ORIGINAL ARTICLE

Clinical attachments: fond farewell or new beginning? A survey of the attitudes and practice of medical consultants and international medical graduates

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Postgrad Med J 2007;**83**:196–199. doi: 10.1136/pgmj.2006.050799

Objectives: To analyse the experience of clinical attachment (CA) of international medical graduates (IMGs) and consultants.
Design: Analysis of questionnaires and CVs.
Setting and participants: 573 IMGs applying for a house officer post and 102 consultant physicians working in North East England.
Results: IMGs had spent a mean of 16 months unemployed, of which 3.8 months was spent on CAs. The median number of CAs was two and the average number of applications sent before obtaining a CA was 73. 90% of IMGs found their CA helpful and 57% would not take up a post without a CA first. Criticisms related to lack of responsibility, isolation and poor job prospects. 90% would apply for honorary posts if advertised. 73% had received induction at the onset of placement, but only 32% had been assessed at the end. 50% of consultants took CAs and only 4% were thinking of stopping doing so. Those without CAs blamed work pressure (43%) and pressure from their employer (23%).
Conclusions: There are deficiencies in pastoral care, the application process and assessment, but CAs are valued by IMGs and offered by half the consultants surveyed. New immigration rules will mean fewer IMGs will come to the UK, but CAs will be needed by those that do, as well by refugees and European Economic Area (EEA) graduates. The tradition of CAs for international graduates could be used to accommodate those coming to the UK on exchanges and scholarships and form part of the recently announced Medical Training Initiative for IMGs.

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Received 24 June 2006
Accepted 11 October 2006

In 1966 the difficulties overseas doctors were having in finding appointments and adapting to practice in the UK led to the introduction of the clinical attachment (CA) scheme.[1] The scheme has continued since, remaining voluntary, mostly unregulated and pro bono.

The British Medical Association (BMA) and the NHS Rose website have outlined the aims of the scheme,[2 3] which are to help international medical graduates (IMGs) understand the role of the doctor and the nature of UK clinical practice, particularly its legal, ethical and cultural aspects. The scheme also gives consultants the opportunity to judge IMGs' skills and competencies in the workplace. The recent increase in IMGs passing the Professional and Linguistic Assessments Board (PLAB) examination and the increased training needs of junior doctors and medical students made us question whether the CA scheme was still viable. Furthermore, the March 2006 ruling of the Department of Health (DH) that IMGs without leave to remain in the UK are required to have a work permit means that any NHS trust wishing to employ such a doctor will have to prove that a ''home-grown'' doctor cannot fill the vacant post.[4] This ends the current permit-free training arrangement for international doctors and together with the increase in UK medical school output will reduce the chance of an IMG obtaining a post in the UK. Consequently, there will be less need for CAs in their present form.

We report the experience of hospital consultants and IMGs before this ruling was announced, looking at the percentage of time unemployed spent on CAs, their perceived value, training opportunities offered and how the scheme could be improved. In the light of this information we discuss whether the tradition of CAs will still have value under the new immigration rules.

METHODS

The CVs of 573 doctors applying to an advertisement (closing date 5 November 2005) for two medical house officer posts in North East England were analysed. Unemployment was calculated from the interval between last post at home and either the first post in the UK if they had worked in the UK, or the closing date of the advertisement if they had not. Unsuccessful candidates were sent a letter regretting that they had not been appointed together with a questionnaire to return anonymously asking for their experience of CAs including how they had applied, their duties and educational activities, and the high and low points. Those not replying within 1 month were sent one reminder. The questionnaires' source code was destroyed before analysis to ensure anonymity.

At the same time (October 2005) an anonymous questionnaire was sent to 150 practicing consultant physicians in teaching and non-teaching hospitals on the database of the Northern Region Association of Physicians. Consultants were asked whether they currently had CAs under their care; if not, had they in the past and the reasons for stopping. They were asked for details of CAs' educational activities, induction and assessment. Both groups were encouraged to give free text comments.

Approval was obtained from the local research ethics committee and consent for using personal data from the trust's Caldicott guardian.

