and practical points*

Considerable media coverage of the shortage of doctors in the United Kingdom has prompted many doctors to seek work here. However, when they arrive some find the situation is very different. While the United Kingdom has a severe shortage of general practitioners (GPs) and consultants, demand for training posts is high, especially in popular specialties such as surgery and paediatrics, and competition can be fierce. If you decide to come to the United Kingdom, it is essential that you research fully the situation within your chosen specialty before you leave.

To overcome the GP and consultant shortages the Department of Health in England has undertaken a recruitment drive. More information is available on the website www.dh.gov.uk/PolicyAndGuidance/HumanResourcesAndTraining/MoreStaff/InternationalRecruitmentNHSEmployers/fs/en

The next step

Once you have sorted out whether you are an overseas doctor and why you want to come to the United Kingdom and you have arranged immigration and visa requirements, the hard work begins. Your main aim before you can begin any clinical work or write prescriptions is to get limited registration with the General Medical Council (GMC) so that you can be put on the UK medical register.

This article is a basic guide and does not cover everything in detail. You can obtain a comprehensive *Guide for doctors new to the United Kingdom* from the BMA's International Department (internationalinfo@bma.org.uk).

Immigration

Overseas doctors coming to the United Kingdom must satisfy immigration requirements. Immigration law is complex and doctors who are in the United Kingdom should seek detailed advice from the Home Office (www.ind.homeoffice.gov.uk). If you are outside the United Kingdom you should contact your local British embassy or high commission for further information. A list of British embassies and high commissions is available on the Foreign and Commonwealth Office website (www.fco.gov.uk).

Doctors who are citizens of the countries in the European Economic Area (EEA) are entitled to enter the United Kingdom freely and work here.

Doctors from beyond the EEA may have rights to live and work in the United Kingdom if, for example, they are the spouse of an EEA national or work permit holder or because they have Commonwealth ancestry. Doctors who think that they may have such rights should seek advice from the Home Office or the British representative overseas.

Postgraduate permit-free training status

Doctors wishing to do postgraduate training in UK hospitals or community health services must have permit-free postgraduate training status, which means that they may work without a work permit. The GP registrar year can now be done under permit-free postgraduate training status. To qualify for this, the doctor must have GMC registration and show that he or she intends to work in a training post within the NHS. Full details can be found on the Home Office website. Current Home Office guidance states that leave to enter on postgraduate permit-free training status should be granted in line with the period of appointment offered. This is the case even for shorter appointments—for example, six months or less.

On 1 August 2003 the Home Office introduced charges for applications for leave to remain. These charges will be incurred by any doctor seeking permit-free postgraduate training status, either for the first time or when extending their existing leave to remain. Current charges are £250 ($446; €371) for the premium same day service for personal callers and £155 for postal applications.

Work permits

Doctors working in hospital career grade posts (non-training grades), as consultants or as salaried or locum GPs, will require a work permit. Employers apply for the permit from Work Permits United Kingdom. A usual requirement is that no suitably qualified EEA national is available to do the job. A work permit is specific to a particular post and cannot be transferred should you obtain another job before it expires.

On 1 April 2004, the work permit application process gained another stage. After the employer has successfully applied for a work permit the employee is now required to apply for leave to remain in the United Kingdom, which costs £121 at the time of writing. For up to date information check www.workingintheuk.gov.uk/working_in_the_uk/en/homepage/work_permits.html

Highly Skilled Migrant Programme

The Highly Skilled Migrant Programme (HSMP) allows highly skilled people to migrate to the United Kingdom to look for work opportunities. Applicants can apply from both within and outside the United Kingdom, although certain immigration categories are excluded from applying from within the United Kingdom. It is a points based assessment of skills and achievements and successful applicants are initially granted permission to work in an appropriate field for 12 months without being tied to a particular employer. At the end of the 12 months you can apply to stay for longer on provision of certain evidence. For further information see www.workingintheuk.gov.uk/working_in_the_uk/en/homepage/schemes_and_programmes/hsmp.html. This can be applied for from both within and outside the United Kingdom.

Author: Jo Constable

At the time of writing, fully trained GPs who hold a vocational training certificate or who have been assessed by the Joint Committee on Postgraduate Training for General Practice (JCPTGP) and hold a certificate of equivalent experience are considered priority applications and given an additional 50 points.

Asylum seekers and refugees

The BMA maintains the BMA/Refugee Council refugee doctors database. The project collects details on the number of refugee doctors in the United Kingdom, their location, and the stage of their career and registration process. For more information and a copy of the Jewish Council for Racial Equality's *Guide for Refugee Doctors* please contact the BMA International Department.

Doctors from the European Economic Area

One of the most important principles of European law is that of free movement, which is underpinned by mutual recognition of qualifications. Under Directive 93/16/EC doctors who are citizens of an EEA member state and who have qualified in an EEA member state have the right to live and work in any other country in the EEA. Asking EEA nationals to take a linguistic test is unlawful as it would be a barrier to their right to live and work in another EEA country. It is the responsibility of the employer to make sure that the doctor is proficient in written and spoken English.

The accession states

On 1 May 2004, 10 new member states acceded to the European Union: Cyprus, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Slovakia, and Slovenia. However, doctors from these countries will be able to use mutual recognition legislation to get automatic registration in the United Kingdom only if their country's training regimens satisfy the requirements within Directive 93/16/EC and they started their basic medical training after 1 May 2004.

For doctors who qualified before 1 May 2004 it is anticipated that they will have to use acquired rights or treaty rights on a case by case basis.

Acquired rights are negotiated separately in each country. They mean that doctors coming from most accession states would have to be registered in their home countries before a certain date and have been in practice since that date.

Treaty rights are more general. They would entail rights to freedom of movement, freedom of establishment, and freedom to provide services accorded to all European Union citizens by the Treaty of Amsterdam. These would enable doctors who are not covered by either Directive 93/16/EC or who do not have acquired rights to make the case for their qualifications to be recognised through the general system of recognition.

Where doctors' qualifications are from third countries—for example, in the case of doctors from the Baltic states with qualifications issued in the former Soviet Union—accession states have been asked to make declarations about the equivalence of such qualifications. They will have to attest that these doctors have recently been practising medicine.

This information is correct at the time of writing, but owing to the fluid nature of this area it is strongly advisable that individual doctors check their position with the GMC. A fact sheet is available on the GMC website at www.gmc-uk.org/register/eu_accession_member_states.htm

GMC registration

Currently, doctors who wish to practise medicine in the United Kingdom must be registered with the GMC.

There are four different types of registration with the GMC: provisional, limited, full, and specialist. The GMC is currently undertaking a comprehensive registration review. The draft new rules and regulations are due to be published in the latter part of 2004. Please see the interview with Amanda Watson, director of education and registration with the GMC, for more information. (p 255)

Provisional registration allows doctors who have qualified in the United Kingdom or EEA (who are also EEA nationals) to work in preregistration house officer posts which are approved for the purpose of preregistration service.

Limited registration allows overseas qualified doctors who hold an acceptable qualification (included in the World Health Organization's list of medical schools—www.who.int/hrh/documents/HRH_documents/ en/index1.html) to practise in supervised NHS training posts (preregistration house officer, senior house officer (SHO), GP registrar, specialist registrar) which are educationally approved. It is also granted for locum posts at these grades. (Note that although the post you may take is at junior house officer level you need to be at SHO standard to pass the Professional and Linguistic Assessments Board (PLAB) exam needed to get GMC registration.)

Dr John Thomas

Full registration allows doctors to practise in unsupervised medical practice in any post in the NHS and in private practice. This type of registration is needed to work as a GP.

Specialist registration allows doctors to take up a substantive or honorary consultant post in the NHS. No doctor can take up these appointments unless they are on the specialist register.

In some special cases overseas qualified doctors can be granted *temporary full registration*. This is for doctors who are coming to the United Kingdom to provide a temporary specialist service (for example, demonstrating a particular technique that is not available in the United Kingdom) for a short time. All other overseas doctors have to apply for limited registration.

How long does limited registration last?

Limited registration is granted for periods totalling no more than five years. The first grant of limited registration can be for 12 to 18 months. After this it may be granted for a period of up to two years. Registration expires at midnight on the last day of registration shown on your certificate of limited registration. You can apply to renew your registration up to three months before the date on which you need further limited registration.

How do I renew my limited registration?

Before further limited registration can be granted, the GMC needs to be satisfied that a doctor's performance complies with the standards of competence, care, and conduct described in the GMC's publication *Good Medical Practice*. The assessment of performance is carried out by the doctor's supervising consultants using a GMC report form.

Application forms, report forms, and fact sheets can be downloaded from the GMC website (www.gmc-uk.org/register). You should aim to submit the application form for renewal of registration as early as possible. Make sure you have all the evidence and fees required or your application may be delayed.

How do I progress to full registration?

You normally need at least 12 months' experience at SHO or specialist registrar level with limited registration to apply for full registration. (The GMC's website has a fact sheet giving all the criteria for full registration—www.gmc-uk.org/register/fr.htm) Again, you need to submit an application form (available on the GMC's website), a report from your supervising consultants, and a registration fee.

What are the costs of registration?

You have to pay a fee every time you apply for registration. The amount depends on which type of registration you are applying for and whether it is an initial registration or a renewal. At the time of writing an initial application for 12 months' limited registration costs £390. For detailed information about all registration fees see www.gmc-uk.org/register/fees.htm. Refugee doctors pay only £290 for their initial application for 12 months' limited registration and are entitled to pay their registration and subsequent annual fees by quarterly instalments.

New GMC licence to practise

The GMC is changing the registration system for doctors. At present, any doctor eligible to practise medicine in the United Kingdom is included in the medical register. This system is being enhanced, and by the end of 2004 each doctor who is on the medical register will be granted a licence to practise. Any doctor joining the medical register after this date will automatically receive a licence to practise when they are granted registration. From early 2005, it will be a legal requirement that any doctor wishing to practise medicine in the United Kingdom must hold a licence to practise. As yet, the GMC has not confirmed the form that this licence will take. However, it anticipates it will be held with a doctor's registration information on the internet. The licence will be of a general nature only and not related to the doctor's specialty. In addition, no conditions or restrictions will be added to it. Any such provisions will be entered in the medical register, as with current practice.

Revalidation

In order to maintain their licence to practise, doctors will be subjected to revalidation at regular intervals—normally every five years. The revalidation process will start sometime in 2005 and the GMC will be selecting doctors on a random basis. Doctors will be required to show that they have been practising medicine in line with the standards contained within *Good Medical Practice* which are relevant to the doctors' specialty and practice.

For the most up to date information about revalidation see the joint GMC and Department of Health website—www.revalidationuk.info

Explaining the IELTS

One of the registration requirements for all doctors who qualified outside the EEA is that they must show that they have the necessary knowledge of English by obtaining a satisfactory score in the International English Language Testing System (IELTS) exam. The GMC is currently reviewing the IELTS test as a method for assessing language skills. Please check with the GMC for up to date information.

Facts about the IELTS test

- The IELTS test is a test of the skills that are needed for study in an academic context in the United Kingdom.

Dr Sahana Kini

- The test has four separate components: listening, speaking, reading, and writing; each is scored individually and an overall score awarded.
- It is not a pass or fail exam: the test is banded from 1 to 9, with 1 indicating a basic knowledge of English and 9 indicating language skills at native speaker level.
- A score is provided for each individual module, as well as an overall score.
- The GMC asks for an overall score of 7.0, with a score of at least 7.0 in the speaking component and a score of no less than 6.0 in the other three components. To be exempt from the PLAB tests you must gain at least 7.0 in all four sections of the IELTS test.

How can I apply for the IELTS test?

Candidates can sit the exam in centres all round the world. www.ielts.org.uk gives information on your nearest IELTS testing centre. IELTS test preparation courses run in many colleges and universities across the United Kingdom and in other countries. For more information contact your local testing centre (found at most universities and some colleges and at www.ielts.org).

How much does the IELTS test cost?

The IELTS test currently costs £83. Payment should accompany the completed application form.

How long does the IELTS test last and how often can I do it?

Any doctor who has not obtained registration within two years, or in the case of PLAB test candidates has not passed part 1 of the PLAB test within two years, will need to prove they have actively maintained or tried to improve their English language skills since passing the IELTS test. There are a number of ways to provide this proof, including:

- Sending the GMC proof of participation on a postgraduate course of study within the two years since taking the IELTS test where the main language of instruction and examination was English
- Submitting a reference by a UK employer, tutor, or lecturer on a postgraduate course of study. The GMC provides a structured reference form
- Sending proof that the IELTS test has been taken again and the required score was obtained.

This list is not exhaustive and the GMC will consider each request on an individual basis. For further information go to www.gmc-uk.org

There is no limit on the number of times a person may sit the IELTS exam. However, a candidate is not allowed to sit the exam within three months of a previous attempt.

For links to some excellent sites with information on the IELTS, practice papers, and tips for IELTS candidates go to www.britishcouncil.gr/english/materials3_ielts.htm

Explaining the PLAB test

The PLAB test is difficult and is somewhere between finals and postgraduate examinations in level of difficulty.

What does the PLAB test entail?

The PLAB test consists of two parts:

- *Part 1* consists of a three hour extended matching question exam which emphasises clinical management but also includes science as applied to clinical problems
- *Part 2* is an objective structured clinical examination (OSCE) with 14 stations. The aim of the OSCE is to test candidates' clinical and communication skills in a number of controlled situations.

Requirements for taking the PLAB test

Candidates must have:

- A primary medical qualification acceptable for limited registration (see WHO list www.who.int/hrh/documents/HRH_documents/en/index1.html)
- Taken and obtained an acceptable score in the IELTS test. The GMC currently requires a higher IELTS score for doctors who are exempt from the PLAB
- A valid IELTS report form dated not more than two years before each attempt or proof of maintaining the required level of English.

Although newly qualified doctors can apply for the PLAB test, you need to be competent to the standard of an SHO to pass (even though you will be allowed to work only as a preregistration house officer) and so clinical experience is advisable before applying.

Where can I take the test?

In addition to the United Kingdom, part 1 of the test can currently be taken in Australia, Bulgaria, Dubai, Egypt, India, New Zealand, Nigeria, Pakistan, Russia, South Africa, Sri Lanka, and the West Indies. A list of specific test dates and centres can be obtained from the GMC website. Part 2 of the test can be taken only in the United Kingdom.

How much does the PLAB test cost?

Current fees are £145 for part 1 and £430 for part 2 (but see the website for more up to date information). Refugee doctors living in the United Kingdom do not have to pay the fee for part 1 on their first two attempts, and they pay a reduced fee of £330 for their first two attempts at part 2. Eligible doctors need to send the GMC a copy of a letter from the Home Office confirming their refugee status.

Dr Muhammed Kamaal Khan

How many times can I take the PLAB test?

There is no limit to the number of times you can take part 1 of the PLAB test. However, you may have only four attempts at part 2, which must be within three years of passing part 1. A pass in PLAB 2 is valid for only three years. If you fail part 2 of the PLAB test on the fourth attempt you must retake the IELTS and part 1 again.

How do I apply for the test?

You must fulfil all the preconditions and complete and return an application form (which you can download from www.gmc-uk.org/register/plab.htm) with the appropriate fee.

Exemption from PLAB

There are a number of different ways to gain exemption from the PLAB test:

- Participation in the overseas doctors training scheme (ODTS) or sponsorship by the British Council (see below)
- Completion of basic specialist training—for example, passing the exam for membership of the Royal College of Physicians (MRCP) or the Royal College of Surgeons (MRCS)
- Appointment to a type 1 specialist registrar post
- Eligibility for specialist registration.

Sponsorship by the medical royal colleges

The ODTS is a scheme run jointly by the Department of Health and the medical royal colleges; it is therefore also referred to as a double sponsorship scheme. However, some royal colleges no longer operate the double sponsorship scheme and sponsor overseas doctors independently; contact the relevant royal college for the latest information.

The scheme allows experienced overseas doctors to be exempt from the PLAB test so that they can continue their specialist training in the United Kingdom before returning home. The scheme is not designed for overseas doctors to remain in the United Kingdom after completion of specialist training.

Requirements for sponsorship vary, so you would need to contact the individual colleges to find out details (go to www.aomrc.org.uk/pages/links/collegelinks.html for the college relevant to you).

All colleges require a score of at least 7.0 in all four bands of the IELTS test, at least two years' experience in the specialty in which you wish to practise, and a primary medical qualification acceptable to the GMC for limited registration. However, there are some criteria for excluding applicants from the scheme (see box)

Exclusion from the ODTS

Applicants to the ODTS will be excluded if they:

- Have previously failed the PLAB test
- Do not hold part 1 of the relevant royal college's exam (clarify requirements with appropriate royal college)
- Have qualified in or are nationals of an EEA country or a country with enforceable European Community rights
- Are already working in or are resident in the UK or another member state of the European Union.

Some of the colleges will not accept applications directly from candidates—only appropriate sponsors may apply on their behalf. Always check directly with the appropriate royal college.

British Council sponsorship and trust fellowships

For detailed information about sponsorship and trust fellowships contact the British Council in your country of origin. Contact details can be found at www.britishcouncil.org/where/index.htm Where there is no British Council office, contact the British embassy or high commission. Funding is administered overseas. There can be limitations, but to find out more information and get a pack detailing criteria call the National Advice Centre for Postgraduate Medical Education (NACPME) on 01609577218 or go to www.britishcouncil.org/health/nacpme/

What are clinical attachments and why might you do them?

What?

A clinical attachment is a work placement carried out at a hospital where you are able to shadow a doctor and find out about the work they do and how the hospital works. You will not be paid for a clinical attachment; it is purely for your own benefit. You will normally have a named supervisor who is responsible for you. Clinical attachments normally last between two and four months.

Why?

Clinical attachments can be useful, especially before the second (clinical) part of the PLAB test. It is advisable to do an attachment after passing the IELTS or PLAB tests so that you can get the most out of it and get a good reference.

Clinical attachments may help to give you an understanding of how the NHS works and how medicine is practised in the United Kingdom. They might also help you to brush up on clinical skills, which may be rusty if you have been out of work for a while, and give you some insight into the knowledge base that is required of UK doctors.

A clinical attachment might also help you overcome cultural differences that you will face in the United Kingdom and will familiarise you with local accents and peculiar phrases. You may also encounter diseases and investigations that are common in the United Kingdom and with which you may not be familiar.

An attachment may be the only way an overseas doctor can get a reference from a UK consultant, which could prove helpful when it comes to looking for jobs.

How?

There is no central body which arranges clinical attachments. The best way to find an attachment is to write to individual hospitals, enclosing your curriculum vitae. Personal contacts can also be useful. The BMA has published guidelines on clinical attachments, which are available on http://www.bma.org.uk/ap.nsf/Content/ClinicalAttachmentGuidelinesIntro. Please be aware that demand for clinical attachments is high and it can take time to secure one.

Finding a job (to get limited registration)

To recap, in order to get limited registration with the GMC you need to find a job in a supervised NHS training post. Before that, you need to have passed IELTS and PLAB exams (or be exempt from the PLAB test).

Most jobs in the NHS are advertised in *BMJ Careers* (www.bmjcareers.com). You have to apply to the employer directly and send a curriculum vitae (see *BMJ Career Focus* 2002;325:165) or an application form (check the job advertisement to see if an application form is required). Employers then form a shortlist from all the applicants and invite these applicants for an interview. You need to be shortlisted and pass the interview to get the job. Unfortunately, the process of securing a job is often fraught with difficulties.

Modernising Medical Careers

In August 2002 the chief medical officer published a consultation paper proposing reforms to the SHO grade. A response was published in February 2003, entitled *Modernising Medical Careers*, which proposed radical changes to the UK medical training system. It created a new two year foundation programme for all medical graduates from August 2005 which will focus on developing key competencies. This means that from August 2005 preregistration house officer posts will cease to exist. Instead, doctors will apply for either foundation year one or foundation year two posts. It is envisaged that junior overseas doctors will probably enter the foundation programmes in year two, although they will not be excluded from applying for year one posts.

