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 9,000 overseas qualified doctors were registered for the first time with the General Medical Council in 2003. Most of those 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." 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. 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 competence and performance.

Unstructured
Although good practice guidelines exist, 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.

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—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 were skilled and competent role in it, and who were educated in 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, amnioncensis. 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.

**CLINICAL ATTACHMENT**

A positive experience of a clinical attachment

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.

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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.

Transferrable 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 specified 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.

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, men 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
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.

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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.

**Turab Syed**
specialist registrar in orthopaedics
Milton Keynes General NHS Trust

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.
is stressful. Often nostalgia sets in, and ordi-
nary things back home start to look very
attractive.
Although there are large overseas com-
munities in almost every city in the United
Kingdom, and although the United King-
dom 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 set-
tings. 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 vac-
cancies 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 health-
care personnel and increase job vacancies.

Registration
Initially overseas doctors were granted lim-
ited 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 reg-
istration for both overseas and indigenous
doctors sometime early next year. This will
hopefully remove an obstacle in the near
future.

Vocational trainingschemes
General practice is the cornerstone of pri-
mary healthcare services in the United King-
dom. There is a three year formal training
programme to become a general practi-
tioner (comparable to consultant in mon-
etary 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 impos-
ible 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 practition-
ers. 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 Brit-
ish government is inviting highly skilled
migrants and offering them full citizen status.
Overseas doctors can qualify for this scheme
after getting a job. It is highly attractive for
many overseas doctors to settle in the United
Kingdom permanently, to avoid later com-
plaints of repatriation and cultural traumas.

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

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ADVISE

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 over-
seas 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 vari-
ous reasons, including their colour, lan-
guage, 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 per-
song's eyes while speaking is considered disre-
spectful. 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 constantly when 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 hon-
estly 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
dtheir 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 King-
dom it will be seen as a nuisance rather than
as a sign of respect.

Please and thank you
Instead, you show your respect to odiers 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. How-
ever, 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,
dearly 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 difficult
ties 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.

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BITEBACK

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. 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 dearly 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 business profits. Mostly the General Medical Council, but also die 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 question 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, Sarir 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.” Disgrunement 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 ajob, 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 Prabhoo, 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.

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