MEDICAL PRACTICE

Contemporary Themes

Overseas doctors: coming to Britain

RICHARD SMITH

Without doctors who qualified overseas the National Health Service would not have been able to grow as fast as it has done nor would it be able to do the work it does today. In 1978 there were about 66 000 doctors working in the NHS and of those about 18 000—about one-third of hospital doctors and one-fifth of general practitioners—had qualified overseas.^{1 2} Ever since the 1950s they have been coming to Britain in large numbers, as many British doctors were emigrating and British universities could not produce medical graduates quickly enough for the rapidly expanding NHS.

The relationship between the NHS and overseas doctors was tacitly assumed to be one of mutual benefit: overseas doctors did essential work and in return received a good training. No comprehensive study of overseas doctors in Britain was made, however, until 1977. The results of that study—carried out by David Smith for the Policy Studies Institute—were reported last year,² and they will be discussed at a conference in London this week. That study, looming medical unemployment, and the worries of overseas doctors who want to remain in Britain and yet who do not have career posts have thrust overseas doctors' problems to the fore. There are two main problems, and they are quite different. Firstly, how can Britain contribute in the future to the training of overseas doctors? Secondly, what will happen to the overseas doctors who want to stay in Britain and yet who do not have career posts?

An emotional debate on these questions is already beginning in the medical press, while the Commons Social Services Committee, the General Medical Council, and the British Medical Association are all looking at various aspects of the problem. Furthermore, the Central Manpower Committee, which has since 1972 advised the Health Departments on staffing in the hospital grades, has to take into account the impact of overseas doctors on NHS manpower planning. These three articles aim at supplying information for the debate and discussing suggested proposals for change. One thing that emerges from studying overseas doctors' problems is that they

are in many ways the problems of the whole profession. As a vulnerable group, they have always experienced the worst aspects of manpower, training, and career problems. But their problems today are likely to be those of other groups—particularly women doctors—tomorrow.

Where do overseas doctors come from and why do they come?

Doctors may be described as overseas doctors either because they were born overseas or because they qualified overseas. The two categories are almost but not quite the same: Smith's study of nearly 2000 doctors showed that 6% of them were born outside the British Isles yet qualified in either Britain or Eire. This study, which was carried out from September 1977 to February 1978, provides the best available figures on where overseas doctors were born and where they graduated. About two-thirds were from the Indian subcontinent, a tenth from white anglophone countries, and a tenth from Arabic countries or Iran. (Because the study was cross-sectional and not longitudinal the results are biased towards those doctors who stay longer in Britain, and there is a considerable turnover of overseas doctors each year—the Royal Commission on the NHS estimated that about 3500 to 4000 enter each year and about 3000 leave.)

About 85% of the overseas doctors in the study said that they came to Britain primarily to further their medical training or career; only 7% came intending to stay permanently. Nevertheless, many of the doctors stayed much longer than they expected: only 18% of those who came before 1959 actually intended to stay permanently, and, of those who came in 1960-4, 69% intended to stay for five years or less. Perhaps these doctors were fooling themselves about their original intentions or perhaps they were fooling the interviewers, but most gave reasons why they had stayed longer. Some (16%) could not return for political reasons; 37% stayed because they had not attained their original career aims; 35% said they had marriage or family reasons for staying; and 26% said they were attracted to medical life in Britain.

In spite of increasing difficulty in finding jobs in Britain the number of overseas doctors wanting to come to Britain is increasing. Every year since it was introduced in June 1975 the Professional and Linguistic Assessment Board test (PLAB) has been taken by an increasing number of candidates. There were 2420 candidates in 1979 and about 3300 in 1980.

What information do overseas doctors get before they come to Britain?