Since 2003 a number of pilot foundation programmes have been running throughout the United Kingdom, and some overseas doctors have been able to participate in these pilots. One positive aspect of the foundation programmes is the scope to meet individual needs through programmes that are tailored specifically for a particular doctor.

For further information about *Modernising Medical Careers* go to www.mmc.nhs.uk/index.asp

The Specialist Training Authority

The Specialist Training Authority (STA), along with the Joint Committee on Postgraduate Training for General Practice (JCPTGP), currently approves curriculums for specialist training and judges whether individual doctors have reached the standard set for them by satisfactory completion of training. One of the STA's roles is to approve or reject applications for specialist registration from doctors with overseas qualifications.

For overseas doctors, the medical royal colleges act as agents of the STA and undertake an initial assessment of an application, seek references and further documentary evidence, and submit a recommendation to the STA. Once the STA receives the recommendation with the applicant's details from the relevant college or faculty, it will make a decision on each application on whether a CCST should be awarded.

In October 2004 the Postgraduate Medical Education and Training Board (PMETB) will take over the functions of the STA. While the proposed new arrangements for the assessment of applicants to the specialist register are not yet available, the STA website has some information (www.sta-mrc.org.uk/news.html#1).

Postgraduate Medical Education and Training Board

The PMETB was established in 2002 as an independent body to supervise postgraduate medical education and training in the United Kingdom. In October 2004 it will take over from the STA and JCPTGP assessing training qualifications and experiences for the purposes of gaining entry to the specialist register or getting a JCPTGP certificate to work in general practice. For the first time, experience will count towards entry to the specialist register. In future, doctors will require a certificate of completion of training in general practice and each of the various specialties in order to practise as a GP or consultant (see *BMJ* 2004;328:103-5). Further information can be found at www.pmetb.org.uk, which while under construction takes you to information on the Department of Health website.

Higher specialist training

The process of obtaining higher training and registration as a specialist is rather bewildering, even for those of us living in the United Kingdom. There are many alternative career paths which do not lead to registration as a specialist but allow you to work at a higher level not in a specialist training programme.

Medical royal colleges are responsible for specialist training and a network of regional postgraduate deaneries administers and monitors the system. Appointment is by open competition to the relevant deanery. The minimum entry requirements are two years in the SHO grade plus the first part of a postgraduate qualification (for example,

Further reading

- *Guide for doctors new to the United Kingdom*. London: BMA, 2003. (Available free from the BMA International Department.)
- *Guide for refugee doctors*. London: Jewish Council for Racial Equality, 2004. (Available free from the BMA International Department.)

part 1 of the exam for membership of the Royal College of Obstetricians and Gynaecologists (MRCOG)). Those who are successful in getting a specialist registrar post will get a national training number. Unfortunately the number of national training numbers is limited.

Type 1 specialist registrar training

After entry into type 1 specialist registrar training, annual assessments called RITAs (record of in-training assessment) take place, for which you need to receive a satisfactory grade. When you have completed all of them, you will be eligible for a CCST and entry to the specialist register held by the GMC. The STA, supported by a recommendation from the relevant royal college or faculty, decides whether or not an individual doctor has met the standard required for a specified training programme to merit the award of a CCST.

Type 2 specialist registrar training

Overseas doctors can also work as type 2 specialist registrars on fixed term training appointments. Type 2 training programmes are specifically designed to meet the needs of the individual overseas doctor, but they do not lead to a CCST. Doctors are able to transfer from a type 2 to a type 1 post if they are successful in open competition (where they will be awarded a visiting training number).

The specialist registration process

By law in the United Kingdom, doctors must have their names on the GMC's specialist register before taking up a fixed term NHS consultant post. However, doctors can hold locum NHS consultant posts without being on the specialist register

Although it is a legal requirement to be on the specialist register, it is not a legal requirement to be on the register in the exact specialty in which a doctor may wish to practise if the employer decides the doctor has the particular skills and expertise required. Being listed on the specialist register does not automatically mean you will be shortlisted for or appointed to a consultant post.

Other work options

Locum appointments

All doctors, with or without right of indefinite residence or settled status and irrespective of their training status, are also eligible for locum appointments for training, which offer opportunities for training similar to the type 1 training programme, and locum appointments for service, which are not training appointments.

Staff and associate specialist group

The term staff and associate specialist group (SASG) is an umbrella term for the group of senior career grade doctors in hospital and community specialties whose posts do not require them to be on the specialist register. The group comprises associate specialists, staff grade doctors, clinical assistants, hospital practitioners, community health doctors, and a plethora of local non-standard trust grades. Some publications you may read use the term service grades. Sometimes it is used as an umbrella term to encompass SASG, consultants, and general practitioners; other times it is used to mean the same as a SASG post.

Under current arrangements, opportunities for career progression are limited but it should be much easier for this group of doctors to join the specialist register after the PMETB becomes operational on 1 October 2004.

Staff grade

Staff grade posts were originally introduced to make up the shortfall of specialist doctors following the limitations in the number of specialist registrar posts in order to find a way of providing essential services to patients in the acute specialties without training doctors for non-existent posts.

Associate specialist

Associate specialist is a senior grade usually filled by doctors who have, for one reason or another, chosen not to complete higher medical training or, having completed higher specialist training, have not taken up a consultant appointment. They must have completed 10 years' medical work since registration.

Trust doctors

Trust doctors are doctors employed by trusts on non-standard contracts to fill service gaps. They are not protected by national terms and conditions of service and might even be exploitative (see *BMJ Careers* theme issue http://careerfocus.bmjjournals.com/content/vol327/issue7421/index.shtml).

Training as a GP

Both the hospital and GP registrar components of GP training can be done while holding limited or full registration. You can either make up your own training scheme by applying for individual accredited posts or apply for a place on a vocational training scheme, which will organise these posts for you. Vocational training schemes are organised by local directors of postgraduate general practice education. There is no defined order in which posts should be completed.

The training path for a GP in the United Kingdom is to:

- Work as an SHO for two years in a hospital, rotating round hospital specialist posts that have been accredited for GP training. You can do this with limited registration with the GMC. The accreditation process is overseen by the JCPTGP and the Royal College of General Practitioners
- Work in an approved general practice partnership under the guidance and instruction of an approved GP trainer. This is called the GP registrar post, and you need limited or full registration to enter it
- During training, doctors undergo an assessment (summative assessment) process to test their competency (see www.rcgp.org.uk)
- Towards the end of their training many doctors elect to take the Royal College of General Practitioners' membership exam (MRCGP), but this is not a requirement for completion of GP training
- On completion of the training programme a doctor is eligible to apply for a certificate of prescribed experience from the JCPTGP, which is the competent authority for GP training. The JCPTGP certificate is a legal requirement to work in general practice in the United Kingdom. The functions of the JCPTGP will be transferred to the PMETB in October 2004 (see information box for more details).

Please note that all overseas doctors who are successful in applying to a deanery for a general practice training programme will be funded by the NHS for the GP registrar element of their training programme.

Dr S Krishnan

Immigration requirements for GPs

Once you have finished training as a GP registrar, two options are open to you. You can apply for salaried GP posts, for which you will need a work permit, or you can become a GP principal and apply to remain in the United Kingdom through the highly skilled migrant programme (see www.workpermit.com/uk/highly_skilled_migrant_program.htm and www.workpermit.com).

You can also apply to the highly skilled migrant programme if you are already a fully trained GP in your own country. However, you must obtain a certificate of equivalent experience from the JCPTGP before you can take up a post.

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P+ *Go to webextra at bmjcareers.com/careerfocus for more information, and advice from overseas doctors.*

Key points for overseas doctors to consider

Overseas doctor Shaaz Maboob *now works at the NHS London work programme office, on behalf of London strategic health authorities and workforce development confederations, specifically to look after the needs of overseas doctors. He outlines what overseas doctors should consider before they come to the United Kingdom and at every stage after that*

Each year, a sizeable number of overseas medical graduates decide to pursue their postgraduate medical training in the United Kingdom. Not only do they acquire quality education in specialist areas, but they also contribute to service provision in the NHS. The number of such doctors willing to train in the United Kingdom has increased steadily, and over the past few years the number of applicants to the General Medical Council for limited and specialist registrations has increased notably. It is anticipated that this number will continue to grow during the coming years in unprecedented levels.

The aim of this article is to provide practical guidance to overseas doctors who intend to train and work in the United Kingdom. The information provided should be useful not only for those doctors who are in the process of preparing for the Professional Linguistic Assessments Board (PLAB) examination or who are going through registration processes with the GMC, but should also act as a useful decision making tool for those doctors who are contemplating coming to the United Kingdom to obtain specialist training and qualifications.

One of the main problems faced by overseas junior doctors is lack of preparation and adequate advice. This article should not only provide useful information, but also help you cope with any unforeseen circumstances.

Background

There are several reasons for overseas doctors to come and train in the United Kingdom. One is the British model of higher medical education adopted in their home countries. Most doctors who join the British health system as a postgraduate trainee or as a member of the service staff originate from countries whose medical education system is based on the British model, with the medical school curriculum being taught by using renowned British reference books. Examples of such countries are India and Pakistan.

Similarly, the clinical tutors and professors at the teaching hospitals in these countries often possess memberships or fellowships of one of the UK royal colleges. This also proves an incentive for young medical professionals to attain similar training.

Language

Another key factor in attracting overseas doctors to Britain is the English language. Most overseas medical graduates study medicine with English language books and lectures delivered in the same tongue. English is also the official or second language of most of these countries, and fluency in both written and oral English is widespread. Naturally, for some of these doctors their first choice is to complete their training in the United Kingdom or other English speaking countries such as the United States and Australia.

Considerations for overseas doctors:

In addition to the information in Jo Constable's article (p 245), I have detailed the key steps towards obtaining higher medical training in the United Kingdom. This should allow overseas doctors to make informed decisions about their careers and assist in planning appropriately for their time spent in Britain.

Decision to train in the United Kingdom

Before taking any practical steps towards going to the United Kingdom for higher medical training, the prime consideration for overseas doctors should be to evaluate the existing circumstances in their home country and in the United Kingdom.

Any evaluation should include the following:

- **Equivalence of qualifications and training:** Doctors should establish whether their primary medical qualification is recognised by the GMC for the purpose of registration, either through the PLAB test or through any other route with possible PLAB exemption.

It is also important for doctors to find out whether their postgraduate training in their home countries is recognised by the royal college and GMC. For example, a period of training spent in an institution, which is recognised by the royal college of chosen specialty as appropriate training, might count towards gaining a post as a specialist registrar (SpR) rather than a post at senior house officer (SHO) level.

Useful websites: www.gmc-uk.org

- **Specialty (subspecialty) training options in Britain:** The doctors should decide on a particular speciality in which they intend to pursue their career. They should also try and find out whether any particular subspecialty training that they intend to undertake, is easily accessible to overseas doctors in Britain. Examples are: cardiothoracic surgery, child and adolescent psychiatry, or clinical oncology. Owing to a limited number of training placements, there may well be excessive competition and the overseas doctors' level of training would not be sufficient to allow them to be selected for such a placement. This might warrant gaining further qualifications or work experience while in their home countries before taking the next steps towards training in the United Kingdom.

The job prospects at SHO level might be different from SpR level posts. It is advisable for doctors to explore the possibilities of securing employment while deciding whether to train in the United Kingdom.

Useful websites: www.aomrc.org.uk

- **Registration requirements—PLAB or exemption:** With a recognised medical qualification and at least one year's internship (or house officer job) completed in their home country most doctors should be eligible to take the PLAB examination. There might be instances where the doctor's experience could lead to exemption from this examination. However, all overseas doctors, regardless of their level of experience, would be required to score at least 7.0 in the international English language testing system (IELTS) test.

Useful websites: www.gmc-uk.org

- **Information about the healthcare system in the United Kingdom:** Doctors should find out about the healthcare setup in the United Kingdom—the NHS. The NHS is funded by general taxation, and only a small percentage of service provision is through private organisations.

Doctors in training are all employed by the NHS, with standard pay scales and terms and conditions, and not by private hospitals. At this stage it is advisable to gain a thorough understanding of NHS organisations.

Useful websites: www.dh.gov.uk
www.nhs.uk/thenhsexplained
www.nhs.uk/thenhsexplained/HowTheNHSWorks.asp

- **Career in secondary or primary care:** It is extremely important for doctors to decide whether they wish to pursue a career within primary care or secondary care—that is, general practice or hospital jobs. Overseas doctors can find it easier to enter the training for general medical practice or the vocational training scheme (VTS) as it is called, which enables them to become general

Author: Shaaz Maboob

practitioners at the end of the training. This depends on each individual region and vacancy rates may vary.

Useful websites: www.rcgp.org.uk
www.dh.gov.uk/assetRoot/04/03/47/20/04034720.pdf
www.healthcentre.org.uk/hc/pages/gpvts.htm

- **Family considerations:** Any family commitments and the potential career prospects for the spouse should also be kept in mind before taking any decisions. It is quite common for the spouse of a doctor to be associated with the healthcare or medical profession and their future career options may act as an influencing factor in deciding whether to train in the United Kingdom. Employment for the spouse generally cannot be guaranteed at the same hospital. Any educational requirements for spouse or family should be taken into account while deciding to train in the United Kingdom.

Useful related websites: www.nmc-uk.org (Nursing and Midwifery Council)
www.hpc-uk.org (Health Professionals Council)
www.jobs.nhs.uk
www.nhscareers.nhs.uk
www.dfes.gov.uk
www.universitiesuk.ac.uk
www.ucas.ac.uk/getting

- **Correspondence:** It is advisable for doctors to keep a record of all their correspondence with the GMC or colleges, during the course of the decision making process and to keep it safe. It may be needed for future references (and may have to be shown at airports).

Deciding to train in Britain: before taking the international English language testing system (IELTS) test, PLAB, or applying for registration

- **Entry into the United Kingdom and visas:** Initially doctors need to apply for an entry clearance into the United Kingdom as a visitor. PLAB part 2 is held only in Britain and to appear in the examination, doctors must obtain a visitor visa from British embassies, consulates, or high commissions. At this stage doctors should also find out the procedure for entry clearance of their family.

Dr Paveen

Useful websites: www.fco.gov.uk
www.homeoffice.gov.uk

- **Exam timetables and travel plans to be coordinated:** Doctors should make every effort to coordinate travel plans according to the examination timetables. An initial visitor visa granted for the purpose of sitting the PLAB part 2 examinations is for a limited duration, and it is crucial that doctors make best use of their time spent in the United Kingdom. Doctors might also want to apply for college membership or other professional qualifications and should bear in mind the dates for all such examinations.

While applying to sit for an examination it is advisable that doctors keep in mind the estimated time duration in order to obtain a visitor visa through the British embassy or consulate in their country. Any unforeseen delays might cause anxiety and lead to potentially missing exam deadlines.

- **Documentation:** Doctors should obtain a list of documents to be collected and submitted to the GMC or royal colleges for the purpose of registration or other formalities. This might involve contacting previous educational authorities and teaching hospitals for the purpose of obtaining certificates and references. This may take considerable time and energy and doctors should bear in mind the estimated time needed for completing the required documents when applying for the PLAB or UK entry clearance visa.
- **Weather and clothing:** Doctors should make adequate preparation to cope with the weather in the United Kingdom, especially for the first few weeks. Generally the northern areas of Britain such as Scotland and north England are colder than the southern regions such as London or Birmingham. Average summer temperatures are generally not higher than 20°C in the north and 25°C in the south, and they can drop down to below freezing during winter months depending on the areas. Daylight hours also vary according to the time of the year with just over seven hours in the winter and up to 16 hours during the summer.

Useful website: www.bbc.co.uk/weather

- **Financial preparation:** Adequate financial preparation to support the doctor and his/her family during the period before finding a job in the United Kingdom is absolutely necessary. They might be asked for proof of such arrangements during the visa clearance process.

Opening a "current" bank account in the United Kingdom immediately on arrival may prove difficult, and arrangements should therefore be made to be able to access cash or other forms of currency, such as travellers cheques, before travelling to the United Kingdom. It should be established whether credit or bankcards from the home country would be accepted in the United Kingdom. Exchange rates and commission charged by banks or currency dealers also should be kept in mind.

- **Contacts in home country:** It is advisable to maintain up to date contact details of references and other contacts within your home country. This could be extremely helpful in obtaining any missing documentation or for providing job references. Referees are contacted by trusts interested in employing you directly and asked to return their reference directly to hospitals, unlike open letters of appreciation or recommendation that are used in some countries.

Arriving in Britain

- **Bank accounts:** One of the major problems that overseas visitors face when they arrive in Britain with the intention of staying for a long period of time is opening bank accounts. An everyday account for cash transactions and for issuance of a cheque book and debit card is called a "current" account. It might be helpful to try to open a bank account in one of the international banks that have branches in Britain. This may at least be beneficial in that doctors could use their existing bank debit cards before opening an account in Britain.

Normally, proof of employment or a letter from the hospital offering "clinical attachment" is required to open an account, along with utility bills and other information. The four large banks in Britain are Barclays, NatWest, Lloyds, and HSBC, along with various other overseas ones. There are numerous building societies that have converted to banks and offer the same services as regular banks.

Useful websites: www.banks.uk.com
www.compare-online-banks.co.uk

- **Accommodation:** Overseas doctors can look at various websites that offer accommodation-finding services before coming to the United Kingdom, such as loot.com or fish4homes.co.uk among others. Accommodation costs differ between regions; southeast England is generally more expensive than the other regions.

For a typical furnished self contained rented flat (with bedroom(s), living room, kitchen, and bathroom) the landlord is responsible for maintaining the property and providing adequate working appliances (such as a washing machine and cooker).

The tenant is responsible for paying the council tax (local municipal tax) and the utility bills. Sometimes the bills are included in the rent; this may be the case where the

tenant has to share certain facilities such as kitchen or toilet and shower. Electric heating is generally more expensive than gas central heating.

- **Unforeseen expenses:** Overseas doctors need to consider coping with any unforeseen costs (such as travel insurance to cover medical or accidental expenses, currency fluctuation), which may arise.

It is advisable to purchase a travel insurance to cover for costs such as illness, etc. The NHS will provide emergency treatment to visitors on visit or visas but they must arrange for any other medical expenses that might be incurred during the hospital stay.

Useful websites:
www.doh.gov.uk/overseasvisitors

- **Email addresses and contact details:** Doctors should maintain an email address that they could access from places such as internet cafés, etc. This allows them to be accessible to hospital medical staffing and other departments, consultants, GMC, and colleges. For some email addresses junk email folders need to be checked constantly as some email accounts such as hotmail.com automatically filter out emails from unknown sources to such folders and delete them automatically.

Bringing a mobile telephone that works in the United Kingdom can be useful for immediate contact (very important for job interviews etc), but it might be cheaper to purchase a prepaid mobile phone in the United Kingdom.

Useful websites: www.carphonewarehouse.co.uk
www.phones4u.co.uk

- **Travel:** Public transport is abundant across the country and nearly everywhere is accessible by train and bus, (or the tube in London and Glasgow or tram in Manchester and Sheffield). In certain cities a season ticket for most public transport is available on a daily, weekly, monthly, or yearly basis and is cheaper than purchasing individual tickets. Also, it is cheaper to book train or coach travel before the day of travel; booking a week in advance allows purchase of the cheapest fares.

Useful websites: www.rail.co.uk
www.baa.com
www.thetube.com
www.tfl.gov.uk
www.dvla.gov.uk

- **Shopping:** Every major city and town has plenty of shops. They are generally located in the high street or in shopping complexes on the city outskirts. Grocery shopping can be done at local supermarkets, and ranges of options are available to cater for dietary requirements, such as vegetarian, organic, or gluten free products. There are plenty of bookshops in every major shopping area, and specialist literature, such as medicine related books, can be found at the larger stores. Books can also be ordered through those stores at no additional cost.