Abbreviations: BMA, British Medical Association; CA, clinical attachment; DH, Department of Health; GMC, General Medical Council; IMG, international medical graduate; PLAB, Professional and Linguistic Assessments Board

Table 1 Details of unemployment and examination timings

	Median time, months (range)
MB degree to closing date of current post, 568 candidates	39.2 (0.3–281)
Time working in home country, 540 candidates	25.0 (0.39–262.1)
MB degree to PLAB part 1 (if PLAB part 1 taken after MB), 294 candidates	21.6 (0.3–166.6)
PLAB part 1 to MB degree (if PLAB part 1 taken before MB), 20 candidates	4.75 (0.8–27.2)
MB degree to PLAB part 2 pass, 465 candidates	31.0 (0.1–273.2)
Interval between UK entry and passing PLAB part 2, 182 candidates*	2.0 (0–141.1)
PLAB part 1 to PLAB part 2, 307 candidates	7.0 (2.0–36.0)
End of last post at home to PLAB 2 (excluding 26 who passed PLAB 2 and then returned home to work before returning to the UK), 425 candidates	6.0 (0–144)
Total time unemployed from last post at home to closing date of current post (or start of first post in UK if applicable), 528 candidates	11.1 (0.56–158.2)
Total unemployment	
More than 6 months	84.3%
More than 12 months	46.0%
More than 18 months	28.2%
More than 24 months	18.4%
Time unemployed from passing PLAB part 2 to closing date of present post (or start of first post in the UK if applicable), 464 candidates	5.1 (0.3–67.9)
Unemployment after PLAB part 2	
More than 6 months	42.5%
More than 12 months	10.4%
More than 18 months	3.5%
More than 24 months	1.7%

Number of candidates refers to the number for whom the information could be reliably derived from their CVs or *questionnaire returns.

RESULTS

Of the 573 applicants, 73.2% were from South Asia, 9.7% from the Middle East, 5.8% from Africa and 3.1% from European Economic Area (EEA) states. Four did not give their country of origin but all had passed the PLAB exam and were assumed to have qualified outside the EEA. There were no UK applicants.

Details of employment and examination timings are shown in table 1. All but three had passed part 2 of the PLAB examination and 96.3% had worked in their home country before coming to the UK for a median of 25 months after qualifying.

After arrival in the UK, 29% had had one or more substantive UK posts starting a median of 5.1 months before the closing date of this post.

The average total time unemployed for applicants for this post was 16.52 months (median 11.11 months); the average time after passing part 2 of the PLAB exam was 6.7 months (median 5.1 months).

CA details are shown in table 2. During their time unemployed 90% had done one or more CAs in the UK.

A total of 200 IMG questionnaires were returned. The country of origin (71% from South East Asia), time from qualifying to PLAB part 2 (35 months), time from PLAB part 2 to interview (7.1 months) and time from MB degree to closing date of interview (41.1 months) were similar to the cohort as a whole and their replies were treated as being representative of the whole. Ninety two per cent of those returning the questionnaires had done one or more CAs, their answers reflecting the experience of 409 different CAs.

Medicine was the speciality interest of 69%, surgery 10%, general practice 8%, A&E 3% and other hospital-based specialities 10%.

Graduates applied for CAs principally using random addresses from the Medical Directory (40%), advice from friends (35%) or relatives (13%), and direct applications to deaneries (10%). Most used a combination of methods.

When applying for posts, 36% wrote letters, 33% had gone at least once in person to a hospital they were applying to, 33% had telephoned and 16% emailed. Graduates had applied on average to 73 trusts before being successful in obtaining a CA; 19% had submitted more than 100 applications before being successful. Only 36% of trusts or consultants replied to their enquiries.

Once appointed, CAs' duties were mainly observational, including clerking patients in outpatients (39%) and on the medical and surgical assessment units (48%), but in addition 41% inserted intravenous lines, 12% assisted with minor procedures and 11% assisted in the operating theatre.

Seventy three per cent had either verbal (37%) or written (36%) induction at the onset of their CA. However, only 32% of those who had completed an attachment had been assessed at the end and only 25% had their learning needs assessed. Seventy two per cent were given career advice. Fees were charged for 32% of CAs (average £176, maximum £500 per CA). Charging did not result in any increase in the quality indicators of induction, appraisal, assessment of learning needs or career advice; the percentages offering these did not differ between those hospitals that did and did not charge. Accommodation was provided by 36% of trusts with an average rent of £220 per month.

Six per cent of CAs had attended specific sessions for overseas doctors, 27% had given case, literature or audit presentations and 65% said they regularly attended departmental educational meetings or grand rounds.

Fifty seven per cent said NHS familiarisation was the best point of their CA. Fourteen per cent quoted improvement in their communication skills, 9% the availability of a UK reference, 7% general support and teaching, and 3% an improvement in their confidence or a lessening of anxiety.

The commonest criticism was that posts were purely observational with limited responsibility (43%). Fifteen per cent used the adjectives "isolated", "lonely", "abandoned" or "ignored" when describing the worst points of their attachments. Ten per cent saw no prospect of a post at the end of the attachment, 13% objected to the lack of or the price of accommodation or fees for CAs and 8% to the lack of any structured educational programme. When asked how their posts could be improved, 38% said they wanted more responsibility, 16% wanted a centralised application system, 16% more supervision or defined targets, and 10% a stipend. Others wanted to spend more time in the post, and have more teaching and rotating posts. Example quotes are shown in table 3.