Just over a third of overseas doctors come to Britain on schemes sponsored by the British Council, the Association of Commonwealth Universities, or the World Health Organisation. These doctors are presumably well informed, and they come at least initially for arranged courses or jobs. For unsponsored doctors there are several sources of information. One of the most important is friends and contacts already in this country. Also the British Medical Association, the Overseas Doctors Association, and the Royal Colleges receive many requests for information, but the official source of information is the National Advice Centre (NAC), an offshoot of the Councils for Postgraduate Medical Education. There is no statutory requirement for any doctor intending to come to Britain to contact the NAC, but any doctor making inquiries at British embassies or consulates is likely to be directed to the Centre. Last year it received inquiries from about 5000 doctors, yet in Smith's study only 32% of those overseas doctors who came after 1970 had contacted any official body in Britain, and only 2% had contacted the NAC.

On first receiving a query from abroad the NAC sends out general information on the requirements that overseas doctors have to fulfill to be registered and on postgraduate opportunities in Britain. But the information is bureaucratic, bland, and lacking in realism; the print is small; and the language dull. Nothing is said about the high failure rate of PLAB, the difficulties of getting good jobs, or the general problems of living in Britain. Often, however, the NAC will enter into correspondence with the overseas doctor, and then it may give more hard-headed advice.

The Royal Commission on the NHS recognised this information failure and called on the Government "to make clear to doctors who want to come here what their prospects are." The number of doctors receiving information needs to be increased and the quality of that information needs to be improved; and this should not be difficult.

The rules for overseas doctors

Immigration rules are complex, but in practice doctors and dentists are two of the very few groups who may arrive in Britain and without prior arrangement stay and work. The overseas doctor has to obtain some form of registration with the GMC, but he does not have to obtain a work permit.

The legislation governing registration of overseas medical graduates has recently been changed. The changes had been suggested by the Committee of Inquiry into the Regulation of the Medical Profession (the Morrison Commission)³ and were enacted in the Medical Act of 1978.⁴ There are now three categories of registration: full, provisional, and limited. An overseas graduate is eligible for full registration if he holds a "recognised overseas qualification," has "the experience required" and "the necessary knowledge of English," and is "of good character." In practice, the GMC recognises for full registration the qualifications granted by certain medical schools in Australia, New Zealand, Hong Kong, Malaysia, Singapore, South Africa, and the West Indies. The graduates of these medical schools are automatically exempted from a formal English test (except for those from non-English speaking South African schools, but they are usually exempted); they are also eligible for provisional registration.

Under the EEC directives EEC nationals who are graduates of

medical schools in EEC countries are eligible for full registration. Until recently EEC doctors had to take an English test, but the Government has now accepted that this is forbidden by the Treaty of Rome. Employing authorities are now advised by the Government to satisfy themselves that job candidates have sufficient command of English. Many authorities may require EEC graduates to pass the English language part of PLAB.

The Overseas Doctors Association is upset that non-English speaking EEC doctors should not have to pass an English exam to register. It is also upset that—even if they have full registration in Britain—overseas qualified doctors will not be allowed automatically to practise in EEC countries. Both of these objections are more symbolic than practical. Although EEC doctors will be able to register without taking a formal English test, those few who want to practise in Britain (449 have registered since 1977) will probably not be able to get a job in the NHS (nor in the English-speaking private sector, presumably) unless they have a good command of colloquial English. This means that the end result in terms of employment will be the same for EEC doctors and other overseas doctors. Also there must be few overseas doctors who want to practise in EEC countries.

The 1978 Medical Act created a new kind of registration—limited registration. This is available to an overseas medical graduate who holds (or is eligible for) a qualification recognised by the GMC for this purpose, who is of good character, who has done at least 12 months internship or its equivalent, and who has either passed or been exempted from PLAB. The 1978 Act says that limited registration cannot last for more than five years and allows the doctor to do only particular supervised jobs, but he may apply later to become fully registered. A final category of registration is that available for one year to visiting overseas specialists.