Useful websites: www.oft.gov.uk/Consumer

- **Sale periods:** There are two major "sale" periods in the United Kingdom: starting 26 December (after Christmas) and the summer sale, which begins in July. During these periods, prices on almost every item are reduced. It might prove helpful in terms of finance that overseas doctors do their shopping during these periods.

Post registration issues—applying for the first job

- **Clinical attachments:** Most overseas doctors after clearing their PLAB examination apply for clinical attachments because they think this may help in getting their first SHO or SpR post. This is true to a certain extent, although doing a clinical attachment does not guarantee a job. It merely allows these doctors to observe clinical practice and familiarise themselves with the structure and functions of various organisations in the NHS.

Generally, doctors can apply for clinical attachment without having to go through a lengthy process by contacting hospital consultants directly, but it is advisable that doctors contact consultants in their specialist area of interest through a mutual contact. Alternatively they could contact their local postgraduate deanery, which may be able to provide them with guidance.

It is beneficial for the doctors to make best use of their time during a clinical attachment by attending ward rounds, clinical meetings, and other teaching sessions that they are allowed to participate in. Clinical attachments generally result in gaining a good reference from the supervising consultant and probably a better chance of getting recruited at the same hospital in the future.

- **Induction programmes:** Various postgraduate medical education deaneries organise "induction" programmes for overseas doctors, with the aim of providing a better understanding of the NHS and to create awareness regarding several aspects of medical practice in the United Kingdom, which may differ from the practices in doctors' home countries. Doctors who gain employment should make it a priority to attend an induction programme during the initial weeks of starting the job.

It is advisable for all post-PLAB overseas doctors, whether at SHO level or SpR level, to try to attend at least one induction programme; these are generally offered free of charge over a period of two to three days with local accommodation provided. They are called IDIC or CUKI courses.

Email:
idic@wymas.nhsprofessionals.nhs.uk

Useful websites: www.copmed.org.uk
http://www.nhsprofessionals.nhs.uk

- **CV writing, interview skills and career guidance:** It is crucial that overseas doctors gain good CV writing skills as CVs have an important role in the selection process in the United Kingdom. Interview skills as well as general career guidance are also beneficial at this stage. Sessions covering such topics are sometimes included in induction programmes (also see article by Elitham Turya, p 262).
- **Where to look for jobs:** All training and other placements are advertised in medical journals (*BMJ Careers*) and other health related publications. Generally, substantive and fixed term rotation placements start in August and February with advertisements placed in journals or other publications well in advance to allow potential applicants to apply and participate in the selection process.

Useful websites: www.bmjcareers.com
www.thelancet.com
www.nhscareers.nhs.uk
www.jobs.nhs.uk

- **General advice about job seeking:** There aren't any general timescales, which define how long is spent applying for jobs before a successful appointment is made. Doctors, therefore, are advised to be prepared for any eventuality, emotional or financial, while applying for their first job. They should try and build a network of peers (consultants, SHOs, and SpRs) while doing a clinical attachment through socialising and clinical sessions, and keep in regular contact after their clinical attachment is finished. Similarly, getting to know managers at the medical staffing departments could help in gaining constructive feedback on unsuccessful applications, which could then be used to improve future applications.

After getting the first job offer

- **Career of spouse or partner:** It is important to consider the career options for the spouse or partner, who may or may not have a healthcare background. Depending on the duration of the first job, which could range from six months to two years, it is vitally important that employment options are explored before accepting a job offer.

Dr A Sajayan

Dr B Kuriakose

- **Day care, nurseries, and schools:** There are day care centres or nurseries located at various hospitals as part of their staff facilities, which are staffed by qualified persons. Overseas doctors with children needing day care support should inquire about such facilities and any potential waiting lists while deciding whether to join the hospital. The hospital may also be able to provide information on other day care centres, approved and government registered child minders, etc.

Useful websites: www.childcarelink.gov.uk

- **Long term or permanent relocation:** Once an overseas doctor accepts a job offer, especially for a longer duration of contract, he or she should consider all aspects of relocation. This includes home hunting and relocation of personal effects from the home country or temporary accommodation. The hospital may be able to help with part of the relocation process, although for an SHO post this may not be an option.
- **Rental or property purchase:** Overseas doctors and their families, at this stage, would probably consider renting or purchasing a property, and local banks or building societies would be able to help in making such a decision based on individual circumstances. To buy a property, the overseas doctors would have to apply for a mortgage through a bank or building society, which would consider household income and other factors such as savings, etc, and, on the basis of the information provided, would advise on the price range within which the doctor would be able to purchase a property.

Most hospitals would offer accommodation to doctors on the basis of their family needs. For example, a single doctor might be offered a flat whereas a doctor with family might be offered a relatively larger house. These are generally charged at nominal subsidised rates in the hospital premises or within a short distance. Doctors should inquire about such facilities during the initial period of accepting job offers.

- **Annual leave and study leave:** Two different types of leave are available to doctors, and specific details should be made available by the hospital's medical staffing departments. Other leaves specifically for circumstances such as bereavements, family emergency, sickness, etc are also available, although policies might differ from one hospital to another.
- **Registration with a general practitioner**: The doctor and the family would need to register with a local general practitioner (GP) for medical cover. Should they have already registered with a GP, they would simply need to transfer their details to the new practice. This is generally a fairly simple procedure and does not take very long to complete.
- **How to apply for a permit free training (PFT) visa:** The hospital medical staffing department should be able to provide details of the procedure to apply for PFT UK clearance. Alternatively doctors should contact the Home Office for any queries.

Useful website: www.homeoffice.gov.uk

- **Miscellaneous**: Doctors should make an effort keep in contact with their peers at a hospital even after they have completed their job or clinical attachment. Similarly, they should maintain contact with their medical school or other colleagues from their home countries. This allows them to keep informed about relevant developments back home as well as acting as a support network for those doctors who wish to come to Britain for their postgraduate education. It is also advisable that they join an overseas doctors' association for social support and career guidance where available.

Conclusion

Deciding to come to the United Kingdom for higher medical training is an important step in an overseas doctor's life. However, he or she should consider all the steps outlined in this article and seek advice from anyone they know who is already working in the United Kingdom. This would also allow potential trainees to become aware of new developments and changes to postgraduate medical education and to the healthcare setup as a whole.

The financial element should be evaluated carefully as this could prove a deciding factor about whether, or at what stage, to pursue higher medical training in the United Kingdom. these factors should be considered carefully before an overseas doctor decides to come to the United Kingdom to enhance their medical career.

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Tips on ...

Making the decision to come to the United Kingdom

Moving to another country is the sort of decision that should not be taken lightly. We suggest that you speak to someone who has migrated to the United Kingdom from your locality so you can benefit from their experiences and insights. We have made a list of questions anyone wishing to work in the United Kingdom ought to consider. There may be other questions that are specific to your circumstances. Time spent weighing up these arguments may not prevent you from making a wrong choice, nor experiencing the unexpected, but we believe that it is time well spent:

- What do I hope to gain by working as a doctor in the United Kingdom?
- What is the best stage of my career to work abroad?
- What is the best time of year for me to go?
- Who do I need to contact?
- Are my qualifications recognised or will I have to study for additional exams before I can work?
- What will it be like to leave family and close friends behind?
- What will I miss about my current job and life?
- Can I speak medical English?
- What do I know about British culture and what will it be like living there?
- Are there any visa requirements or restrictions?
- Where will I live when I get there?
- What can I do if I encounter racism?

Sabina Dosani *specialist registrar in child and adolescent psychiatry*
Maudsley Hospital, London

Peter Cross *freelance journalist*
London

Competition

This tips on .... is adapted from "Expectations" in chapter one of Sabina and Peter's book, *Making it in British Medicine: Essential Guidance for International Doctors*, which will be published by Radcliffe Medical Press in September. The retail price is £21.95, but as a special prepublication offer to *Career Focus* readers, you can reserve your copy now for just £19.95 + package and posting. It will be sent to you immediately on publication. Please email your name and postal details to orders@radcliffemed.com citing, Making it in British Medicine: Career Focus offer, in the subject line.

INTERVIEW

The GMC view on how it can help overseas doctors

Graeme Catto, *president of the General Medical Council, shares his thoughts with* Rhona MacDonald

"We are absolutely dependent on good quality doctors coming to work in the United Kingdom. Anything we do from the GMC's end ought to help them," says Professor Sir Graeme Catto, president of the General Medial Council.

The idea that the GMC may be there to help them rather than hinder them may seem incongruous with how many overseas doctors feel about it. Sir Graeme explains, "The issue is that we may not know about all the issues. We need to be aware of changing circumstances for doctors coming to work in this country. It's important to bear in mind the GMC's role. Our main responsibility is to set standards for practice in the UK. The professional and linguistic assessments board (PLAB) test is one way in which doctors can satisfy us that they meet the standards of knowledge and skills we expect for practice here. The question of employment for these doctors is not therefore primarily one for us. That said, we are as concerned as others about ensuring that doctors have access to helpful and realistic advice before embarking on the PLAB test."

> We need to be aware of changing circumstances for doctors coming to work in this country

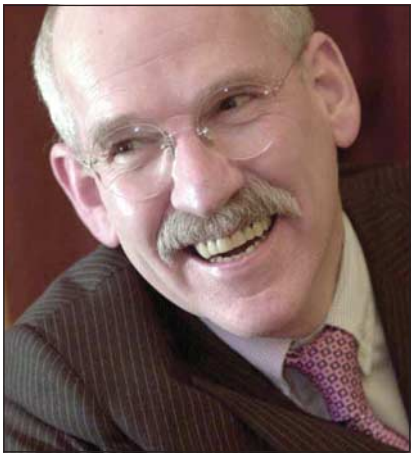
Surprisingly, the current statistics for overseas doctors passing PLAB and finding a job apparently look good. According to GMC statistics, 90% of doctors who have passed PLAB find a job within a year.[1]

No or misinformation

However, Sir Graeme cautions, "Most doctors are able to find work in the United Kingdom, but I have no doubt looking at the increase in the number of doctors sitting the first and second part of the PLAB that we are going to get to a situation very soon where that is not the case."

He continues, "Currently, we don't have any information about the quality of the jobs that these doctors coming to work in this country are able to get. There may be an issue of potential or real unemployment for doctors coming and there probably is a real issue about the quality of the posts that are available to them. We need to work effectively with the Departments of Health and make sure that doctors who are thinking of coming to this country understand what is and what isn't available."

Can he expand on this? "I don't think there is any particular benefit in making high quality career information available only for overseas doctors. It should be for everybody and they should be directed or helped to participate in that." He continues, "Providing that information not just on a UK-wide basis but on a regional basis might be more helpful to any doctor but also to the overseas doctors."



Graeme Catto

The problems with PLAB part 2

What about the accusation that as doctors have to come to the United Kingdom to sit part 2 of the PLAB and that the numbers sitting this exam are not limited, they come in their thousands, get stuck, and become an unused surplus?

"Information about employment should be much more readily available so doctors can assess what their chances are. There has been a perception that the United Kingdom is so short of doctors that there were jobs for almost anybody and of course that's not true."

And about PLAB part 2 not being in the United Kingdom? "We are having a PLAB review at the current time and that is one of the issues we are looking at. The practicalities of sitting part 1 in different countries are considerable but not insurmountable. It is a much more extensive exercise to get PLAB 2 introduced in overseas countries. So we need to look at this sensibly perhaps in conjunction with other groups of people because there are currently different forms of assessment going on in many countries at the present time. We might be able to limit the costs by combining with other countries and the boards who run the exams."

Can he tell us more? "The International Association of Medical Regulatory Authorities is beginning to work together much more effectively to help overseas doctors." There are two reasons for that. One is of course countries such as the United Kingdom are dependent on them and the other is that medical migration is beneficial in raising the standards of medical care to patients in all countries not just the host country that the doctors migrate to."

Other ways to help

Amanda Watson, director of GMC registration, tells us more about how the changes to the GMC registration procedures will help overseas doctors on p 255. But what else can the GMC help with. Can it help with clinical attachments?

Sir Graeme replies, "I'm not sure we could have the right input into that, although once again, coordinating these schemes and making doctors aware of what is available is the best way of dealing with that."

What would you say to an overseas doctor who is sitting in a crummy bedsit somewhere in a bad area and is sending out 500 applications and not getting anywhere and running out of money and time in the United Kingdom?

"From my perspective what we would want to do is to see how many of such doctors exist and how we can work with others to avoid that. The GMC on its own probably can't be effective, but the GMC working together with the NHS and the Departments of Health could be much more effective in smoothing the path for such doctors."

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1 General Medical Council. *Information for international medical graduates.* www.gmc-uk.org/council/200405/7c%20-%20Information%20for%20International%20Medical%20Graduates.doc (accessed 23 May 2004).

Useful information for overseas doctors

- GMC: registration enquiries—tel +44 (0)20 7915 3635 or email registrationhelp@gmc-uk.org, www.gmc-uk.org
- BMA International Department: tel +44 (0)20 7383 6793, internationalinfo@bma.org.uk, www.bma.org.uk/international
- British Council: www.britishcouncil.org/health/nacpme
- Medical Royal Colleges: for a list see www.aomrc.org.uk/pages/links/collegelinks.html
- Regional postgraduate medical deaneries: for a list see www.copmed.org.uk/deaneries
- Home Office. www.ind.homeoffice.gov.uk

INTERVIEW

All change at the GMC

Next year, the General Medical Council will abolish limited registration and will introduce a licensing system for all doctors. This will coincide with the start of revalidation. This has huge implications for overseas doctors as Amanda Watson, *director of registration and education at the GMC, explains to* Rhona MacDonald

Having made no changes to its registration system for 50 years, the General Medical Council is making up for lost time by switching over to a new licensing system and introducing revalidation at the same time. But what does this mean, specifically for overseas doctors? I caught up with Amanda Watson, director of registration and education at the GMC, to find out.

Revalidation

"The GMC has been developing a major programme of reform over the past few years. One of the main planks in the reform programme is revalidation. This is the process by which doctors will demonstrate regularly that they are up to date and fit to practise.

"This is a very important part of modernising and developing the regulation of the profession in the United Kingdom. Under the old system, once you got onto the register with the GMC you stayed there until you died or did something that resulted in you being struck off. For most doctors payment of the annual retention fee and keeping the GMC appraised of your up to date registered address was all that was required to secure continued registration.

"In 1995 we codified our guidance for doctors practising medicine in the United Kingdom in *Good Medical Practice*. This is the core guidance for practice in the UK.

"When *Good Medical Practice* was established, the next logical step was to ask all doctors to produce evidence on a regular basis to show that they are practising in accordance with the guidance—in other words that they are up to date and fit to practise. It's this process that we call revalidation. In the future doctors will undergo a first revalidation assessment two years after joining the register, then every five years after that.

"In order to do that we made the assumption 'We've got 210 000 doctors on our register. We do not expect that all those doctors will wish to revalidate.' So we decided to establish a two tier system of registration and licensing. All doctors will be registered with the GMC and a subset of that group will hold what we call a licence to practise.

Licence to practise

"The licence to practise will give doctors the rights and privileges that are currently attached to registration. For example, doctors who are currently registered with the GMC can prescribe. In the future that right will be attached to the licence to practise. So if you wish to prescribe in the future you will have to be both registered and licensed by the GMC. Licensed doctors will be required to participate in revalidation in order to continue to hold their licence. Having at one time been licensed with the GMC you might want to retain registration (but not a licence). It will be possible for people who have held a licence to relinquish it but retain their registration.

"Say, for example, you decide that you are going to work in another country for five years but you want to retain a professional connection with the GMC. You could relinquish your licence but keep your registration. Doctors holding registration will continue to receive our guidance and *GMC News*, and will be obliged to adhere to the GMC's standards (including *Good Medical Practice*), but will not be required to revalidate. When you come back we envisage a straightforward process to restore your license. You wouldn't need to start the registration process all over again. That said, if we hadn't seen you for a number of years we would expect you to submit for an early revalidation—that is, within two years of the date your licence is restored.

Amanda Watson

Licensing, revalidation, and registration

"Licensed doctors will be required to revalidate. All new entrants with a licence will be required to revalidate within two years. So your first revalidation happens two years after you are given a licence, and thereafter it is every five years. Now, in terms of overseas qualified doctors the position is rather more complicated because the changes that we are going to bring into force next year will abolish limited registration.

"What we have decided instead is that if overseas qualified doctors have not done an internship they will be granted provisional registration. But as the vast majority of them have completed their one year internship, they will be granted a full licence, in the same way that UK qualified doctors get a full licence after they have done their provisional registration.

Faults in the current system

"Under the current system, doctors must show us proof of a job offer before they can have limited registration. I think this has probably contributed to a problem we notice with the way in which a lot of recruitment is currently carried out. You will see advertisements that say that the doctor must be GMC registered to apply. As I understand it, a lot of employers insert that qualification to ensure that they do not invite candidates who haven't even taken the PLAB [Professional and Linguistic Assessments Board] test. However, this was also prohibiting doctors who had passed the PLAB test, but had been unable to get registration as they did not have a job offer. Once limited registration goes so too will the requirement for doctors to have an offer of employment before gaining registration.

Still have PLAB

"What will be in place instead of limited registration will be a general licence. Doctors will still have to satisfy us of their medical knowledge and skills, so they will still need to take the PLAB test, and the rules of PLAB will be the same.

"Because the PLAB is a general test across a range of specialties, doctors who pass the PLAB test are not restricted to work in specific specialties. But if you are sponsored by one of the royal colleges, we will restrict you to work in that specialty.

"*Good Medical Practice* tells you that as a doctor, you must practise within the limits of your knowledge. So, under the new system, you've got to revalidate within two years of you being given your first licence.

Timing and the law

"We have to get a change in the law [the Medical Act] in order for it to happen because currently that requires doctors to have the offer of a job. We expect to secure these changes early next year. Our expectation is that limited registration will be abolished in mid-2005 and that this will coincide with the introduction of the licence to practise. The first revalidations are expected to be completed shortly after that.

What else is happening?

"We are planning to put a lot more of our services on the internet and we have just introduced a new PLAB booking system, which allows doctors to book a place on the test on-line. We produce the results via the web as well.

"So in the future, we won't have lots and lots of doctors physically delivering bits of paper to the GMC. If you are overseas qualified, you will come to the GMC once (for most this will be at the time they take part 2 of the PLAB test) and have your primary medical qualification and any other documentation checked at the same time.

"Under the new system, the situation for overseas doctors should be much more straightforward."

Rhona MacDonald *editor, Career Focus*
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INTERVIEW

Modernising Medical Careers and overseas doctors

Rhona MacDonald *asks Steve Field, chair of the Modernising Medical Careers delivery board, about what the programme will mean for overseas doctors*

Q: Can you explain Modernising Medical Careers (MMC) to doctors just coming into the United Kingdom, and how it is going to affect them?

SF: "The MMC 'movement,' if you like, is all about changing education so that it's better for trainees, as it is more focused on their needs, and better for patients. It's all about improving care for patients. We can improve patients' care by recruiting and retaining the best doctors. But we do really need to improve the quality of training and assessment of our doctors whether they are general practitioners or specialists to meet the needs of this new century.

"What it means is that training will be streamlined and will be competency based. Any assessments that happen during training including college exams will be based on those defined competencies. The system hopefully will be less open to any form of prejudice against a particular group, and I really hope that by looking at training and moving to a 'run through' system, we won't have any artificial hurdles between basic and specialist training. Rather, it will be about appropriate selection to a programme be it foundation or for specialist or general practice training. While passing through the programme, junior doctors should receive more feedback so that they can optimise their learning and really see where they are going.

"A lot of overseas doctors complain to me about difficulties with selection and particularly getting into basic programmes and then into specialist programmes, and many often say that they get stuck in senior house officer (SHO) posts and can't progress.