Despite these criticisms, 90.4% said their CA(s) had been helpful and 56.8% would not wish to take up a substantive post without a CA first.

Ninety per cent would apply for an honorary post if it were advertised, giving reasons of increased responsibility and easier application for substantive posts.

A total of 103 consultants returned their questionnaires. Fifty two (50%) took CAs and 23 had a CA currently attached to them. Only four planned to stop taking CAs in the near future. Of those who did not take CAs, 90% said they had in the past and had stopped a mean of 2.1 years ago, quoting pressure of work (45%), competing educational activities (9%) and lack of posts for IMGs (18%). Twenty three per cent of consultants said the trust discouraged them from taking CAs. One consultant quoted the poor quality of applicants.

When appointing CAs, 58% of consultants dealt directly with CAs, 14% had a lead person in the department of medicine who was the focus for CAs and 28% said the trust human resources department coordinated CAs.

Table 2 Details of clinical attachment timings

Total time in months spent on CAs, 559 candidates, median (range), average	3.0 (0–29), 3.8
Total % of IMGs undertaking any CA, 559 candidates	90.2%
% doing CAs before PLAB part 2	25.9%
% doing CAs after PLAB part 2	82.8%
Numbers of CAs, 559 candidates	
None	9.8%
1	35.8%
2	34.0%
3	14.1%
4 or more	6.2%
Length of each CA (months), 498 candidates, median (range), average	2.0 (0.25–21), 2.4
% of total time unemployed spent on CAs, 498 candidates	23%
% of time unemployed after PLAB part 2 spent on CAs, 191 candidates*	47.5%

Number of candidates refers to the number for whom the information could be derived from CVs or *questionnaire returns.

Formal educational activities were given by consultants in the form of induction (58%), assessment (69%) and written information (40%). Ninety seven per cent said CAs attended routine educational meetings.

Seventy three per cent of consultants taking CAs felt the CA contributed to patient care by assisting junior doctors in clerking patients and acting as locums if needed. Sixty nine per cent said they would not appoint an IMG to a definitive post who had not done a CA.

Eighty four per cent limited the time of the attachment to a median of 8 weeks (range 4–52 weeks). Sixty one per cent used CAs as locums if they became available.

Most consultants in their free text comments spoke warmly about CAs but were deeply unhappy about their career prospects.

DISCUSSION

The increase in the number of IMG numbers passing the PLAB examination since 2001[5] has led to high levels of unemployment among overseas doctors. Our cohort of 573 graduates had already wasted 788 ''doctor years'', of which 40% was spent job-ready after passing part 2 of the PLAB examination. Less than a quarter of the time unemployed was spent as a CA. In the present climate, even before the new DH ruling, CAs will be seen more as a way of maintaining medical skills, keeping in contact with patients and colleagues, obtaining a UK reference and filling in time in the hope of obtaining a UK post, rather than as a time-limited attachment with clear educational aims. Ninety two per cent of IMGs aspired to careers in hospital specialities with only 8% wishing to pursue a career in general practice. The mismatch between the career aspirations of the IMGs and the needs of the NHS may result in further disappointment for IMGs. Despite warnings of the poor employment prospects and the high level of competition for junior posts,[6] unemployment amongst IMGs has shown no sign of decreasing (average time unemployed was 11.2 months in 2003[5]). It is no surprise that unemployment rather than education formed the focus of IMGs' comments.

Induction, written or oral, took place in three quarters of attachments but learning needs and end of attachment assessments in only a quarter, and we identified a need for more pastoral support. Consultants offering CAs gave comparable figures, although they recorded higher percentages for assessment (69%) and for attendance at in-house educational sessions (97%). Our consultant survey included only physicians, but in this, as in a previous study,[5] medicine was the commonest speciality sought by IMGs. We cannot comment how other groups of consultants would view CAs.

Only 6% of CAs attended specific sessions for overseas doctors during their CA. Some could have already attended courses or not felt the need, or not been aware of them. Details of overseas doctor courses are found in only half of the UK postgraduate deanery websites.[7]

Table 3 Representative quotes from IMGs on their clinical attachments

''My consultant guided me in my career options and gave me every possible opportunity of understanding the NHS, but an honorary SHO post would be better''

''CAs are very important for international doctors, even more important than some medical exams''

''I feel I am now pretty in tune with the NHS system and although I still have a lot to learn, I feel confidant I can work comfortably. I just need a job though to put all I have learnt into practice''

''Clinical attachments are very essential to acclimatize to the new system and help to get into the system. Also they keep us engaged so that we don't slump into depression''

''There should be a list of hospitals with specialties available for observership made available at the BMJ site/GMC site and a clear-cut process for application made''

''It's great being part of medical community again. It feels that I am still a doctor … and free food at meetings''

