Should postgraduate training places be reserved for UK graduates?

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YES

For decades the United Kingdom has recruited overseas doctors to supplement its workforce. In more recent times, the number of doctors needed has increased as a result of an ageing population, labour intensive new technologies, and shortening of working hours. Recognising these factors, the UK greatly increased medical student places. In a few years there will be many thousands of additional medical graduates annually, and for the first time the UK will be able to meet its medical workforce needs largely through its own graduates. This large increase in medical student numbers creates an increased need for foundation programme places for new graduates and eventually for training places in the specialties if new graduates are to be effectively employed in the workforce.

Most medical disciplines require many years of postgraduate training for full certification, and graduation from medical school is at about the halfway point of a young doctor's training path. Little can be done with a medical degree without completion of both the requirements for GMC registration and a period of post-registration training leading to full registration as a family doctor or specialist. Medical student training times are longer than for most other university courses, requiring five or six years of undergraduate training or a basic degree followed by a four year graduate entry course. Young people invest a great deal of time and hard work in completing their primary degree. The financial costs to the individual and to society are considerable.

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Some other professional degrees—notably a law degree—provide useful skills for work outside the primary discipline, but this is less so with medicine, where the integrated training is useful only in medical practice or research and to a limited extent in industry. A strong case can be made that society has a moral obligation to ensure that young people who successfully complete a demanding primary medical course have the opportunity to complete their training and enter medical practice.

The European Union treaty requires a free flow of medical professionals across the continent and increasing numbers of non-UK graduates are now applying for both foundation training and further postgraduate training. Many hundreds of non-UK graduates applied for a foundation training place in 2007-8, and this number is likely to increase. The increasing number of UK graduates in the next few years make it likely that most foundation positions will be required for UK graduates to meet the requirements of GMC registration. Language barriers limit the ability of many UK graduates to obtain adequate early postgraduate training in non-English speaking countries. This situation may improve if language skills in general increase, but a lot of work is needed in this area.

There are clear advantages for doctors in early postgraduate training being supported by the health system they have started to gain some familiarity with as students. The more a student is in need of special mentorship and support, the more relevant a period of further training in the UK may be to assisting them gain the expertise for independent practice.

International exchange

We live in a global world, and free exchange of expertise is clearly desirable. This and a need for global movement later in medical training needs to be balanced against the likelihood that the training needs of UK graduates will place increasing demands on local training positions as the increase in graduate numbers filters through into family medicine and specialist training programmes. One possible solution would be to encourage a period of work in other countries towards the end of specialty or family medicine training and to encourage the development of bilateral exchange programmes. Creative programmes should be developed with postgraduate deanery, trust, and, where appropriate, university support to ensure that international training opportunities continue to be available both for UK graduates and international graduates, but such programmes should be aligned in scale with overall capacity at each stage of postgraduate training.

Fully trained family doctors and medical specialists are capable, language skills allowing, of working anywhere in the European Union or indeed internationally. Full mobility should be encouraged at the end of specialist training. If in future the UK has a transient excess of fully trained young doctors, they will be able to make a considerable input to health in other countries. If, instead, substantial numbers of medical graduates are not able to complete their training it would be a considerable waste of both personal and national investment.

Medical training in the UK is among the best in the world at both an undergraduate and postgraduate level. It is appropriate that a country with the wealth and stature of the United Kingdom cover its medical workforce needs without drawing doctors from less well advantaged countries in Europe or elsewhere. If the UK can contribute a relatively small number of fully trained medical doctors to work in other countries that would be a useful contribution to international health. A failure to provide training opportunities for the great majority of UK graduates and enable them to enter practice would represent a waste of human potential and a failure of care for young doctors.

Competing interests: EB completed his undergraduate training in Australia and benefited enormously from the opportunity to do further training in the NHS a quarter of a century ago.