"Some of the existing SHO posts are not of good educational quality; we need to deal with that. Some posts are in educationally unapproved trust grade posts [non standard and non-training] and not SHO posts, and I'd say doctors coming from outside are bewildered by what's on offer and therefore open to the suggestion that there is prejudice against them. Some doctors end up in those trust grade posts for years without support, without security, and this is made worse by the fact that there is very poor careers advice and guidance for people who are not UK graduates. Having said that the careers advice for UK graduates is not much better. So the system needs to be improved and be much more trainee centred.

"Doctors coming into this country don't always get the induction into the health service they need, and we might be able to help that through Modernising Medical Careers in the F2 [second foundation year] programmes. We should be able to develop and tailor specific programmes to help them.

"For example, In the West Midlands, we will be able to provide a number of opportunities for a one year long second foundation year, alongside the UK graduates who have been doing the two year programme, which is about the care of acutely ill patients. It will also have educational opportunities to induct them more into the NHS, into NHS management, and the whole ethos of it."

Steve Field

Q: So overseas doctors couldn't apply for basic specialist training after passing PLAB [the Professional and Linguistic Assessments Board exam]? They'd have to do some form of foundation?

SF: "Well, I think some would elect to apply for the second year of a foundation programme. If they have full registration and the appropriate competencies equivalent to doctors who have been through foundation programmes, then of course they could apply for 'run through' specialist or general practice training programmes. But hopefully, even then, we will be able to do much more about induction for overseas doctors and adequately support them."

Q: But isn't it still going to be open to discrimination. Presumably it's still open competition?

SF: "The work hasn't been done on the issue of entry into specialist programmes yet and of course the standards will be set by the PMETB [Postgraduate Medical Education and Training Board]. But the standards for entry will obviously have to reflect the standards for exit for foundation programmes. The competencies that the Academy of Medical Royal Colleges has produced for F2 can be used. This should remove discrimination because it doesn't matter who you are or where you are from—it's about demonstrable competencies.

Further information

Modernising Medical Careers—www.mmc.nhs.uk/

Career Focus theme issue about trust grade doctors—careerfocus.bmjjournals.com/content/vol327/issue7421/index.shtml

Career focus topic collections on modernising medical careers—http://careerfocus.bmjjournals.com/cgi/collection/modernising_medical_careers

"These competencies will be advertised on the web. So doctors who want to come into the United Kingdom need to know that they are going to be treated fairly and what they need to do to be able to get on the programme. At the moment entry to programmes varies across the country and entry to SHO posts varies even more. What we will do with MMC is push for agreed national standards in partnership with the PMETB who are working with us and will help assure these standards."

Q: So will this do anything to end the exploitative trust grade posts?

SF: "A number of things have happened already. For example, some trust grade posts have been absorbed into foundation programme pilots across the country. There has also been a scheme running for the last two years where suitable Trust grade posts have been transferred into general practice training programmes in England. The big change, however, will be in 2006, when foundation programmes take off, many more trust grade posts at that level will be absorbed into programmes, so that most posts which currently exist will become educationally approved posts.

"When we start to move towards 'run through' programmes, or whatever model comes out working with the colleges, many of the trust grade posts will be absorbed into that system as well. Hopefully we can put more logic into the system."

Q: So basically, the bottom line is Modernising Medical Careers is a fantastic thing for overseas doctors?

SF: "Yes. I think it is a tremendous opportunity to make the system fairer for overseas doctors and to help them realise their potential.

"I don't think we've respected or valued overseas doctors or their contributions to the NHS. You see a lot of negative press about overseas doctors, but frankly they hold the health service together and many of them work in areas that UK graduates have refused to work in. They haven't had the support that they have needed in the past. Many of them have floundered in the system as trust grades. I do believe there has been a lot of abuse going on, and this is a way of stopping that."

Rhona MacDonald *editor Career Focus*
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INTERVIEW

Postgraduate medical education and training board and overseas doctors

Rhona MacDonald *talks to* Alan Craft, *president of the Royal College of Paediatrics and chair of the article 11 and 14 subgroup of the postgraduate medical education and training board*

Alan Craft, president of the Royal College of Paediatrics and Child Health, is the chairman of the subcommittee of the postgraduate medical education and training board (PMETB) overseeing articles 11 and 14. Several other members of the PMETB board are on this subcommittee, and according to Alan Craft, "We are in the process of appointing other people with special expertise who will help us. So the committee will have all of the expertise on that we need to do the work we need to do."

Now let's get down to business.

Q: Can you explain what articles 11 and 14 mean, and how they will help overseas doctors?

AC: "Articles 11 and 14 are the parts of the new legislation which cover overseas doctors. At the moment we have to show that a doctor who qualified overseas and wants to be on the specialist register has to be equivalent to a UK CCST holder [certificate of completion of specialist training]. Currently, that equivalence is determined on the basis of their qualifications and training. In the future we will also be able to take into account experience as well as qualifications and training and this is a big difference."

Q: What about general practice (article 11)?

Alan Craft

AC: "General practice isn't going to change very much. They already take into account experience. It is mostly the specialist areas of practice that will be affected." (Article 14.)

> In the future we will also be able to take into account experience as well as qualifications and training

Q: How are you going to quantify experience?

AC: "We are currently developing our systems. We will be using the experience gained in the past by the royal colleges. It may well be different in each of the specialties.

Q: What about the application process?

AC: "The first thing we will ask doctors to do is to submit an application in a standard way. That will be assessed by a group of people who are used to assessing that particular specialty.

"The answer then might be, 'yes, your qualifications, training, and experience seem to be very appropriate, so we will recommend you for the specialist register,' or it may be 'no.' We will of course give reasons for the no answer and suggest what the doctor would need to do before reapplying. This might be that we need more information or that the doctor needs a work place based assessment, or even a period of formal SpR [specialist registrar] training."

Q: Are the royal colleges helping you set the criteria of what is acceptable?

AC: "They will be. We will be working with the colleges, as clearly they have the people with the experience having done equivalence procedures for overseas doctors for many years."

> So nobody should apply until the application packs are ready

Q: Will there be a triage process for applications?

AC: "We are busy producing application packs, which will have full information about what it is all about and how to apply, and what you need to produce in terms of certification and references and details of your experience. So nobody should apply until the application packs are ready, and it will be widely publicised when they are going to be ready. So if the date we go live is 1 October, the packs will be available no later than this."

Q: If? I thought 1st October was the launch date of PMETB?

AC: "Yes that was the target set to go live but a decision has to be made by the PMETB board as to whether we are ready or not. Then a decision will be made by the Secretary of State, because there needs to be an order in Parliament to activate the PMETB.

So we are working towards 1 October, but we can't say at the moment that, come 1 October, you will be able to use your experience as well as your training. But from the start of PMETB, whenever that is, that's what will happen."

Q: So, whenever PMETB goes live, you have to turn the applications round in three months?

AC: "Yes, but I don't think there will be any problem in turning them round in three months. That's not our major piece of work; the major piece of work is to get a robust method of assessment set up, and once we've got that then there shouldn't be any trouble in turning them round in three months.

> Once we agree that it is a complete application there shouldn't be a problem in turning it round in three months

"It will be three months from when we receive a completed application, and we know that in the past most of the applications actually came in incomplete so there will be a process where we will have to send it back to you and say this isn't completed you will need to do x, y, and z; get the right references; and give us the right sort of information. Once we agree that it is a complete application there shouldn't be a problem in turning it round in three months."

Q: So what does this mean for overseas doctors?

AC: "I think that the biggest group that we will be dealing with initially, is the more senior overseas doctors, many of whom currently work as staff grades and associate specialists doctors [or non-consultant career grades]. Many have previously applied to get onto the specialist register and failed because they didn't have sufficient training. They will now be able to say, 'now you can take into account my experience as well, please reassess me.'

"If you are on the specialist register you can apply for a consultant job. It doesn't mean that you automatically get a consultant job, but it enables you to apply for one. People won't automatically be upgraded from their current post, but I think a lot of overseas doctors will expect to get a consultant job."

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How can the deaneries help overseas doctors?

Geoffrey Wright *gives a brief guide*

Doctors from overseas fill about one third of the training posts in the United Kingdom[1] and so they have considerable involvement with deaneries. However, the wide variety of deanery activities and services may not be fully appreciated by overseas doctors, especially those who have arrived in the United Kingdom only recently. I hope that this short article helps to make things clearer.

What happens in a deanery?

The main role of a deanery is to manage and "quality assure" the delivery of postgraduate medical education in the United Kingdom. This role extends to recognised training posts only—that is, preregistration house officers, senior house officers, specialist registrars, and doctors on vocational training schemes for general practice. Of course, we are aware of non-consultant career grade doctors (trust doctors, staff grades, and associate specialists), but we do not have responsibilities for them.

We approve preregistration house officer posts for training jointly with universities and, in conjunction with the royal colleges, grant educational approval to suitable senior house officer posts and specialist registrar posts. An advertisement for any of these posts must clearly state that such approval has been granted.

Through regular inspections we monitor the continuing suitability of posts for educational purposes. Non-training posts may be converted to training posts with appropriate education approval under certain circumstances and not retrospectively.

The postgraduate training arrangements in the United Kingdom are undergoing a radical change, and the deaneries are instrumental in implementing the changes recommended in *Modernising Medical Careers*, which will affect all the training grades.[1–3]

The box summarises the different tasks of the deaneries.

What deaneries do[4]

- Commission, develop, and "quality assure" the delivery of postgraduate medical and dental education
- Manage postgraduate medical and dental education in partnership with other relevant agencies
- Inform, develop, and implement national polices on postgraduate medical and dental education
- Maintain databases of doctors and dentists in training
- Approve advertisements for training posts
- Manage the size and distribution of the junior doctor workforce in the area covered by the deanery
- Contribute to integrated workforce planning
- Manage recruitment and appointment of specialist registrars
- Appoint programme directors for specialty training programmes
- Issue national training numbers, visiting training numbers and fixed term training numbers
- Oversee annual reviews and records of in-training assessments and confirm trainees have completed their programme of training for the purpose of the award of the certificate of completion of specialist training (CCST)
- Facilitate career development in special areas

What we do in deaneries for doctors

We are responsible for appointing doctors to preregistration house officer posts through matching plans, jointly with the universities. We are also responsible for collating the necessary documentation for submission to the General Medical Council (GMC) for these doctors to obtain full registration at the end of the year.

We do not have any responsibilities for the appointment of senior house officers or for monitoring their progress, although we do check on their education and determine that assessment and appraisal is taking place. Progress of vocational training scheme doctors is monitored more directly. We are responsible for advertising specialist registrar posts, for arranging the interviews, for monitoring progress in the post, and for organising for the approval of the CCST.

Each deanery has designated individuals, usually associate deans, with special responsibilities for different groups of doctors. You should be able to find someone with special expertise in dealing with questions about:

- Preregistration house officers
- Senior house officers
- Specialist registrars in different specialties
- Careers advice
- Flexible training
- Interdeanery transfers
- Counselling
- Doctors with difficulties.

What the deaneries do for overseas doctors

Someone in the deanery, usually an associate dean, has special responsibilities for overseas doctors. This is the person to contact for advice about specific issues. This is also the person you need to write to if you wish to extend your permit-free training. Some may be able to offer advice on writing your curriculum vitae and job applications. They may be able to give information on clinical attachments and tell you about the suitability of particular jobs.

The South Western Deanery organises regular induction courses for overseas doctors; many other deaneries do the same. The courses take place over two to five days depending on the deanery, and there is not usually any charge. If you wish to go on one of these you need to apply to NHS Professionals, who coordinate them. Topics covered by the South Western Deanery course include: the NHS and how it works, clinical governance, audit, principles of good record keeping, informed consent, death certification, safe working practices, drug prescribing and policies, medical indemnity, working in the United Kingdom, *Modernising Medical Careers*, the functions of the GMC, registration with the GMC, how to write a curriculum vitae, and interview skills.

Any doctor may have problems and difficulty progressing in their career, whatever their background, and a few need special help. For some overseas doctors, communication may be a problem despite passing the Professional and Linguistic Assessments Board (PLAB) test. We can help here in a number of ways. Doctors can discuss career problems with us away from their workplace. We can organise specific remedial training in areas of language and communication. We have access to counselling services, and we can help organise and fund remedial medical training.

Further information

- www.copmed.org.uk
- www.mmc.nhs.uk
- www.nhsprofessionals.nhs.uk

What the deanery doesn't do

We are not an employment agency, and neither are we able to organise clinical attachments. We may be able to give you information about the availability of clinical attachments in the area served by the deanery, and we can tell you about posts and rotations that are available. We can also give career advice, but we do not organise placements on an individual basis apart from remedial placements and we do not "pull strings" for individuals.

What about the future?

The role of the deaneries may well change, but it is unlikely that any of the functions that I have outlined will disappear from its portfolio. *Modernising Medical Careers* is producing new challenges at all training levels to all involved, including those concerned with overseas doctors. Determination of equivalence of previous training and the proper point of entry to the new training grades are items high on the agenda needing clarification.

Geoffrey Wright *associate dean for overseas doctors*
South Western Deanery

P+ *Please go to webextra at bmjcareers.com/careerfocus for the references.*

VIEWPOINT

The human resources perspective on the PLAB dilemma

John Adsett *shares his personal views*

This is one of the biggest riddles of medical workforce planning in the modern NHS: the NHS has a shortage of doctors, and yet each year there are hundreds of unsuspecting overseas doctors let loose on the UK labour market, each one brandishing a new shiny pass certificate for their Professional and Linguistic Assessments Board (PLAB) examination. Each one, unless extremely lucky, destined to spend months seeking their first proper job in the United Kingdom. Why?

Quite simply because with their PLAB, they can obtain limited registration with the General Medical Council, which restricts them to posts in the training grades. The best they can achieve on arrival is senior house officer level, where there are already too many candidates chasing too few jobs.

The size of the problem

It is common for the average sized trust to receive in excess of 200 applications each time it advertises a post in at that level in an acute specialty. Many candidates will already have passed the first part of a postgraduate qualification. In those circumstances it is almost impossible for a newly arrived overseas doctor to compete. The labour market for doctors is such that in some specialties there are often experienced and reasonably well qualified "home grown" doctors who have difficulties in finding a job in their chosen field.

Unfortunately this is not a side of the recruitment process that many doctors see. With the sort of numbers involved it is impossible for employers to give individual feedback to candidates who have not been shortlisted. As a result all they know is that they are applying for dozens of jobs and not getting invited for interview. At that point it becomes too easy to blame the system, mainly because the alternative (that they may not have all the essential skills and experience that employers are seeking) is too awful to contemplate.

John Adsett

Lessons learnt

So where does that leave our newly arrived overseas doctors? Struggling, quite frankly, unless there are changes to the entry and registration rules. Are there any lessons to be learned from the present situation? Several spring to mind.

Firstly, it is noticeable that doctors coming to the United Kingdom for the first time generally have unrealistic expectations about how the system works—and, more importantly, the length of time it will take to get a substantive job. It is important to get experience of the British healthcare system and the most popular way of doing this is via "clinical attachments." These can be valuable to individual doctors, especially if they result in the doctor getting an appraisal and feedback from the consultant in charge. Unfortunately, clinical attachments often end without the doctor getting feedback or any semblance of career support or counselling.

It is tempting for a doctor to seek clinical attachments in large prestigious hospitals, because that looks good on a CV. Unfortunately these same hospitals are populated by consultants who are often too busy to spend time assessing and appraising their "attached" doctors. So what is the solution?

Solution?

Overseas doctors considering having a career in the United Kingdom should ask themselves:

- Am I prepared to spend a number of weeks or even months before I find a substantive job?
- Can I afford to live in my chosen town or city for periods during which there is no guarantee of pay?
- If not, is there somewhere less expensive where I would be prepared to live?
- Is the range of areas where I am applying for jobs too narrow—would I do better looking somewhere (anywhere) else?
- Would I be prepared to do agency work whilst waiting for a "proper" job to turn up?
- Do I have any contacts in UK hospitals (relatives, friends) who can give me introductions, advice?
- Would I be prepared to work in another specialty, subspecialty, to get a job?
- If I am unable to get paid work as a doctor for a few weeks would I be prepared to work as something else, still using some of my skills, to get experience of the UK health system?

I am not suggesting that doctors should or could do all of the above. These questions highlight the reality of trying to find jobs in the United Kingdom under the current circumstances.

John Adsett *honorary secretary*
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Tips on ...

Dealing with bullying and harassment

Discrimination, bullying, and harassment can affect any doctor, but research shows that doctors from ethnic minority groups are most affected. For example, only 29% of doctors registered with the General Medical Council are overseas graduates, but 58% doctors who appear in front of the GMC conduct committee are from overseas.[1] Also, only 18% of consultants are from ethnic minorities but 70% of staff grade and associate specialists are from ethnic minorities.[2]

If you feel that you are being bullied or harassed, think carefully about any action you take. Do not suffer in silence, otherwise it is possible that others who will take the job after you will also go through the same thing. Here are some tips to help you through what will be a very difficult time.

- Keep a diary of events including day, what time the incident happened and any witnesses
- You must be polite and firm in whatever action you want to take
- If you are writing to a consultant, write a polite letter giving the details of the incident and how you feel
- If the bullying and harassment do not stop, continue to keep evidence in your diary
- You can officially write to the trust's human resources department. Every trust must have a policy for dealing with harassment, bullying, and racism. Ask for a copy, and follow the procedure
- Join a union such as the BMA or Medical Practitioners Union. The Medical Practitioners Union is a more radical union that is probably better at fighting race discrimination cases
- Talk to your overseas doctor mentor or postgraduate dean with a responsibility to overseas doctors or your educational supervisor or clinical director
- You can write to the GMC. One of the duties of a good doctor is to treat your colleagues with respect and dignity.

Rekha Shroff *Specialist registrar in obstetrics and gynaecology*
Cardiff

1 Allen I. *The handling of complaints by the GMC: a study of decision making and outcomes.* London: Policy Studies Institute, 2000.
2 Allen I. *Summary and conclusions from an analysis of the nature and outcome of complaints received by the GMC, annex A.* London: Policy Studies Institute, 2003.

PLAB

How to pass PLAB

Sabina Dosani *and* Peter Cross

give the lowdown on the Professional and Linguistic Assessments Board test which non-European Economic Area doctors have to pass to be allowed to work in the United Kingdom. The authors interview examiners and candidates for their tips on passing

PLAB, the Professional and Linguistic Assessments Board test, is conducted by the General Medical Council and supported by the British Council, which organises and administrates PLAB part 1 exams outside the United Kingdom. The test is designed to assess overseas doctors' ability to work safely as senior house officers in a UK hospital and is a prerequisite for most overseas doctors' GMC registration. Every year, about 12 000 doctors sit PLAB.

Part 1

Part 1 is a written paper, usually taken in the candidate's home country. Examiners expect doctors to have the breadth of knowledge needed to qualify from medical school supplemented by a year's experience as a preregistration house officer. Currently the paper consists of 200 extended matching questions.

Part 2

Part 2 is an objective structured clinical examination. This tests clinical and communication skills in 14 stations. At each station you carry out a task. This may be talking to or examining a patient or demonstrating a procedure on an anatomical model—for example, suturing, phlebotomy, or resuscitating a dummy. You get an overall A, B, C, D, or E at each station. As long as you don't get a D at more than four stations or an E at two you will pass. There are 16 stations in total, but there is a rest station and a pilot station where new questions are tested. Marks from the pilot station do not count towards the exam. You must pass part 2 within two years of passing part 1.

Pass rate

The part 1 pass rate varies but is usually somewhere in excess of 60%. The pass rate for part 2 is around 70%.

How much does it cost?

- Part 1 £145
- Part 2 £430

Who writes the questions?