''The experience I am gaining from attachment is really great. But staying in UK without job is very difficult as it is so costly''

''It would be appropriate if all trusts are compelled to give at least a locum shift for all clinical attaches''

''So many working hours of many talented enthusiastic and capable doctors are being wasted just in applying for clinical attachments''

''I was forced to do the attachment in a speciality which I was not interested. This was only for UK reference''

''Please make the unemployed doctor work either by giving … at least honorary posts''

''Clinical attachments are actually a tool to cage junior doctors at one place, offer nothing but false hope and reflect little good''

''Please solve the riddle where should doctor go without a job when he is jobless because of no GMC registration because he has no job''

''It [my clinical attachment] made me loose my sleep, confidence, my time, my energy''

''..we come with great hopes and expectations. Within two months you lose hope. By six months you are a nervous wreck. Completely lonely. No family. No ...comfort . No money. No job. No other professionals is made to go through the hardship we have to face as doctors…''.

Educational supervision may be difficult in short CAs, and more than 50% were of 2 months or less, and difficult because of competition from the more closely monitored junior doctor training posts. It is surprising that trusts had discouraged 23% of consultants from taking CAs. IMGs fill one third of junior doctor posts[5] and trusts could not deliver services without overseas doctors.

Despite these shortcomings, 90% of CAs felt their CA had been of value. Their criticisms related to limited responsibility, feelings of isolation and the difficulty in obtaining a CA in the first place. That 90% of applicants had obtained a CA is a tribute to their tenacity.

Ninety per cent of IMGs would apply for an honorary post if advertised, giving improved experience and the possibility of GMC registration as reasons. Some argue that honorary posts are exploitative,[5] but only two mentioned exploitation as a reason for not applying. Clinical indemnity might be seen as a problem by some trusts, but CAs would be eligible for GMC registration on appointment to an honorary post and could be automatically registered after PLAB if limited registration is phased out in 2007 as the GMC intends.[2] Occupational Health and Criminal Records Bureau (CRB) checks would also be required but are now accepted as standard practice for most CAs.

What alternatives have been considered for introducing IMGs to the NHS? The BMA's working paper on international foundation posts proposes graduates be appointed from their home country in numbers that match projected vacancies in the UK.[8] Although this would reduce IMG unemployment, workforce predictions are often inaccurate[9] and may be more so in the future with increasing numbers of EU migrants who under DH work permit rules will have precedence over IMGs.[4] The BMA scheme would replace CAs, but CAs may still be needed to allow a period of supernumerary observation for the doctor to be acceptable to consultants, 68% of whom would not appoint an IMG who had not done a CA first. Despite their frustrations, 58% of IMGs would not wish to do a substantive post without a CA.

NHS Professionals Doctors and the postgraduate deans propose managed clinical placements for post-PLAB graduates with 4 month supernumerary attachments and a central clearing house for all graduates.[10] This initiative would allow hands-on introduction to the NHS with more responsibility and would address many of the criticisms of the current scheme. IMGs could apply from and continue to work in their home country until a placement became available. Once placed, craft skills and competencies could be assessed in the workplace. As with the BMA system, accurate workforce planning would be needed and both schemes would need funding.

The North East London Strategic Health Authority is piloting a managed centralised CA scheme. This will help CAs already in the UK applying for CA posts in London, with the aim of taking the strain off trusts processing very large numbers of applications.[11] The scheme proposes increased provision of educational activities and addresses trusts' concerns on clinical risk issues.

There are around 1000 medically qualified refugees in the UK[12] and any CA scheme will need to take into account this small but significant group, many of whom have additional needs arising from language difficulties and long periods of unemployment. Only one of our applicants was a refugee.

The increase in medical school input from 5062 in 1998 to 7898 in 2006,[13] together with the increase in graduates coming from EU accession states, means very few IMGs will be needed to fill NHS vacancies and the need for CAs will decrease. Can the tradition of physicians taking on international graduates for training be harnessed in other ways? Despite conflicting demands, lack of remuneration and IMG unemployment, only 4% of consultants in our survey who were currently taking CAs were planning to stop doing so. There will still be a need for CAs by small numbers of IMGs coming to the UK, the majority of whom are likely to be on dependant's visas, and CAs will also be needed by refugees. The recent announcement by the Home Office of a new category (medical training initiatives or MTIs) within the Training and Work Experience Scheme (TWES)[14] will allow IMGs up to 2 years' experience in the UK before they return home. An initial period of observation and acclimatisation similar to a CA will be needed by doctors taking part in this scheme.

The CA scheme has served the NHS and IMGs well for 40 years and will continue to be of value. However, our study shows CAs would value more pastoral care, practical experience and assessment.

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Competing interests: None declared.

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