After many young doctors failed to get NHS jobs this summer, **Edward Byrne** argues that training posts should go to UK graduates. But **Edwin Borman** believes restricting access would damage the profession

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NO Rumblings of revolution can be heard within the medical profession. What with relentless reforms to the health service, threats to our professionalism, the chaos of the medical training application service (MTAS), and a very real risk of doctors being unemployed, the forces of "blame someone," "get rid of all of them," and "I want the best for me and my own" have been let loose.

But that does not justify shutting the door on our colleagues who have come from abroad to work and train beside us in the United Kingdom. Just the opposite; when we prepare to "staff" the barricades, it is worth remembering that "United we stand, divided we fall."

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For most of the lifespan of the NHS, the UK has had an implicit policy to rely on international medical graduates to "top-up" the number of UK graduates. Such a system is cheaper (doctors coming from abroad bring their qualifications to the UK for free), it is more amenable to changing needs (recruitment of trained doctors within a year, rather than having to wait for them to graduate), and it provides for a sharing of experience and the development of healthcare links in a world where disease is globalised and medicine needs to be. The current medical workforce figures confirm this: 36% of doctors registered to practise in the NHS qualified abroad.[1]

Freedom of movement

For many years, therefore, the UK has benefited from freely accepting doctors from abroad. Freedom also applies, and always should apply, to the migration of doctors,[2] whether the reason is to escape from tyranny, to get a better life, or to have access to specific training. And it is with freedom that doctors choose, from among many countries, to come to the UK to advance their medical career.

That decision carries responsibilities. A doctor who chooses to migrate to the UK accepts both the risks and the potential benefits; however, in a society based on fairness, it should also provide a right to be treated fairly. That right should encompass detailed and easily obtainable information on career prospects, reasonable notice of changes to immigration rules, and fair access to the posts that they had been told were available.

Populations also have rights: to health and healthcare workers.[3] It is to the UK's credit that it has led the way internationally in recognising that some countries need their own doctors more than the UK does. The NHS's ethical recruitment policy does not allow doctors to be actively recruited from developing countries.[4] But this cannot be used as an excuse to limit the rights of individuals to migrate.

Equal opportunities

The UK, and in particular the NHS, also has an admirable, though not perfect, record in providing equal opportunity, determined only on the basis of eligibility and merit. While politicians seem to be shying away from the word "multiculturalism," all who work in the NHS accept that we do so on an equal basis with colleagues from many faiths, cultures, and countries.[5]

That is not to say that there are no problems; there is ample evidence of unfair discrimination in the NHS, as there is of vigorous efforts to eradicate such unacceptable behaviour.[6] The crucial point is that, perhaps more than in any other aspect of life in the UK, the principle of equality is embedded in our function. The NHS, as the largest single employer in the UK, sets an example for others to follow.

Hence, it is to the credit of the medical profession that during the current crisis—even when jobs for UK graduates might have been safeguarded—all eligible applicants have been treated equally and posts have been allocated according to merit. This shows a level of solidarity that is characteristic of the best of the medical profession.

This sense of fraternity extends more widely than doctors from abroad working in the UK. The NHS also leads the world in encouraging links with practices and hospitals in developing countries. This initiative recently was given a further boost by Lord Crisp,[7] but success and the benefits—that flow in both directions—are dependent on links that almost always are based on personal ties of colleagues who have worked together.

The good name of the medical profession in the UK has already been damaged by the government without notice introducing changes to the immigration rules. It would be a tragedy for the profession itself to sully its reputation by abandoning the principle of solidarity that goes back as far as the Hippocratic oath.

If you are looking for somewhere to allocate blame for the chaos that is MTAS, I suggest that you consider where it was decided that medical staffing no longer needed to be planned for centrally, and that training numbers should be limited to numbers that do not reflect the projected future need for consultants and general practice principals.

Competing interests: Edwin Borman is chairman of the BMA's international committee. He trained in South Africa. The views expressed here are his own.

All references are on bmj.com
see Analysis p 593