The GMC advertises for a panel of writers. Interested doctors are invited to a question writing day. They are taught how to write questions. Questions are written by a general practitioner with a surgeon, a psychiatrist with a paediatrician, and a physician with an obstetrician, to prevent them writing effete questions at specialist level. Questions are written in the morning, and in the afternoon the groups swap and check the style and format of the other groups' questions. If they don't understand the question, or think it too difficult, it is scrapped.

Examiner's advice for part 1

Professor Kenneth Cochran advises candidates to work from general textbooks used by UK medical schools. "There are no hidden traps. People who become specialised find the exam hard because it is at the very general level of a recent medical graduate.

We ran a pilot on UK graduates coming to the end of their preregistration house officer year. We asked them about timing and appropriateness of questions. Those are the questions we are using now.

It's not obscure knowledge. It's more like, 'a mother brings a child who has a rash.'"

Examiner's advice for part 2

Dr Malcolm Campbell, chairman of the part 2 panel, says, "We are looking for basic clinical competence at the level of a first day senior house officer in any specialty. Candidates shoot themselves in the foot by rote learning and by going to these dreadful crammers. Many learn the right questions and don't listen to patients' answers. For example, the doctor says to a simulated patient 'How are you feeling?' The simulated patient says 'I think I'm going to kill myself,' and the doctor says: 'And how are your bowels?'

"I would recommend people try to scrape together enough cash to spend a month in the United Kingdom, doing a clinical attachment. That would serve two purposes: they would learn how medicine is done in the United Kingdom, and improve their medical language skills making them confident.

Once you know the system you just fly through

"Our simulated patients are trained to behave like real ones. A lot of candidates are taken aback when patients ask questions like, 'Why should I do this?' 'What are the side effects of this?' 'Is that the best course of action?' We are not saying that the way we interact is better, but that is the way that patients are dealt with in the United Kingdom.

"We don't expect candidates to be brilliant, rather the kind of doctor a consultant can trust to know their limitations, make basic diagnoses, and not harm too many patients. We are not looking for perfection. Everybody makes mistakes."

Advice from candidates

Mohammad Amjad Khan sat PLAB part 1 in Pakistan: "I used several different study methods; studying on my own, in a group, and using past papers from the market. The hardest part was subspecialty EMQs on skin diseases, orthopaedics, and psychiatry. With the benefit of hindsight, I would not have relied on Indian EMQ books from the market as most of them were substandard and not clinically relevant.

"Stick to EMQ books written by UK authors such as Una Coles. If you can find a partner to study with, it is worth anything. I recommend the *Medic Byte PLAB 1 Course* (www.medicbyte.com) as well as the Pastest EMQs."

You have to learn exam technique

Archana Mischra from north India is a paediatric senior house officer in Manchester. She passed PLAB part 2 and remembers, "Once you know the system you just fly through. But if you don't know how to approach it, or what you are expected to do you're sure to fail."

A refugee surgeon from the Congo who preferred to remain anonymous feels, "In my country I spent a long time training in surgery and to pass PLAB you have to be good at everything, even things you read 10 years ago at medical school. Go back and learn them again. I go to a study group for refugee doctors at Queen Mary College, which teaches you how things are done in the United Kingdom, and that's what we need for part 2."

Examiners' and candidates' top tips for the OSCE

(1) Introduce yourself and be courteous to patients.
(2) Read or listen to instructions carefully.
(3) Ask for permission before examining and explain the procedure, even if you are examining a dummy.
(4) Offer patients choice. If you are asked to take blood, ask which arm they would prefer you to use. If you are required to give them information, establish what they know and ask if they have any questions.
(5) Don't hurt your patient. For example, if the patient has abdominal pain, start palpating in an area that is not painful. If pain is unavoidable,—for example, when you are taking blood, warn the patient beforehand. Say something like, "Sharp pain coming now."
(6) Look first. There may be clues around like a hearing aid, asthma inhaler, or colour chart telling you what blood bottles to use.
(7) Describe physical findings before giving a diagnosis.
(8) Look the examiner in the eye. Speak confidently. Don't mumble or look at the floor.
(9) Don't dwell on a bad station.
(10) Thank patients and examiners at the end of each station.

*Further resources**

- GMC website PLAB page can be found at www.gmc-uk.org/global_sections/sitemap_frameset.htm (accessed 8 Feb 2004)
- The medicbyte course can be found at www.medicbyte.com
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*The resources mentioned in this article are not a complete list but those recommended by the candidates and examiners the authors interviewed for this article.

Otmane El Mezoued, a refugee general practitioner from Algeria, explains some of his difficulties with PLAB "In Algeria we had to write essays. In this country there are MCQs, EMQs, and OSCEs. You have to learn exam technique. I didn't pass PLAB 1 the first time. I thought books would be enough, but even if you are a genius and try to do PLAB without practising EMQs, you will fail. Go to any PLAB centre and wait for people who have just done the exam. Ask them when they come out where the study groups are. I joined a study group and passed."

> If you don't know the culture and how people react to bereavement, you will fail

Otmane also encountered some cultural difficulties with the OSCE: "For part 2 there may be a station on how to break bad news. If you don't know the culture and how people react to bereavement, you will fail. In the United Kingdom you involve patients in management decisions, and they have the right to know what is wrong with them. In Algeria, if a patient has cancer you talk to the family and they decide whether to tell the patient. The family make those decisions, not the clinician. Be careful with body language. If you come from a Mediterranean country you use more hand gestures, which UK patients might interpret as aggressive. I have problems controlling my hands. Now I clasp my hands together and interlink my fingers. Make yourself familiar with how UK hospitals run. What are the protocols? How do you take blood? How do you put a urinary catheter in? If you don't see how people do it in this country, you are in trouble."

A refugee paediatrician from Afghanistan who also wished to remain anonymous describes his frustrations with PLAB: "I did a driving test here and passed on my fourth attempt. PLAB is like a driving test. It is about doing things in a certain way. I took PLAB so many times I gave up and just left it. I realised I was knocking at a closed door, but I had to keep on knocking. If you want to make it, keep knocking. I went back and sat it and passed."

Essentials for PLAB part 2

Clinical skills

Make sure you are competent at the following clinical skills: examining respiratory, cardiovascular, abdominal and neurological systems, examination of joints, vaginal examination including taking a cervical smear, funduscopy, taking blood, inserting an intravenous cannula, inserting a urinary catheter, inserting a nasogastic tube and checking its position on an x ray, blood pressure measurement.

Communication skills

Practise obtaining informed consent to common procedures. Be able to explain clinical conditions in layman's terms. You should be able to break bad news of a variety of conditions, including motor neurone disease, multiple sclerosis, and cancer.

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Dr Yawer Saeed

Tips on ...

Passing PLAB 2

PLAB 2 (the Professional and Linguistic Assessments Board test part 2) consists of 16 objective structured clinical examination (OSCE) stations, which usually include one rest station and one pilot station. Each station is graded from A to E. (www.gmc-uk.org gives further details.) It covers a wide range of tasks including history taking, examination skills, practical skills, use of equipment, emergency management of patients, and communication skills such as consenting and counselling.

Have you practised enough?

It is important to practise each given task as many times as possible. Practising in groups—for example at PLAB classes—is useful for this. With more and more practice, your communication skills and examination skills will improve and help you perform with increased confidence.

Be clear and task specific

One common reason for failing is diverting from the task. If you concentrate on the specified task, your performance will improve and you will not go off track. The task specified is always clear—for example, perform a knee examination on this 18 year old girl complaining of a clicking sensation in her right knee.

Be confident and convey the message clearly

Confidence is the key to success. Stay calm and relaxed and be sure of what you want to say. Speak clearly.

Be systematic

Greet the patient when you enter the station and introduce yourself. Ask for the patient's permission before doing any examination or procedure. If you are performing a procedure such as intravenous cannulation, it is important that you follow all the steps properly.

Do not forget to ask for a chaperone

Ask for a chaperone when necessary—for example, hip examination in a female patient. If in doubt, ask for one.

Do not panic

Often, if you perform badly in one station, you panic and perform badly in the next station. However, it is important to concentrate on each separate station. You will perform a lot better by doing this.

Kuntal J Patel *senior house officer, surgical rotation*
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CLINICAL ATTACHMENT

How to supervise an overseas doctor on a clinical attachment

Elitham Turya *gives some advice to consultants who want to start taking on overseas doctors as clinical attachees*

About 3500 overseas doctors pass the Professional and Linguistic Assessments Board (PLAB), exams every year. After the PLAB exams they face further hurdles—finding clinical attachments, getting shortlisted for jobs, and handling job interviews.

How can you help?

If every NHS consultant offered and supervised a clinical attachment to one PLAB graduate every year, the clinical attachment hurdle would be removed. The "attachees" need more than the opportunity to attend clinics and ward rounds and to shadow senior house officers (SHOs). They need advice and coaching in writing their CVs, applying for jobs, and handling job interviews—skills that UK graduates take for granted. Many countries do not appoint doctors to jobs through CVs, job applications, and interviews. Doctors are assigned posts on completion of medical training.

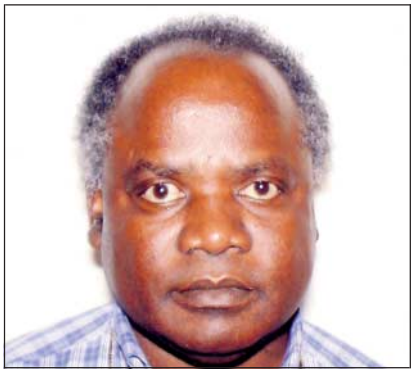
Why should you offer supervised clinical attachments?

For most consultants and general practitioner (GP) principals, supervising a clinical attachment is an opportunity to return acts of kindness received from former medical teachers and professional mentors, who taught them how to practise medicine in the traditions of Hippocrates and others.

> To teach them this art, if they shall wish to learn it, without fee or stipulation; and that by precept, lecture, and every other mode of instruction, I will impart a knowledge of the Art to my own sons, and those of my teachers, and to disciples bound by a stipulation and oath according to the law of medicine. Hippocrates' oath[1]

How do you start?

You do not have to advertise—applicants will find you. Doctors write to many hospitals and consultants in the hope that one of them will give them the valuable introduction to the NHS and a clinical discipline. Multiple applications are made because many hospitals and consultants do not offer clinical attachments.



Author: Elitham Turya

All you have to do is be ready to help some of them. An interested consultant should agree with colleagues to accept candidates for clinical attachment and persuade the hospital's medical director and clinical tutor that the trust should offer clinical attachments. One consultant should liaise with human resources in organising attachments to ensure that you do not suddenly find that you have more attachees than can be effectively supervised.

What does supervising a clinical attachment mean?

The consultant supervising the attachment should ensure that the attachee is aware of the skills essential for effective patient care and survival in the NHS. The supervisor should:

- Introduce the doctor to the NHS healthcare environment and to a clinical discipline
- Enable the doctor on attachment to shadow SHOs and registrars in their clinical duties
- Introduce the doctor on attachment to effective clinical communication (verbal and written)
- Introduce the doctor to clinical audit, clinical governance, and legal aspects of health care
- Help the doctor to appreciate the role of teams, management, and leadership in health care
- Advise the doctor on writing effective CVs and cover letters for job applications
- Coach or facilitate coaching on preparing for and handling job interviews.

How do I supervise doctors on clinical attachment?

I will describe how I, with the support of fellow consultants and the staff of the paediatric department, supervise overseas doctors on clinical attachment in paediatrics. I believe the principles are simple and apply to all clinical disciples.

Who supervises the doctor on attachment?

Supervising the doctor on attachment is the responsibility of consultants. The senior doctor does not have to physically teach or show the attachment doctor everything. Other clinicians—doctors, nurses, and therapists—help in showing them how the NHS works and how patients are managed. The supervising consultant has the duty of checking that the doctor gets opportunities for learning.

Recruitment and contract

Doctors on attachment come to my department either by writing to human resources or to a consultant. The applications are passed to me as the coordinator for clinical attachments. I offer suitable doctors four to six week attachments. The department accepts only one doctor at a time as we also take medical and nursing students from the local university.

The prospective doctor on clinical attachment signs a contract prepared by human resources before starting the supervised clinical experience. Such doctors are permitted to clerk patients under direct supervision of a doctor employed by the trust but not to prescribe drugs or other forms of treatments.

Introducing the doctor on attachment to an NHS clinical discipline

Normally the attachment starts on a day I am in the hospital so that I can meet the doctor on his or her first day; otherwise I arrange for a registrar to meet him or her. The doctor reports to human resources to sign the attachment contract, then finds my secretary who tells him where to find me or the registrar. The attachee is introduced to members of the department in the first two days.

Course of the attachment

On the first day I meet with the doctor for 30 minutes to discuss his or her learning needs—what he or she expects to gain from the attachment. We discuss:

- The need for shadowing SHOs in all their clinical and administrative (writing and dictating discharge summaries) duties
- The importance of observing and studying clinical and social interactions between doctors and patients, doctors and nurses, nurses and patients, etc
- Induction courses for international doctors: Many doctors on attachment have not heard about the useful courses (financed by the NHS).[2] I advise them to contact NHS Professionals (see further information) for course details and bookings.

Coaching and mentoring the doctor on attachment

I meet the attachee for 30 minutes every week to discuss their progress. Over the course of the attachment we cover:

- Importance of language skills in clinical and social communication
- Essentials of writing clinical notes and letters
- Handling sensitive clinical issues (child abuse, confidentiality)
- Clinical audit, clinical governance, and legal aspects of health care
- The role of teams, management, and leadership in health care
- Writing CVs and cover letters, applying for jobs and handling job interviews.

The doctor is encouraged to clerk patients and present them to medical staff and to discuss their management. On ward rounds I

expect the same skill and knowledge from the attachment doctor as I expect from SHOs. They are encouraged to present patients they have clerked. This helps me assess the doctor's clinical skills, knowledge, and approach to clinical management. Such knowledge enables me to write an informed reference for the doctor.

Language skills
In clinics and ward rounds I note the attached doctor's language (English) skills from the way they write notes, present cases, and answer questions. Occasionally I encourage doctors with poor language skills to listen to BBC radio and TV broadcasts and read non-medical books.

Body language
I discuss the need for the doctor not to be afraid of direct eye contact with their seniors and say that is normal and expected in the United Kingdom. I invite them to study body posture and mannerisms such as the handshake and head movements for emphasising points—nodding head in agreement and shaking to indicate disagreement with a statement. Some doctors use head movements to indicate the opposite.

Quality of CV
In the second week of the attachment I look at the doctor's CV. If he or she has difficulty understanding the essence of a good CV, I provide a printed example of how I would write a CV if I had recently come to the United Kingdom, passed PLAB, and were looking for an SHO job.

Applying for jobs
In addition to writing CVs I discuss choice of jobs and applying for them. The doctor shows me the final version of their CV and the covering letter that goes with it. I explain the very important difference between training and non-training jobs. I help attachment doctors who are shortlisted for jobs to prepare for interview. I usually give them *Managing Interviews,* a chapter from the book, *Your Career After PLAB.*[3]

Surviving in the NHS
In the last two weeks of the attachment, we discuss survival and prosperity in the NHS—good clinical practice, postgraduate qualifications, clinical governance and audit, and communication skills. I remind the doctor of the GMC's *Good Medical Practice* and the minefield in non-training posts before saying farewell and good luck.

The future of clinical attachments
Hopefully the Department of Health and GMC will work out a more humane programme for initiating international doctors into the NHS. Such a system existed in the 1970s.

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P+ *Go to web extra at bmjcareers.com/careerfocus for references*

CLINICAL ATTACHMENT

A user's guide to clinical attachments

Umesh Prabhu *has organised many clinical attachments for overseas doctors. He gives some advice to doctors wanting to organise one*

Clinical attachments vary in length from four weeks to three months (rarely six months). They are not mandatory and have their advantages and disadvantages. The advantages outweigh the disadvantages.

Advantages
- You get used to the NHS
- You learn the UK way of working—communication, English language and accent, teamwork, consent, patients' involvement, etc
- You get to know the role of nursing and other staff
- You (hopefully) impress the consultants and others
- You learn about the clinical specialty and acquire some useful skills
- You have a local referee
- You get a job
- You spend time usefully, particularly if you are worried about job and future.

Disadvantages
- Your weaknesses will be exposed
- Doing an attachment does not guarantee a job, and you should be prepared for that
- If you don't get a job in the place where you do your clinical attachment it will undermine your self confidence. There are times when even if you are a very good doctor you may not get the job because there were simply better candidates (with experience of working in this country or part 1 of the membership exam of the Royal College of Physicians (MRCP) or many other reasons)
- The cost of living in the United Kingdom is high, and some places charge you for doing a clinical attachment. Some hospitals offer free accommodation. No national standards exist.

How do I get a clinical attachment?
- Through personal contacts—through your friends or relatives who know a consultant who offers clinical attachments
- By going through websites and sending CVs to consultants and asking for a clinical attachment
- By just trying your luck by asking for an appointment or sending CVs to local consultants or trusts
- Through organisations (see further information).

Further information
British Association of Doctors of Indian origin (www.bapio.co.uk)
Discussion forum for overseas doctors (http://health.groups.yahoo.com/group/Indi_go/)

Currently no centralised database or facilities exists that organise a clinical attachment, and although various groups are looking into this, any change is likely to take a long time.

How long should I do a clinical attachment for?
My simple advice is doing it for a period of four to six weeks only. Go to different hospitals if you can get one as this will give you more chance to meet more consultants and more places where there may be jobs. This is the best way to get your first job. I would not advise doing a clinical attachment in a teaching hospital (unless you are only doing one to pass an exam) as the probability of getting your first job in a teaching hospital is very low.

How do I find accommodation?
Be polite and speak to the accommodation officers (most hospitals have one) and see if they can help you. Even if they don't have accommodation they may be able to suggest other local possibilities. Accommodation may cost between £25 and £80 a week (depending on where you are based in the United Kingdom).

How much will a clinical attachment cost me in total?
In my experience, the average cost is between £200 and £300 a month per person.

What should I do if I don't get a job after doing a clinical attachment?
This is a worrying time. If there is a job in the hospital where you have done a clinical attachment and you are not shortlisted, my advice would be talk to the consultant and ask for an honest explanation. Reflect on it, try to see where you might be going wrong, and improve.

What can I do on a clinical attachment?
This depends up on your consultant. There are no hard or fast rules, except that you can't treat the patient on your own and sign prescriptions or drug charts for treatment or any request forms. You can take a history and examine patients as long as you have their consent. You can take blood sample under the supervision of a senior house officer (SHO) or registrar and with the consultant's permission. Always wear a name badge (you should ask human resources for one).

Final thoughts
Do not forget your individual responsibility. Do not expect others to do things for you. It is only you who can help yourself.

Umesh Prabhu *consultant paediatrician Fairfield Hospital, Bury*

CLINICAL ATTACHMENT

Clinical attachments—time for a change

Alan Rich *and* Cynthia Marvin *discuss the current problems with clinical attachments and propose a new scheme to replace them*

Are clinical attachments still the best way of introducing overseas doctors to UK medicine and the NHS? In the context of Modernising Medical Careers, has their time come and gone? We examine the objectives of clinical attachments and ask if the current system should be replaced by something of more value to both the NHS and overseas doctors.

The current status of clinical attachments

More than 9000 overseas qualified doctors were registered for the first time with the General Medical Council in 2003.[1] Most of these will have been eligible for registration because they passed the professional and linguistics assessment board (PLAB) examination. Successful candidates often view a clinical attachment as an essential step in their objective of obtaining a UK training placement, and crucial in gaining their first reference for a UK consultant (essential for substantive training placements).

"Observerships"

However, clinical attachments are essentially "observerships."[2] Attachees have the same status and capacity as a medical student. They are permitted to take medical histories and carry out routine examinations of patients, provided the patients have given their informed consent.[3] They may assist in the operating theatre and attend outpatient clinics. They can, however, not participate in the supervised clinical management of patients or prescribe treatment. This restricts the usefulness of attachments in assessing competency and performance.