PLAB and objections to PLAB

PLAB consists of written examinations of medicine and the English language and an oral exam. A preliminary part of the exam may be taken abroad if a country can guarantee a certain number of candidates; the rest then has to be taken in London, Edinburgh, or Glasgow. Exams are held every month (except in August) and candidates must pay £130. During the last year there has been a wait of one to five months to take the exam: those who fail marginally may take it again after two months, but those who fail severely must wait six months. Since the beginning of this year candidates are not allowed to take the exam more than three times. Only about 40% pass.

Overseas doctors who are sponsored by the British Council, the Association of Commonwealth Universities, or the World Health Organisation are normally exempted from PLAB. Also exempted are those who before they come are appointed to registrar posts or above and most of those who are doubly sponsored by an overseas university or organisation and a British employing authority. In 1979 of the 1399 doctors granted limited registration for the first time 643 (46%) had been exempted from the PLAB test.

It has been suggested that sponsored overseas doctors should not be exempted from PLAB. The argument is that otherwise some doctors whose English is not good enough or whose standard of competence is unacceptable may slip through the net. The sponsoring organisations are confident, however, that incomprehending and incompetent doctors are not released on to the public through their schemes: all sponsored doctors have their English and their competence assessed in an informal way, and they may be given special courses in English. Moreover, if the sponsoring organisation has any doubts about a doctor's competence it will ensure that he has no clinical responsibility. But, on the whole, the sponsored doctors are the most able overseas doctors. The sponsoring organisation oppose the suggestion that all overseas doctors should have to take PLAB because it would mean administrative delays and increased

costs—supporting doctors waiting to take the test. Also they think that many overseas governments and health departments with whom they have friendly relations will feel snubbed that their doctors have to be examined in this way. The sharp increase in fees for overseas students has already meant fewer sponsored overseas graduates, and the sponsoring organisations are worried that ending the PLAB exemption will accelerate the trend away from Britain as centre for postgraduate training.

But the GMC does need to be certain that sponsored doctors are not given clinical responsibility until their English is adequate and they are fully competent. Such evidence does not seem to be available through any formal study, but nor does there seem to be any evidence of incompetence or incomprehension among sponsored doctors.

None of the organisations that represent doctors in Britain, including the Overseas Doctors Association, is opposed to the principle of PLAB. Everybody is convinced that to practise proper medicine in Britain a doctor must have a good command of English and he must be able to show that he is competent. There are, however, objections to some aspects of the test, and some of these have substance.

The first objection is that it should be possible to take the test before coming to Britain. Many overseas doctors waste time waiting to take the test, and others spend long periods trying to pass the exam and then never pass at all; money is wasted on fares and living expenses. It is possible to take overseas the exams necessary to practise in the United States, and overseas doctors wonder why the British authorities cannot hold PLAB abroad. The Board, however, thinks that the administrative problems make this formidably difficult. PLAB has an oral component, which the American exams do not, and this means that examiners would have to be flown abroad. Also, many countries—for instance, India—do not allow such exams in their countries. Nevertheless, the difficulties do not seem insuperable.

The test would have to be financially self-supporting and might therefore be expensive, but it would still be cheaper for most overseas doctors than a flight to Britain and several days in a hotel. Also, many recently retired British doctors might welcome a few days in Singapore or Cairo examining PLAB candidates so it should not be impossible to find examiners.

A second objection to PLAB is that the waiting list is too long. At the moment more and more overseas doctors want to take the test. The waiting list will shorten only if there are fewer candidates, if more candidates can take the test at one time, or if there are more tests. The Board hopes to shorten the waiting list, and perhaps it thinks that sooner or later the number of candidates will fall and that the present capacity will then be sufficient.

A third objection to PLAB is that the English test demands too much knowledge of colloquial English: candidates are asked to explain terms like “full of beans,” “in the club,” and “can’t get it up.” Nevertheless, the argument against the inclusion of colloquial English is hard to sustain: patients do not speak like the actors on Linguaphone records and must be understood when using their own vernacular.

These are some of the problems that overseas doctors face before they start to practise in Britain. The next article will discuss the problems they have when working in Britain, and a third article will consider proposals for change.