Unstructured

Although good practice guidelines exist,[4] most attachments are unstructured. As a result any meaningful educational supervision is unlikely and opportunities to agree learning plans or provide feedback are few. Supervising consultants who are asked to provide references usually indicate that they are unable to assess clinical skills. This limits the value of such references as discriminators of performance or competency for substantive training placements.

Trusts

Providing clinical attachments is largely voluntary. Attachees usually compete with undergraduate medical students for a limited teaching capacity. Trusts are more willing to accommodate undergraduates, who usually come with special increment for teaching funding. Also, trusts have to bear the cost of employment screening for clinical attachees, since the attachees will have direct patient contact. This often means that trusts actively discourage clinical attachments.

Unfair

Clinical attachments are not usually advertised and there is normally no selection process. Obtaining an attachment is largely due to persistence and luck, and many overseas doctors have to wait a long time before they are successful. In spite of this, many overseas doctors spend prolonged periods in attachments in the expectation that this will improve their chances of obtaining a substantive post. Given their observer status, the value of this extended experience is limited.

Taken together, all of these issues mean that overseas doctors seeking training in the United Kingdom often face a lengthy period of unemployment and hardship before they obtain their first substantive UK post.

Overseas doctors' needs

Surveys carried out at a UK national induction course (figure) have indicated that a sizeable proportion of overseas doctors have not had an opportunity to obtain many of the generic skills that are expected of UK preregistration house officers.

With effect from August 2005, all UK graduates will have started in two year foundation programmes, which will provide generic skills training, experience in the management of acutely ill patients, and contact with primary care. This may further disadvantage overseas doctors, who may not have the opportunity or because of seniority, may not wish to do year 2 of a foundation programme. Then there is also the issue of when and how overseas doctors who wish to join specialty training programmes will be assessed.

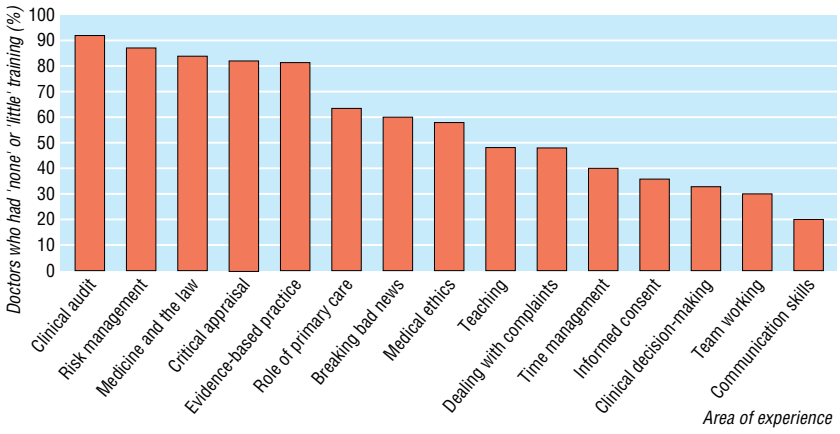

Fig: A sizeable proportion of overseas doctors have not had the opportunity to obtain generic skills

Clinical attachments as part of modernised medical careers

Many of these issues could be addressed by creating a system of supervised and managed clinical placements to replace attachments as overseas doctors' first experience of the NHS. We suggest that these are called NHS Reception Placements (NHSRP).

Such a scheme would be in keeping with the GMC proposals on futures for registration[5]—a managed scheme between registration and first revalidation at two years.

- NHSRP would be available for overseas doctors who successfully complete the PLAB part 2 examination and are eligible for limited registration. NHSRP would fulfil the GMC requirement of "supervised employment"
- NHSRP would be of fixed term (probably four months) and essentially supernumerary at the level of the second year of a foundation programme
- Hospital trusts would offer placements to a central "clearing house"
- Access to NHSRP would only be through the clearing house. All post-PLAB doctors would be eligible and would complete a standard application form
- Placements would be filled only from the clearing house, probably three times a year; local postgraduate deans would be able to grant personal educational approval to a specific NHSRP, so a formal appointment process would be unnecessary
- Until a placement was offered, overseas doctors would be able to return home if they wished, and continue to work until notified of a place on the scheme
- When a placement became available, overseas doctors would be enrolled on an UK international doctor's induction course
- Placements would be closely supervised by trainers with the skills to mentor, appraise, and assess. Educational supervisors for F2 programmes would already possess these skills and be able to extend them to doctors on the scheme
- There would be an entry assessment equivalent to the foundation year 1 exit assessment. This would inform the clinical and non-clinical scope of the placement
- NHSRP would provide an opportunity to work with substantive trainees during the day, but without out of hours responsibilities (when clinical supervision is inevitably less effective)

- Doctors on the NHSRP would have the opportunity to take part in clinics and operating lists and to demonstrate their skills and competencies
- They would participate in the generic skills training and educational opportunities offered to other trainees in foundation programmes (this could include contact with primary care.) Conceivably, if this training was modular it could gain educational credits with the NHS University
- Appraisal would take place throughout the placement, with a formal assessment towards the end. The outcome might include recommending either a further period in a managed placement or an indication of the level at which entry might be appropriate to a basic specialty training programme. This, with a reference from the educational supervisor, should provide ample evidence for overseas doctors to compete for substantive posts
- Managing those who were identified as being unable to proceed beyond a second NHSRP placement would need further consideration
- Such placements could help trusts to meet the demands of the working time directive. So trusts might be willing to meet at least some of the costs of the NHSRP
- Overseas doctors who had successfully completed NHSRP would be a potential source to the trust of locums or applicants for substantive posts.

Conclusions

Such a scheme would have wide benefits. Patients would be cared for by trainees who understood the NHS and their professional role in it, and who were skilled and competent to do the duties expected of them. Overseas doctors would be able to register for their first placement in the NHS with a single application and would be able to continue working in their home country until a placement becomes available. Trusts would find the requirements of the working time directive easier to meet.

Alan Rich *associate postgraduate dean*
Postgraduate Institute for Medicine and Dentistry, Newcastle upon Tyne NE2 4HB

Cynthia Marvin *director of medical services*
NHS Professionals for Doctors, Sheffield S4 7QQ

What do you think about the scheme the authors have proposed? Please join the debate by sending a rapid response to bmjcareers.com/careerfocus

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2 *Doctors acting as observers in hospitals.* Health service guidelines HSG(95)30. London: HMSO, 1995.
3 NHS Executive. *Medical students in hospitals.* Leeds: NHS Management Executive, 1995.
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5 General Medical Council. *New arrangements for GMC registration and licensure: a consultation paper.* London: GMC, 2003.

CLINICAL ATTACHMENT

A positive experience of a clinical attachment

Author: Dr Haitham Alshafey

Two hours after the shock of discovering that I had failed part 2 of the membership exam of the Royal College of Obstetricians and Gynaecologists (MRCOG) for the second time, I decided that it was the time to try a clinical attachment in the United Kingdom. I was fed up and needed to know what else I had to do to pass.

I had previously thought about doing a clinical attachment but discarded the idea as being too expensive and not beneficial. I was naive to think that a clinical attachment would be easy to arrange.

I browsed the web to find the addresses of hospitals in the United Kingdom and then contacted them (300 postal letters). I received many replies, but no one wanted to take me. At that stage, I did not know what to do.

Personal contact

Then I remembered a senior house officer (SHO) that I vaguely knew, who was working in the United Kingdom. I contacted him and told him what had happened. He was helpful and asked for my CV and contacted one of the consultants with whom he worked. Then the impossible happened. My application was accepted. Within a week I had arrived at the hospital.

Muslim doctors praying in the chapel

I was nervous as I thought that I would experience racism, being Arabic and a Muslim. But this was not the case. Initially, I was reluctant to pray in the hospital but discovered that other Muslim doctors pray in the hospital in the chapel, yes the chapel! I found that people here are very tolerant.

Never stay in your room

A senior colleague back home in Egypt advised me to never stay in my room, apart from when I want to sleep—not even for studying. The main reason for an attachment is to know what others do, therefore there is no point in staying in my room alone. This was wonderful advice.

Meet a new person every day

I got to know a new person every day. My day was divided between clinics in the morning and shadowing an SHO on call from noon until late. I found this very useful and gained a lot from it. Most SHOs were very friendly.

I saw conditions that I had previously only read about and attended counselling for patients for investigations rarely done in Egypt—for example, amniocentesis. Every day I noticed my English improving and that I was also getting step closer to my main target: part 2 MRCOG, which I am retaking this September.

Consultant contact

One day the consultant asked me to meet him at his office. He surprised me by asking me to go through some patients' files with him. In every case he read the referral letter from the general practitioner and asked me how I would manage the case. He gave me some very useful feedback.

Another one

As I thought my clinical attachment experience was so worth while, I decided that I needed another attachment. This time, I dressed formally and met a consultant who told me that I could start the next day.

> My advice to other overseas doctors thinking of doing a clinical attachment is be friendly to everyone and not to stay in your accommodation

In my experience, clinical attachments can be very useful to prepare for the objective structured clinical examination (OSCE) in part 2 of the MRCOG. I improved my English and had the opportunity to study the RCOG guidelines (and the ones that the National Institute for Clinical Excellence (NICE) has published about the specialty). This helped me to recognise what would happen in clinical practice in the United Kingdom.

My advice to other overseas doctors thinking of doing a clinical attachment is be friendly to everyone and not to stay in your accommodation. Experience in outpatient clinics and wards is more important than theatre experience as we need communication skills more than surgical skills. Finally, literacy in information technology is very important.

Haitham Alshafey *doctor on clinical attachment shares his experiences Queen Elizabeth Hospital, King's Lynn, Norfolk*

JOB HUNTING

Writing CVs and handling job interviews

Many overseas doctors fear writing CVs and are frightened of job interviews. Elitham Turya *explains that there is nothing to be scared of*

At school Dr Sara Kirabo was a prefect for health issues. At university she participated in health education campaigns to halt the spread of the human immunodeficiency virus (HIV). She learnt counselling to help fellow students cope with the infection.

Her interest in counselling led her into a career in psychological medicine. After working as medical officer in a mental hospital she took and passed the Professional Linguistic Assessments Board (PLAB) tests, did a clinical attachment, and found a post as a senior house officer (SHO) in psychiatry in a desirable hospital.

How did she do it?

The first part of this article discusses how Sara wrote her curriculum vitae (CV). The second describes how Sara handled the job interview. Sara, her CV, and the doctors named in it are fictitious. Names of known institutions are used to maintain a sense of reality.

Writing a CV

Sara wanted a CV that would get her interviews for SHO posts in psychiatry. She read about writing CVs,[1] talked with junior doctors and sought advice from her clinical attachment supervisor.

Sara had a choice of formats—the targeted, the chronological, and the functional. In addition to personal details, a *targeted* CV names the target job and summarises work history; a *chronological* CV lists work history from the first to the last job. A *functional* CV highlights functional skills and achievements and summarises work history from the current or most recent post back to first. Sara, like most doctors, used the functional format to write her CV.[2]

She followed the "Usual format for medical CVs" (box), made notes on all items listed, typed, edited, and arranged them to produce a document (figure) that summarises her personal, educational, and career details. She can use her CV to inquire about, or apply for jobs, training positions and research grants, and as a source of sorted information for application forms.

Sara Kirabo was looking for an SHO post in paediatrics

She showed the CV to her attachment supervisor and was advised to sort out a few points, and to list her publications in a standard format. They also discussed a *cover letter* to accompany the CV when applying for jobs.[2]

Sara knew that when a recruiter started reading her CV, she would have less than a minute to convince them of her suitability for a post. She wrote a CV that is concise, attractive, and easy to skim in search of important information. It was printed on good quality, white, 80 g/m^2 paper. It would not be the weight or cost of paper on which the CV was printed, but the content and quality of her writing that would impress consultants when they shortlisted for interviews.

Sara *avoided excess prose and tables* and presented the information mostly in note form. Long paragraphs would not allow key points to stand out, and tables would not highlight past duties and achievements. Sara's CV emphasised her achievements, but contained no lies:

> The GMC's professional conduct committee found a doctor guilty of serious professional misconduct after she made false claims about her academic achievements and employment history. The committee suspended her registration for 12 months.[3]

Sara wrote the CV in an *active language* showing that she is an active and decisive individual: she was careful with *grammar* and *spelling*, used a spellchecker, and then *read the CV carefully*. Sara was afraid that bad spelling and poor grammar might lead to rejection of her application.

Let us briefly clarify a few items in "Usual format for medical CVs" that puzzled Sara as she wrote her CV.

The ***heading*** announces the subject of the document and avoids the need for a front sheet naming the doctor described in the CV. Sara's CV is headed: Dr S Kirabo MB ChB.

Sara's ***contact details*** are adequate for the recruiter to telephone, email, or send her a letter. Her ***personal identity*** does not include her marital status, spouse's nationality or size of her family (she is married and has two young kids). She could have included her hepatitis B status.

Sara's ***qualification*** is MB ChB. When she gets other degrees or membership of the royal college of psychiatrists she will add them to her CV. Her pass at PLAB tests is not a qualification; so she listed it separately. When she passes part 1 MRCPsych she will list it separately too till she gets the full membership. She will not include failed exams.

Sara's ***career plan*** was concise and described how the job would help her achieve it. It was on the first page of her CV.

Sara summarised ***skills*** she gained from her career. In future when she applies for a specialist registrar (SpR) post she will summarise her ***skills and achievements*** to highlight what the employer would get by appointing her to the post.

The ***education*** entry highlights leadership responsibilities held at high school and university to indicate Sara's leadership potential.

Under ***work experience*** Sara listed posts she had held and her duties and achievement in each. Her clinical attachment is not an employment post. She listed it separately under "*clinical attachment*."

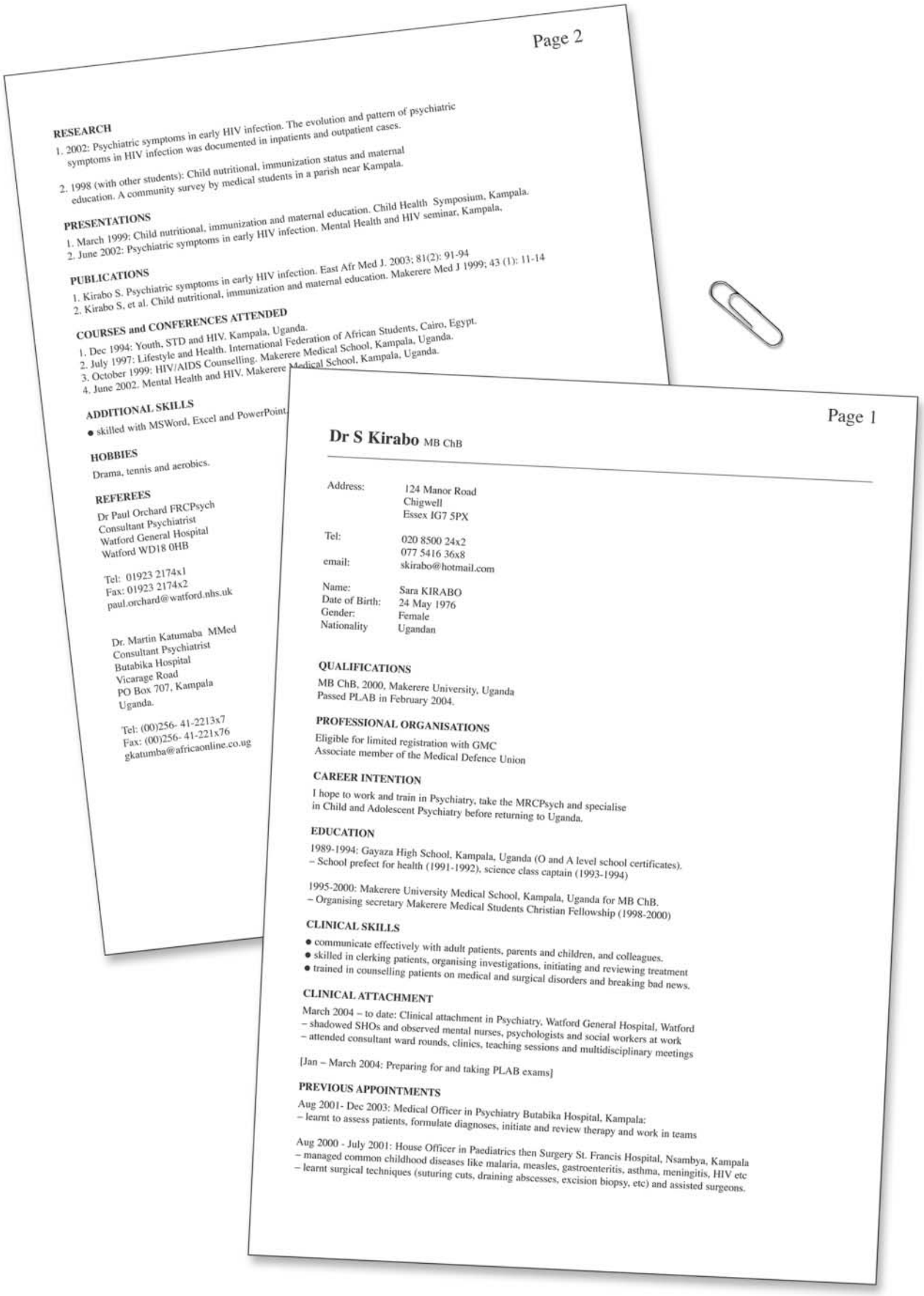
She has no need to hide or minimise any aspect of her medical career. All legitimate medical work, including national service, should be included in a CV. Interviewers like to ask questions about atypical careers.

Sara accounted for *significant gaps* in her career. She had heard that some consultants scrutinise CVs for career breaks and discard those with long unexplained gaps.

Sara described her research activities, listed *conferences* attended and *presentations* made.

Usual format for medical CVs

Heading (initials, surname, one qualification)
Contact details
- Postal address
- Telephone
- Email
- Personal identity
- Names (first name(s), surname)
- Date of birth
- Nationality
- Sex
- Career summary
- Qualifications, dates, institution, and location
- Professional organisations (GMC, royal medical college, MDU, etc)
- Career plan and how the job will help you achieve it
- Summary of skills and achievements
- Education (dates, institution, course, prizes, other achievements)
- Work history (date, position, employer, location, duties, and achievements)
- Courses, conferences attended
- Presentations at meetings
- Clinical audit, research
- Publications in journals or books
- Additional information—useful skills (information technology, languages, etc) that do not fit elsewhere
- Hobbies—leisure interests and activities.
- Referees—names and contact details of two people



Page 2

RESEARCH

1. 2002: Psychiatric symptoms in early HIV infection. The evolution and pattern of psychiatric symptoms in HIV infection was documented in inpatients and outpatient cases.

2. 1998 (with other students): Child nutritional, immunization status and maternal education. A community survey by medical students in a parish near Kampala.

PRESENTATIONS

1. March 1999: Child nutritional, immunization and maternal education. Child Health Symposium, Kampala.
2. June 2002: Psychiatric symptoms in early HIV infection. Mental Health and HIV seminar, Kampala.

PUBLICATIONS

1. Kirabo S. Psychiatric symptoms in early HIV infection. East Afr Med J. 2003; 81(2): 91-94
2. Kirabo S, et al. Child nutritional, immunization and maternal education. Makerere Med J 1999; 43 (1): 11-14

COURSES and CONFERENCES ATTENDED

1. Dec 1994: Youth, STD and HIV. Kampala, Uganda.
2. July 1997: Lifestyle and Health. International Federation of African Students, Cairo, Egypt.
3. October 1999: HIV/AIDS Counselling. Makerere Medical School, Kampala, Uganda.
4. June 2002. Mental Health and HIV. Makerere Medical School, Kampala, Uganda.

ADDITIONAL SKILLS

- skilled with MSWord, Excel and PowerPoint.

HOBBIES

Drama, tennis and aerobics.

REFEREES

Dr Paul Orchard FRCPsych
Consultant Psychiatrist
Watford General Hospital
Watford WD18 0HB

Tel: 01923 2174x1
Fax: 01923 2174x2
paul.orchard@watford.nhs.uk

Dr. Martin Katumaba MMed
Consultant Psychiatrist
Butabika Hospital
Vicarage Road
PO Box 707, Kampala
Uganda.

Tel: (00)256- 41-2213x7
Fax: (00)256- 41-221x76
gkatumba@africaonline.co.ug

Page 1

Dr S Kirabo MB ChB

Address:	124 Manor Road Chigwell Essex IG7 5PX
Tel:	020 8500 24x2 077 5416 36x8
email:	skirabo@hotmail.com
Name:	Sara KIRABO
Date of Birth:	24 May 1976
Gender:	Female
Nationality	Ugandan

QUALIFICATIONS

MB ChB, 2000, Makerere University, Uganda
Passed PLAB in February 2004.

PROFESSIONAL ORGANISATIONS

Eligible for limited registration with GMC
Associate member of the Medical Defence Union

CAREER INTENTION

I hope to work and train in Psychiatry, take the MRCPsych and specialise in Child and Adolescent Psychiatry before returning to Uganda.

EDUCATION

1989-1994: Gayaza High School, Kampala, Uganda (O and A level school certificates).
– School prefect for health (1991-1992), science class captain (1993-1994)

1995-2000: Makerere University Medical School, Kampala, Uganda for MB ChB.
– Organising secretary Makerere Medical Students Christian Fellowship (1998-2000)

CLINICAL SKILLS

- communicate effectively with adult patients, parents and children, and colleagues.
- skilled in clerking patients, organising investigations, initiating and reviewing treatment
- trained in counselling patients on medical and surgical disorders and breaking bad news.

CLINICAL ATTACHMENT

March 2004 – to date: Clinical attachment in Psychiatry, Watford General Hospital, Watford
– shadowed SHOs and observed mental nurses, psychologists and social workers at work
– attended consultant ward rounds, clinics, teaching sessions and multidisciplinary meetings

[Jan – March 2004: Preparing for and taking PLAB exams]

PREVIOUS APPOINTMENTS

Aug 2001- Dec 2003: Medical Officer in Psychiatry Butabika Hospital, Kampala:
– learnt to assess patients, formulate diagnoses, initiate and review therapy and work in teams

Aug 2000 - July 2001: House Officer in Paediatrics then Surgery St. Francis Hospital, Nsambya, Kampala
– managed common childhood diseases like malaria, measles, gastroenteritis, asthma, meningitis, HIV etc
– learnt surgical techniques (suturing cuts, draining abscesses, excision biopsy, etc) and assisted surgeons.

Fig: Dr Sara Kirabo's CV

She followed the Vancouver style when listing her publications.[4] All publications, be they journal articles, abstracts in conference proceedings, book chapters, or whole books, qualify for listing in a CV whether done abroad or in the United Kingdom.

Sara listed her *hobbies* to show that she has a life outside medicine. She gave names and contact details of two *referees*. After settling in her new job she will ask two suitable consultants for permission to name them as referees. References from consultants a doctor has worked with are more influential than those from supervisors of clinical attachments.

The *length* of Sara's CV—three pages—was determined by jobs, audits, research, presentations and publications done, and courses and conferences attended. Two to three pages should suffice for most house officers and junior SHOs. A senior SHO applying for an SpR post may need four to five pages.[2]

Sara did not pay a *commercial* company to write her CV. Such companies do not *write* CVs, but *type, edit, and print* (*produce*) documents from information supplied by clients. They print the document on unnecessarily expensive paper and charge a lot of money for the service. By following "Usual format for doctors' CVs" Sara crafted her CV and asked her supervisor's secretary for advice on getting it professionally typed and printed. Because she asked politely, the secretary typed and printed the CV free of charge. She could have directed Sara to one of several commercial typists nearby. Sara recently brought her an ornamental basket from Uganda.

Handling job interviews

An interview is an occasion when individuals or groups meet and talk with each other, with one side asking questions and the other answering them. In a job interview an applicant (interviewee) is seen and questioned by an employer or their representative to determine the applicant's suitability.

Although interviewees strive to convince interviewers on their suitability, interviewers ask themselves a few questions about each candidate:

Is she the most suitable? Did Sara have the right personality and drive? Was it the right job for her?

Will she do the job? If interviewers felt that although capable, Sara would not willingly perform her duties, they would not appoint her.

Will she fit in? People want somebody who will fit in nicely. Sara would be appointed if interviewers felt she would fit into the team—character, drive, dependability, initiative, congeniality, etc.

Pre-interview inquiries

After sending out 60 applications, Sara was shortlisted for interview by two mental hospitals—one in Yorkshire and the Maudsley in south London. The interviews were on the same date. Her supervisor recommended attending the London interview.

Sara did not have to visit the Maudsley. She could have rung and spoken with the incumbent of the post she would be interviewing for. But as she did not know London, she visited the hospital, noted the route and where the interview would be held. She met people in the post, some nurses, and one consultant.

Preparing for interview

Sara sought advice from junior doctors at Watford Hospital. One registrar advised her to read her CV before the interview. "*Interviewers will have copies of your CV*" he said, "*and will question you on its content.*" Two SHOs who had recently succeeded at job interviews took Sara through a mock interview and explained how they had handled questions like:

- Why did you apply for this job?
- What are your career objectives?
- What are your weaknesses/strengths?
- Tell us about a clinical audit you have done
- Tell us about an interesting case you have handled recently
- What is the most challenging clinical situation you have met?

Presenting for interview

What did Sara ***look*** like *(appearance, confidence),* and ***sound*** like *(voice, language)*? Critical decisions (*trust and distrust, like and dislike,* etc) are often made after brief encounters—interviews. Only qualified candidates would be interviewed. So, it would not be qualifications but the ***impression*** she created by her ***appearance***, ***confidence***, ***speech***, and ***demeanour*** that would determine the outcome.

Sara dressed for a professional interview and not a party. She wore smart, clean, and socially appropriate clothes—not a T shirt or jeans. She could have worn trousers, a shirt, and a jacket, but she felt more comfortable in a skirt, a shirt, and a matching jacket. She took her hepatitis B serology status, eligibility for limited registration, and passport with her.

Demeanour

At the human resources department Sara made her inquiries politely and waited calmly. On entering the interview room she was introduced to three consultants and a human resources officer. She shook hands with a moderately firm grip and made direct eye contact with panel members as they were introduced to her. She sat in the chair indicated by the chairman, made herself comfortable, and waited for questions.

She spoke clearly, concisely, and simply; neither whispering nor shouting. She watched interviewers' faces to see if they heard and understood her answers. She did not draw attention to her weaknesses nor argue with interviewers. She smiled and laughed appropriately.

Sara answered the questions asked. She gave concise but informative answers confidently and politely. If a question was not clear she asked for an explanation or for it to be repeated. When she did not know the answer, she said so confidently. She did not use jargon or abbreviations unless she was sure the interviewers knew them too. When

an interviewer was speaking she did not interrupt, but listened and answered the question that followed the speech.

Sara was asked about her work in health education and counselling fellow students. She gave succinct but full answers. Interviewers were impressed by her understanding of the HIV pandemic.

Questions about the past

Sara was aware that she might be asked about past failures. She was prepared to talk about one case that did not go well. The cause of mishap had been identified and lessons learnt. She had reflected on the incident and could discuss it confidently and rationally stressing the lessons and not the failure. She was not asked.

Finally, she was asked if she had any questions. She thanked the panel for the opportunity, said she had talked with doctors and nurses on the ward, and had no questions. She was told a decision would be made later that afternoon and that she could wait for the result if she wished. She said she would wait. She left the interview room confidently and politely.

At 5.30 pm., three of the 10 interviewees were offered jobs. Sara was among the successful doctors. She accepted the job offer.

Elitham B Turya *consultant in child health*
Trafford NHS Trust, Manchester
elitham.turya@trafford.nhs.uk

EBT acknowledges the help of a Ugandan senior house officer whose career inspired Sara's CV.

1 Strunk W, White EB. *The elements of style.* London: Longman 1999.
2 Ritter RM. *The Oxford manual of style.* London: BCA for Oxford University Press, 2002.
3 GMC. GMC case book: doctor suspended after making false claims. *GMC News,* 14 October 2002.
4 International Committee of Medical Journal Editors. Uniform requirements for manuscripts submitted to biomedical journals. *Ann Intern Med* 1997;126:36-47.

Further reading

- Turya EB. *Your career after PLAB: survival tools for young doctors.* Manchester: Edukom, 2003.
- McErin S. *Writing the medical CV.* Manchester: Edukom, 2004.

JOB HUNTING

Are you ready to work in the United Kingdom?

Catharine Arakelian *challenges you to redraw your cultural map if you want to get a job in the United Kingdom*

"Every week I sit in an internet cafe in London and download the job vacancies advertised in *BMJ Careers*. I spend three days sending off applications and CVs. I got to the UK four months ago and cannot work on my visa. I came with £2000 [$3700, €3000], which I have spent on living here, photocopying, and other costs. I have sent off 450 applications and have had no success. Now I have no money. I don't understand why I haven't been shortlisted."

Doesn't this story sound like a dreadful nightmare? Not just for the overseas doctor but also for the selectors. How are they to deal with such an overload of paper? But ask yourself, "Can this doctor really expect a positive result with such a scatter gun approach? Is he or she really ready for work in the United Kingdom?"

Job seeking in the United Kingdom can be a time consuming activity and you need to have plenty of mental stamina and a positive approach. You must be ready on several fronts. You need to have the organisational readiness to undertake a structured search for a job, the psychological readiness to seek opportunities and deal with rejection, and the cultural readiness to prepare to meet the expectations of the selectors at each stage. In this article I will focus on the third type of readiness—cultural readiness.

Cultural maps

Knowing how to behave in a certain situation can be considered metaphorically as a cognitive map which is culturally accurate. Your old cultural map which fits your own background perfectly may not be useful in predicting how your actions will be perceived in a new culture. You have to construct a new cultural map as, unfortunately, it is not a map you can pick up on arrival at Heathrow.

Prerequisites

Part of the cultural map of getting a job entails accepting that the following apply in the United Kingdom: your previous experience has given you a bank of transferable skills; these skills are evidenced by your experience; and your aim in the job application form (and later in the interview) is to demonstrate your suitability to the selectors through well judged examples of your skills in action elegantly cross referenced to your curriculum vitae (CV). Many overseas doctors find these culturally determined expectations difficult to fulfil, yet these define the communication skills, language, and behaviour you will need to secure a post in the United Kingdom.

Author: Catharine Arakelian

Transferable skills

Why not make a list of your transferable skills now? Draw a line down a page. On one side list your experience (as in a typical CV entry) and on the opposite side list the transferable skills you have gained from this experience. After doing this with your whole CV, including your non-medical activities, move the list of transferable skills to a separate page. Now consider concrete examples of times in the past when you put these skills into use. For example, this could be an anecdotal story which illustrates the skill in action (box 1). So now you have a list of your skills with evidence to back them up.

No scatter gun

It should be easy to see now why a scatter gun approach of sending the same CV for every application will lead to a lack of success. Handcrafting your CV to show how you meet the criteria of the person and job specification saves time for the selector and indicates a serious attitude to the job. It is interpreted by the selectors as showing "professional commitment." No doctor can send off 30 or 40 handcrafted applications in a week—so you will need to become more selective in your targets.

The interview process

Think about how the interview process itself is constructed. Consider these real attitudes to the interview process:

- "In Kosovo, when you graduate from medical school your first job is lined up for you. You never have to go for an interview. The state organises everything"
- "In Columbia, you depend on your family and people you know to help you find your first job, and then career advancement is up to how well you get on with the powers that be in your region."

If you apply unquestioned the values and beliefs from your previous work culture, your UK selector may interpret your response as inappropriate.

Reflect on the cultural positions that underpin the interview. Look at the statements in box 2 and consider whether you think they are part of the values and beliefs underlying the selection process in the United Kingdom.

Box 1: An example of illustrating a transferable skill

Prioritising a workload

When I was working as a house officer in the surgical unit, I discovered one day that I was the only house officer on duty. The two other house officers were absent for different reasons. My initial assessment was that this difficult day would need careful management. I did the following:

- Controlled my immense desire to panic
- Acknowledged that I was not alone—there were other people who could help, such as the nursing team
- Organised tasks according to need
- Took care of myself by having proper meals and regular short breaks to help keep me going.

The basis of effective communication

Effective communication relies on what you say being interpreted through shared knowledge and values. To join this cultural group you need to learn its ways. Members of the "in group" recognise each other as belonging to the same community—they have the same cultural map. Such appointments feel safe. To communicate effectively, you should listen to the inference behind the question and answer according to the selectors' own agenda rather than your own. Fortunately, the types of questions asked are limited so you can practise.

Typical questions

Let's have a look at some of the typical questions in an interview. For example, "Tell us a little about your background?" If your previous cultural map is drawn on the belief that contacts and family involvement in appointments are valuable, then when asked about your background you may well bring out a string of influential family connections. This would be seen by the interviewer at best as irrelevant and irritating. More crucially, it may indicate poor judgment. The question is intended to provide you with an opportunity to show how your previous experience fits you for this particular post. This is the inference you need to make so that you give the sort of answer that is expected.

The importance of inference

An overseas doctor with impeccable clinical credentials and excellent language skills when asked, "Why do you think you would be right for this position?" simply could not see what was expected of her and gave a lengthy life history. This was not what the interviewers had in mind. They wanted to see what research she had done on the post, how much she knew about the department and

Box 2: UK beliefs and values underlying the selection process[1]

Here is a list of possible beliefs which may or may not conform to procedures and questions in UK professional interviews. Which do you think **do not apply**?
(1) The interview is an opportunity to sell yourself.
(2)The interview is an opportunity to demonstrate the relevance of your skills and experience to the position.
(3) Formal qualifications are an important indication of the skills and qualities needed to do the job.
(4) Interest in and knowledge of the organisation are an indication of the effectiveness of a potential employee.
(5) The personal needs of applicants should be taken into account in selection.
(6) Family and business connections are indicators of personal qualities and abilities.
(7) Ability to talk about a job reflects ability to do the job.
(8) Respect for age and status is essential to harmonious and efficient workplaces.
(9) Humility is a desirable quality in an applicant.
(10) Long term commitment and loyalty are important.
(Only 5 and 6 do not apply, and 1 and 9 seem to be contradictory but both are important beliefs.)

institution, and whether she had a specific commitment to this post rather than any other post. What the question really means is, "Tell me what you know about this specific opportunity and how you would fit in with us."

Similarly, the question, "Why do you want this job? implies, "What does this job require and how does your skill and experience meet the requirements and what will you bring to the post." Don't be tempted to tell the selectors how much good this job will do your career chances—that's not what the question is about.

Dr J Jagdish

So why not take advantage of the offer of an informal visit or chat, which is often made in a job advertisement? During the visit you can find out more about the culture of the hospital and the consultants' expectations.

Sociopolitical context

What else can you do to show your commitment to the profession? In my experience many overseas health professionals are ignorant of the sociopolitical context in which medicine is practised in the United Kingdom. It is a cultural black hole.

Despite excellent clinical skills and experience in the relevant area, they lack knowledge of how the NHS works. Do you know how your post is funded or what current guidelines, standards, and targets apply in your specialist area? Could you explain confidently UK concepts of patient centred practice, audit, and governance? Cultural readiness entails taking an interest in the whole of the health context in the United Kingdom—through medical journals, newspapers, and open lectures.

Networking

Clinical attachments are good for developing contacts, but sometimes they can be hard to get. But you can still develop useful networks. Take advantage of informal visits to hospitals to develop the network. Ask for help and referrals and make friends and find out about how people feel about their work. Discuss with them any challenges and exciting developments. You will be able to draw on these experiences yourself in future interviews. The more you feel like an insider in the culture the better you will read the interview and perform confidently as a potential junior member of your profession.

Final thoughts

After the first day on the programme the Indian doctor mentioned in the opening quotation had changed his strategy and started to make informal visits. By the end of the fifth week he had been offered several interviews. After four months of getting nowhere, he was at last transforming his luck—he was culturally ready to work.

Catharine Arakelian *intercultural education consultant*
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The Oxford and Thames Valley Refugee Health Professionals Support Project (run by the Oxford Deanery and funded by the Department of Health) provides the Readiness Programme, a five day programme for preparing refugee health professionals in job seeking in the NHS. When there are places available we also accept overseas doctors who are not refugees. You can contact us through project@arakelian.co.uk or telephone 01865 849768.

1 O'Grady C, Millen M. *Finding common ground. Cross-cultural communication strategies for job seekers.* Macquarie University, Sydney, NSW: National Centre for English Language Teaching and Research, 1994.

Tips on ...

Interview and travel expenses

When shortlisted for interviews ring human resources to confirm that you are attending. Most hospitals provide overnight accommodation in hospital or pay for it outside (see web extra). Keep all the receipts of the travelling (expenses for rail travel, food, drink, etc) and claim from human resources. (Do not forget to get receipts for any parking at or travel to airports, which can be reimbursed as well.) Here is a rough guide of expenses that you can claim for.

- Night's subsistence: commercial accommodation

—Actual receipted cost of B&B (bed and breakfast) up to £55, plus
—Meal allowance of £20 to cover the cost of main evening meal and any other daytime meal.

- Night's subsistence: non-commercial accommodation

—You can stay with friends and relatives or in caravan accommodation (while on an interview or course) and can claim at a flat rate of £25 a day. This includes an allowance for meals and no receipts are required for this

- If you require accommodation, especially accommodation for a married couple, at your new job ask at the interview as usually a member of human resources is present
- If a job is offered confirm in writing with your requirements, for example, accommodation for a married couple. Confirm how many beds you require
- Also confirm from human resources the relocation expenses they are willing to pay. They should pay in full the cost of relocation and will usually ask you to obtain three quotations and use the cheapest. It is easier to use removal firms as it saves you the headache of packing and unpacking. Check with the hospital as most have a preferred removal firm. To get quotations look up in yellow pages (www.yellowpages.co.uk) and request written quotations. But remember that there is no point in getting a cheap quotation from a firm who are not free on the day you are moving.

Turab Syed *specialist registrar in orthopaedics*
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Please go to web extra at bmjcareers.com/careerfocus for more information and advice for overseas doctors about practical and financial matters (different sorts of bank accounts and how to set up an account, and how to get a driving licence) by Turab Syed.

ADVICE

From PLAB test to job: some practical considerations

Mohammad Shaiyan Rahman
gives some advice

An overwhelming number of overseas doctors join the NHS via the Professional and Linguistic Assessments Board (PLAB) test route. This article will focus on making the best of the time spent between passing the PLAB test part 1 and successfully finding your first post in the NHS. It is not meant to be a comprehensive guide but rather a practical approach to some of the issues that concern overseas doctors.

Preparation before the PLAB test

Committing yourself to doing the PLAB test, and eventually working in the United Kingdom, is a major life decision and you should have given enough thought to the pros and cons of working as an overseas doctor in the United Kingdom before coming.

Two recent changes will have a profound effect on the training of doctors in the United Kingdom and directly affect overseas doctors. Firstly, the European Working Time Directive (EWTD), which comes into force on 1 August 2004, will probably mean that more non-training posts will be created to conform to the directive. Secondly, now that the 10 new member states have joined the European Union, competition for jobs will become more intense.

For success in such a market, you need to have a clear goal for your training and the specialty you want to train in.