References

- 1 Royal Commission on the National Health Service. *Report*. London: HMSO, 1979. (Cmnd 7615.)
- 2 Smith DJ. *Overseas doctors in the National Health Service*. London: Heinemann, for the Policy Studies Institute, 1980.
- 3 Committee of Inquiry into the Regulation of the Medical Profession. *Report*. London: HMSO, 1975. (Cmnd 6018.)
- 4 *The Medical Act 1978*. London: HMSO, 1979.

What is the best method of sterilising and maintaining sterility of hair-brushes and combs?

Pediculosis capitis and tinea capitis are the only infections spread by combs and hairbrushes. In a household infection will not be prevented by sterilising the family's combs and brushes because direct physical contact between members of the family will provide adequate opportunities for cross-infection. Infection is more likely to occur in hairdressing salons as there is no satisfactory method of sterilising combs and brushes. Although many hairdressers place them in ultraviolet light cabinets for minutes or even hours, there is no certainty that all fungal spores and ova are killed. Others place combs and nylon brushes in Dettol (chlorinated phenol) solution, which should be effective if left for at least half-an-hour, but because brushes made with natural bristles or those with bristles embedded in rubber would be ruined by regular soaking in Dettol this method cannot always be used. Fortunately, the hazard of infection by this route is low. The organism that was readily spread at the hairdressers—*Microsporum audouinii*—disappeared from Britain in the 1940s.

What advice would you give to a middle-aged patient with an eight-year history of unilateral tinnitus, high frequency hearing loss, and a long history of allergic rhinitis?

A detailed history must be obtained with special reference to the onset of the symptoms, whether gradual or sudden, if there is any fluctuation, the tinnitus preceded the deafness, there was any vertigo at any time, and has the patient been exposed to any noise trauma, such as shooting. A viral infection may cause unilateral tinnitus and hearing loss, but there is often a history of vertigo and the onset is acute. A middle-ear infection, particularly a chronic otitis media, may lead to these symptoms, and examination of the tympanic membranes may find signs of previous infection, such as a scarred drum, or there may be active infection present. The most important condition to exclude

is an acoustic neuroma, and a full examination of the central nervous system together with radiograph of the internal auditory canals, complex audiological tests, and tests of labyrinthine function must be performed. Any patient with this history will need examination by an otologist. Endolymphatic hydrops, or Menière's disease, will cause tinnitus and a high frequency hearing loss in the later stages, but there will be a history of attacks of episodic vertigo over the years. Allergic rhinitis is common and may be a factor in producing secretory otitis media in some patients, usually children. It does not cause sensorineural deafness.

Can you provide any information on the drug 13-cis retinoic acid in treating acne?

13-cis retinoic acid is indeed a potentially most interesting drug for managing acne, but not the wonder cure for all cases. So far it has been tried out only in a few centres in the United States, in Munich, and in Britain the dermatology department at Leeds is the only centre where the drug is available for clinical trial. Roche Products hope that it may become available to some other centres (strictly for clinical trials) later this year and perhaps subsequently on a named patient basis. The early reports^{1,2} leave no real doubt about the drug's efficacy in reducing acne and also in reducing excretion of sebum. These good effects may long outlast the duration of the treatment. Minor side effects are common, and serious side effects, notably teratogenicity, are still being evaluated. When it has become available it may therefore be a useful drug for managing severe cases. Another retinoid (Tigason) seems to have much less effect on sebum excretion, but perhaps still has some effect on severe acne.³ Even more promising retinoids may emerge.

- 1 Peck GL, Olsen TG, Yoder FW, et al. Prolonged remissions of cystic and conglobate acne with 13-cis retinoic acid. *N Engl J Med* 1979;300:329-33.
- 2 Jones H, Blanc D, Cunliffe WJ. 13-cis retinoic acid and acne. *Lancet* 1980;iii:1048-9.
- 3 MacKie RM, Dick DC. Synthetic retinoids for acne. *Lancet* 1980;iii:1300-1.