When to come to the United Kingdom

If you have taken the PLAB test in one of the UK centres or you are a refugee doctor, you are already in the United Kingdom and can move on to the next section. For those who took the PLAB test part 1 in an overseas centre, coming to the United Kingdom for part 2 poses some difficult choices.

Living in the United Kingdom is expensive so you have to be sure about your finances. Remember, you may have to wait up to nine months from the day you pass your PLAB test part 2 to getting your first post. You will need strong financial backing to live in the United Kingdom without a regular salary.

Probably the best time to come to the United Kingdom is about one to two months before taking the PLAB test part 2. During this time, you may want to do a clinical attachment to gain an insight into the NHS and clinical practice in this country.

The clinical attachment

A clinical attachment is essential. It will not only give you a sound base for your PLAB test part 2 but it will also provide you with that all important UK reference.

How to find one You need to plan at least six months to a year before you actually start an attachment. There are several ways to find a clinical attachment. One way is to email, fax, or telephone the human resources department and tell them you would like to do an attachment in that hospital, mentioning any particular specialty you are interested in. Don't be too specific about the specialty though. The consultant who is in charge of your chosen specialty may not be interested in having you. A list of the NHS hospitals can be found at www.nhs.uk. Go to "local services search" and choose "alternative search option."

Another way of arranging a clinical attachment will be through your medical school or social network. If you know someone who is already working in a hospital, you can ask him or her to speak to the consultant or medical personnel on your behalf and see if there is a possibility of doing an attachment. This will cut through a lot of red tape and you may find it easier to arrange this way.

District general hospitals or teaching hospitals The burning question in everyone's mind is which type of hospital. Ideally, you should try to do an attachment in both of these settings. Your first attachment should be in a big teaching hospital. It will give you experience of working in a tertiary centre. It may also give you an opportunity to work with a consultant who is well known in his or her field.

Working in a district general hospital is a friendlier and generally more relaxed experience. It has an added advantage: if there is a vacancy for a post, you may find it easier to get short listed (and eventually selected) if the consultant you are working for is willing to give you a good reference.

For how long Many consultants will be reluctant to give you a reference if you have worked with his or her team for less than five or six weeks. So ideally, each of your attachments should be at least six weeks long.

When to do an attachment There is no hard and fast rule on when to do an attachment. You can do them after your PLAB test part 2 or you can do one before the test and the rest after. Doing an attachment before sitting the test will put you in a better position to understand how medicine is practised in the United Kingdom, which is so important for the part 2 objective structure clinical exams.

Research or audit and presentations

To get short listed, participating in these activities is increasingly important. Most teaching hospitals and some district general hospitals have audit or research projects going on all the time, so it is easier to join in a project that's already up and running. Although the consultants are in charge overall, it's usually the registrars who actively run them. Let them know that you are keen and available for such an opportunity.

Author: Mohammad Shaiyan Rahman

If you are not doing an attachment, you could try to get on to the audit or research ladder via a different pathway. You can ask an academic consultant if you can help with any research project that they may be concerned with. If you are not registered with the General Medical Council your scope for clinical research may be limited, but its something worth trying.

Looking for jobs after passing the PLAB test part 2

Most of the jobs in the United Kingdom start on the first Wednesday in February and August. The jobs are usually advertised four to five months before the rotation starts. So if you want to start in any of those posts, you need to make sure your PLAB test is at least four months before those dates.

If you are a new senior house officer (SHO) in your own country you may have to start at preregistration house officer (PRHO) level in the United Kingdom. PRHO posts are reserved for local graduates and are allocated well in advance. Some graduates may drop out at the last minute, and these places become available to graduates from other medical schools and overseas doctors. Teaching hospitals have PRHO administrators who deal with these posts. Build a good rapport with these people—they may be willing to direct you to a vacant post and talk to the relevant human resources person on your behalf.

Each deanery also has human resources staff. Even though they are not actively concerned with recruiting, they generally have a list of positions that are vacant for PRHOs. Telephoning the different deaneries is another option that you may want to explore. A list of deaneries and contact addresses can be found at www.nosa.org.uk/contacts/deaneries.htm

If you are interested in a particular specialty in a particular hospital it might be worthwhile telephoning the hospital and asking them about it in advance. You may even be able to arrange a meeting with the consultant in charge of the department, which may give you an edge if and when the post does become vacant.

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P+ *Go to webextra at bmjcareers.com/careerfocus for further reading*

ADVICE

PLAB: myth and reality

Before coming to the United Kingdom, many overseas doctors are led to believe that passing the PLAB and then finding a job in the country is hassle free. Rais Irfan Ahmed *sets the record straight*

It is the information age, so it is strange that there are many myths around the Professional and Linguistic Assessments Board (PLAB) exam. Often doctors attempting to sit the PLAB have a misinformed idea of the risk:benefit ratio. This article demystifies the PLAB in order to give overseas doctors a better idea of what they are getting into.

PLAB examination

The PLAB test has been devised to assess the eligibility and suitability of a doctor to work in the NHS in the United Kingdom. It has three components to assess three different aspects of proficiency, and many competent doctors sometimes have trouble with it.

Be ready for any upsets even after passing the international English language testing system (IELTS) and PLAB part 1, as PLAB part 2 is a particularly tricky examination, combining clinical and communication skills in an NHS cultural setting.

There are two very important miscalculations in the time and cost incurred.

Time

Starting with IELTS, PLAB part 1, and the objective structured clinical examination (OSCE) component, it is not only your preparation that matters, the availability of a test place is also important. Doctors who pass all the three components at the first attempt take more than a year to pass. But if you have to take any of the components again, it adds roughly another six months to the time frame. Therefore you should have a clear idea of the time frame of PLAB to avoid later frustration in personal, family, and professional affairs.

Cost

In addition to the fee for the IELTS and the PLAB exams there are many other costs involved. Doctors have to come to the United Kingdom to sit PLAB part 2 and then fund themselves while they are looking for a job after they pass it.

Author: Rais Irfan Ahmed

The box shows a list of the rough costs involved.

After PLAB

After passing the PLAB exam, there can be a delay of many months before finding a job. This is a really taxing time for your patience and resources. Finding your first job is an arduous task. Here are some things that might help.

Organise your CV

The CV is your introduction in your absence and it is considered a very important document in the United Kingdom. You should have a well organised CV, avoiding typical Eastern humility.

Clinical attachment

You need some NHS experience and UK references in the form of a clinical attachment before starting a job. This is an unpaid post, and you have to be able to afford your food and accommodation expenses.

It is better to do two different clinical attachments in the specialty of your choice or any general specialty, to obtain two references. You should try to get as much experience as you can from clinical attachments, including clinical and audit work.

As there is no spontaneous way of getting a clinical attachment, it sometimes proves elusive. So it is better to mobilise your professional contacts in the United Kingdom to arrange it for you before you come over. You may try yourself by locating addresses and phone numbers of consultants through a popular website (www.specialistinfo.com).

Finding a job

This is the most crucial phase for doctors after PLAB and potentially can precipitate some latent depression .There are many jobs on offer (as you will see if you glance though *BMJ Careers*), but you must have a reasonable idea of the job prospects and level of competition. With the recent expansion of the European Union, the competition is likely to be intensified for non-European doctors.

Generally there are hundreds of applications for each post advertised. Therefore, depending on your qualification and experience, you may have to wait for many months before being successful.

Long term considerations

Taking PLAB is not an episode, it is beginning of an epoch. Therefore you should have a clear idea of the long term implications. The most important factor is your professional and personal goal in life. A realistic analysis of long term opportunities and risks will help you to make wise decisions.

Costs involved

- IELTS fee: £75
- PLAB part 1 fee: £145
- Visa fee. Remember that you are being granted a visitor visa to take PLAB part 2 and you are not allowed to do any work to make both ends meet before finding a job and getting your visa changed to a permit- free visa
- PLAB part 2 fee: £435
- PLAB part 2 preparatory course could be costly, but even the cheapest starts from £100 upfront and some later liabilities
- Shopping for an overseas trip as per need, from £200
- Travelling to United Kingdom including airfare, up to £500
- Accommodation in United Kingdom, calculated as single accommodation, at least £50 a week
- Food expenses are variable, but no less than £25 a week
- Keeping in touch with family
- Travelling in United Kingdom is very costly
- Arranging clinical attachment includes internet browsing at £1 an hour and making phone calls and sometimes personally approaching the NHS trust or consultant. Sometimes you land up in a hospital where you have to pay for doing a clinical attachment at about £200 a month
- Job applications involve downloading vacancy information, making phone calls for job applications, photocopying, and sending by Royal Mail
- Registration fee with the General Medical Council: £496. You will be granted limited registration to work in a supervised post for one year. On satisfactorily completion of one year you will get full registration
- Permit-free visa fee: £255

Professional

Most of the doctors taking the PLAB have a professional objective of becoming a consultant in the United Kingdom in a specialty of their choice. Passing PLAB does not guarantee becoming a consultant.

Career development is not smooth for overseas doctors as there are many bottlenecks. Scarcity of higher specialist training posts is the main one. There are reasonable opportunities for basic specialist training but there is a very limited number of specialist registrar posts in most of the specialties. Therefore many doctors end up in non-training posts after completing their basic specialist training or opt to go going back to their home country later in their career.

Personal and family considerations

Sometimes leaving your home and loved ones and plunging into a competitive society

is stressful. Often nostalgia sets in, and ordinary things back home start to look very attractive.

Although there are large overseas communities in almost every city in the United Kingdom, and although the United Kingdom has developed a pluralistic society and everybody is free to live in his or her own way, some feel that they have to compromise their values and norms in social and personal settings. This apparently benign issue can lead to much anguish later. Therefore you should be flexible enough to accept new ideas and practices.

Silver linings

Demand

The NHS is likely to increase its healthcare vacancies and this trend is predictable in foreseeable future. The European Working Time Directive is coming into effect from August this year, and it's generally thought that it will decrease the work load on healthcare personnel and increase job vacancies.

Registration

Initially overseas doctors were granted limited registration only, before being granted full registration after a probation of one to two years. Now the General Medical Council plans to introduce a uniform system of registration for both overseas and indigenous doctors sometime early next year. This will hopefully remove an obstacle in the near future.

Vocational training schemes

General practice is the cornerstone of primary healthcare services in the United Kingdom. There is a three year formal training programme to become a general practitioner (comparable to consultant in monetary and status terms). Therefore many doctors opt for the general practitioner route through vocational training schemes (VTS). In the past it was very difficult if not impossible for overseas doctors to enter into VTS after PLAB. But recently the NHS has been encouraging overseas doctors to join VTS to overcome a shortage of general practitioners. Therefore it is an alternate opportunity for overseas doctors.

Highly skilled migrant programme

In the past doctors were granted only a four year permit-free visa and then they had to leave, but things are changing now. The British government is inviting highly skilled migrants and offering them full citizen status. Overseas doctors can qualify for this scheme after getting a job. It's highly attractive for many overseas doctors to settle in the United Kingdom permanently, to avoid later complications of repatriation and cultural trauma.

Conclusion

Why do you want to take the PLAB? You should consider all the risks and costs in order to make an informed decision.

Rais Irfan Ahmed *doctor on clinical attachment*
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ADVICE

Adapting to British culture

Ramesh Mehta *and* Raj Kathane
give some advice

Moving to the United Kingdom can be stressful, especially if you are from a developing country. It is even worse if you are to sit an exam soon after your arrival. Following are a few common cultural problems faced by the newly arrived overseas doctors and some ideas of how to get over them.

Overcoming hesitancy and feeling confident

Arriving in a completely new culture can seem like being thrown in at the deep end. Believing in yourself and feeling confident is the basis of survival. You must remember that your decision to come to the United Kingdom means that you are an achiever. Some doctors begin to feel inferior for various reasons, including their colour, language, and manners. This often dents their confidence, and they become hesitant and subdued. You should try to avoid this trap. It is important to be seen as confident and articulate, but don't overdo it as this may be perceived as being rude.

Good communication is the key

Your confidence is related to your ability to communicate effectively with colleagues and patients.

Accent

Many overseas doctors are worried about their accent. In reality, what matters is whether you can be understood easily. In any country and in every language accents vary. Try to speak clearly. Your voice should be firm enough to be heard easily.

Eye contact

In many cultures looking directly at the person's eyes while speaking is considered disrespectful. However in British culture having shifty eyes or not looking at the person you are speaking to is taken to show that you have something to hide or you are not speaking the truth. Try to develop the habit of making steady eye contact during—but don't stare at them.

Shaking your head

Moving your head constantlywhen a senior is talking to you is a norm and sign of respect in some cultures. However, in British culture people are expected to treat others, whether seniors or juniors, as equals. Moving your head frequently during a conversation could be a distraction. It is important to listen to the person carefully and express your views honestly rather than agreeing to everything that has been said.

Addressing people as "Sir" or "Madam"

It is customary in many countries to address the seniors as "Sir." In the United Kingdom the common practice is to address others by their names. For example, you can call your consultant, "Dr Smith" and your registrar by their first name.

> Respectful treatment of others is a basic value in all cultures

In some cultures it is taken as an offence if you do not stand up every time your senior stands up. Once again, in the United Kingdom it will be seen as a nuisance rather than as a sign of respect.

Please and thank you

Instead, you show your respect to others by being polite and using words such as "please" and "thank you." In British culture it is expected that you always say please when you ask for anything and say thank you when the work is done.

Controlling your temper

It is important to be able to control your temper. In some countries you need to shout or raise your voice to get work done. However, in the United Kingdom this comes across as quite offensive, and the result may be unwelcome. Instead, discuss any problems politely. You will win a lot of friends if you can be "diplomatic."

Doctors as "gods"

Respectful treatment of others is a basic value in all cultures. This is particularly important when you speak with patients. The GMC document, *The Duties of a Doctor*, clearly mentions "Respect patients' dignity and privacy." In some countries doctors are treated as "gods" and they get into the habit of being rude to patients and nursing staff. Do this at your peril.

Cultivate the art of listening

This is important in any culture. You will be able to avoid a lot of complaints and difficulties if you listen patiently and sympathetically.

Sense of humour

Try to mix with the local population. Going to a pub for a drink is normal in British culture. Once you get friendly with some local people you will feel accepted therefore more relaxed and happier. You may even start to enjoy yourself.

And finally ...

Most people you will come across are good natured and friendly. A little effort on your side to understand and respect the culture of the host country will make you confident and happy.

Ramesh Mehta *consultant paediatrician*
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Raj Kathane *consultant child psychiatrist*
British Association of Physicians of Indian Origin (www.bapio.com)

BITE BACK

Summary of responses

The recent article by Sharon Alcock on the difficulties of overseas doctors coming to the United Kingdom for part 2 of the professional and linguistic assessments board (PLAB) examination, in the hope of finding a position in the NHS afterwards, has predictably resulted in a huge number of responses—well in excess of 50.[1] Judging by the names, most of these were from South Asian doctors; one correspondent was of African origin. The many, strangely similar, stories of their awful plight do not make for comfortable reading, although some even try to put a positive spin on their experiences and seem all too willing to take responsibility for their problems.

What is staggering throughout is the vast number of applications that correspondents report having to submit, mostly to no avail whatsoever, which is clearly a big cost issue in terms of their money and time.

It also causes major frustration, as applicants have found that capping of numbers and random picking of candidates influence the selection process.

The advice given in the many examples and career histories ranges from applying to every single hospital and for any job going to targeting the application very carefully, which further highlights the confusion that characterises overseas doctors' predicament.

Personal histories

The space is not sufficient to go into details of all the individual stories, but what is striking is the similarities they share.

Most correspondents submitted an astute analysis of the reasons for the hopeless situation and share out responsibility for what has caused this. Some are clearly disillusioned and put the blame on the involved institutions' drive to increase their profits continually. Some examine the reasons why overseas doctors might come to the United Kingdom in the first place; and some call for improved communication worldwide about what type of doctor is so desperately needed in the NHS, so that people do not travel here with false hopes and expectations.

As one correspondent, Raman Sharma, a South Asian, British born and trained junior doctor from Burnley says: "I was shocked to see the pounding these experienced doctors received from the NHS." Whereas another British trained doctor returning from Australia shares his own experiences, namely that doctors who have trained in the United Kingdom and are returning to work here, are faced with similar problems of finding positions.

Profiteering or misinformation?

A considerable number of correspondents list the bodies and institutions that they suspect of using the PLAB system and the overseas doctors for the purpose of increasing their business profits. Mostly the General Medical Council, but also the British government, the Home Office and immigration authorities, the Department of Health, hospital trusts, postal services (which profit from the hundreds of applications that individual doctors report sending), and deaneries all come in for strong criticism.

Dr Umesh Prabhu "There is an acute shortage of trained doctors in the UK but there is no shortage of doctors who want to be trained."

Role of the media?

Several also mention the part the media play in possibly conveying entirely the wrong impression to people on the Indian subcontinent about life and work in the United Kingdom, and some explicitly challenge their fellow country people to be more suspicious and gain greater awareness of the real situation before embarking—with no definite place to go—on an indefinite journey into a different work and life culture, which entails huge financial sacrifices and risks.

One, presumably unemployed, doctor, Samir Kulkani, actually says: "Although one other website tried to give us an advance warning about the job situation in UK [sic], I and my friends refused to believe what is presumably the harsh reality now." Disgruntlement and frustration also became obvious in the repeated question why overseas doctors were thought qualified enough to work in trust grade positions or other non-standard jobs but not to be appointed to a training position.

Racism or preference for British or European trained staff?

Numerous correspondents expressed concerns at what seems like an obvious preference for doctors from the United Kingdom or Europe, in the latter case even if their linguistic proficiency and clinical skills may leave much to be desired.

In this extremely competitive environment, one correspondent detected a slight preference for women doctors and others concluded that racism within the NHS hindered their chances—a clear issue of equal opportunities, as one correspondent finds. Raja Sejhar Gajula, "a doctor," in a sharp and witty response, categorises candidates from A to G, lists their characteristics, and concludes on the basis of these characteristics who gets the jobs. Several correspondents warn of the immense brain drain that the PLAB system constitutes for developing countries.

Whose responsibility?

Some correspondents are, perhaps surprisingly, quite critical of their fellow overseas doctors, who are admonished to realise that they are responsible for their condition and to stop blaming others. The issue of loyalty to their own countries, at whose taxpayers' expense the overseas doctors trained, is mentioned, and the assumption is made that the real incentive for their coming to the United Kingdom is financial gain through high salaries—not the much proclaimed pursuit of academic excellence. The fact that the GMC mentions in its literature that it is not responsible for helping doctors to find jobs is also brought up. Are some doctors just more realistic than others, or does fear of alienating their host country play a part in this?

Possible solutions?

Although many of the correspondents criticise the GMC, a consensus seems to emerge that the GMC is not the only body to carry responsibility for the sad state of affairs. Among the solutions proffered are the following.

- The GMC needs to make it absolutely clear that it is senior doctors who are needed, not junior ones.
- PLAB 1 should not run every week, or maybe not at all for some time.
- The GMC should allow doctors to register as soon as they have passed their PLAB, regardless of whether or not they have a job, as this would help them with housing problems.
- The GMC should not run so many exams as it knows it hasn't got a job for every doctor who passes them. This gives them false hope.
- Recruitment should be centralised and all applications go to the same body.
- Career counselling and practical help and advice should be given to those who have passed PLAB part 2.
- The limited numbers of doctors needed should be publicised widely, so that overseas doctors know what they are letting themselves in for.

To conclude with Umesh Prabhu, consultant paediatrician in the United Kingdom: "There is an acute shortage of trained doctors in UK [sic] but there is no shortage of doctors who want to be trained." This message needs to be communicated very clearly to overseas doctors, to enable them to make an informed choice. ■

Birte Twisselmann *technical editor, BMJ*

1 Alcock S. Misinformation, poverty, and overseas doctors. *BMJ Careers* 2004;328:219 (29 May). http://careerfocus.bmjjournals.com/cgi/content/full/328/7451/219