

Letters to the editor

OVERVIEW

Please submit letters for the editor's consideration within 6 weeks of receipt of *Future Healthcare Journal*. Letters should ideally be limited to 350 words, and sent by email to: FHJ@rcplondon.ac.uk

Induction programme of international medical graduates on the Medical Training Initiative scheme

Editor – We are surprised at the lack of mention of the Medical Training Initiative (MTI) scheme which is run by a number of medical royal colleges in the article by Jalal *et al.*¹ Currently there are over 300 physicians working and training in the UK on the Royal College of Physicians (RCP) scheme for up to 2 years.

The RCP provides support to these trainees once in the UK, with tailored inductions held four times a year to provide them with an introduction to the NHS, clinical governance and sessions on medical practice by colleagues from the General Medical Council, communication skills, e-portfolio and introduction to cultural differences that they may face in the UK. We also invite a current MTI doctor to talk about their experience over the past year.

Last year, 164 international medical graduates (IMGs) attended MTI inductions. Feedback is used to inform future sessions. We also organise an annual symposium to encourage them to present their audits and research projects.

We are working with other royal colleges to improve knowledge and experience sharing, with an aim to improve the IMG experience.

The main obstacle to receiving adequate support early on in their training is the variable start dates that, on occasions, do not coincide with the available induction dates. To improve this, we would like to work towards providing some aspects of the induction online with information on settling into the UK (eg accommodation, schooling and opening a bank account).

We welcome and support the suggestion by Jalal *et al* to implement national inductions to improve the quality of information provided to IMGs who have recently moved to the UK.

We are keen to improve the standards of pastoral care for IMGs to ensure that they are able to raise any concerns while in post, ensuring that these do not negatively impact their experiences. We also support the alumni to ensure that the skills and experiences gained in the UK are used effectively to improve health services in their home country.

We also provide pastoral care outlined above to any IMG who has come to UK, regardless of whether or not on the MTI route. ■

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Involving medical students in a community-based project on ADHD: a novel learning experience

Editor – In her interesting educational paper, Frearson reports that hospice placements enabled foundation year 1 doctors to improve their communication skills and enhance their recognition of the dying phase.¹ In a very different training environment, we describe involving Australian medical students from the University of Sydney in a community-based study investigating stimulant dose titration in children with attention deficit hyperactivity disorder (ADHD).

Despite its estimated prevalence of around 8%,² medical students often receive little training about ADHD,³ perpetuating the pattern of under-recognition and under-treatment. Under the supervision of Alison Poulton, four medical students tested children with ADHD using 'Stop Signal Task', a computer-based test of response inhibition. This involves rapidly pressing a key corresponding to the direction of an arrow on a computer screen; if a tone is presented after the arrow, they should inhibit their response. The test was repeated after four incremental doses of stimulant medication. The mornings of testing also provided an opportunity for students to observe the effects of medication and find out from the parents and children how ADHD affected their lives.

The students tested 13 children (10 boys) aged 5–17 years. Eleven children did the test correctly (scoring $\geq 90\%$) at least once; six children managed this even without medication. For 10 children, their best score was after their third or fourth incremental dose of stimulant.

The students observed vast differences in the children's behaviour as the medication took effect. Four children initially did not want to participate and two ran around uncontrollably. Some parents became stressed, expressing their emotion by crying or becoming aggressive. Observing this helped the students

understand how ADHD can affect the whole family. The students also gained insight into the difficulties of doing research in the community, including organising families to keep appointments and persuading children to complete cognitive tests when they wanted to play with toys.

Just as hospice placements can have an important educational impact,¹ so our students experienced first-hand the challenges of community-based research and also had an opportunity to learn about children with ADHD. ■

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- 1 Frearson S. Perceived educational impact, challenges and opportunities of hospice placements for foundation year doctors: a qualitative study. *Future Healthcare Journal* 2019;6:56–60.
- 2 Sawyer MG, Reece CE, Sawyer ACP, Johnson SE, Lawrence D. Has the prevalence of child and adolescent mental disorders in Australia changed between 1998 and 2013 to 2014? *J Am Acad Child Adolesc Psychiatry* 2018;57:343–50.e5.
- 3 Tatlow-Golden M, Prihodova L, Gavin B, Cullen W, McNicholas F. What do general practitioners know about ADHD? Attitudes and knowledge among first-contact gatekeepers: systematic narrative review. *BMC Fam Pract* 2016;17:129.

Clinician cognitive overload

Editor – The October 2018 edition of *Future Healthcare Journal* includes two editorials and seven articles under the theme 'Systems approach to healthcare'; healthcare systems engineering (HCSE) for complex adaptive system (CAS) analysis and design – conjoining the disciplines of systems engineering with medicine and healthcare, both academically and in practice.

The HCSE for CAS approach to medical practice and healthcare delivery offers great promise for the much-improved cost-effectiveness of healthcare, but only if the manual- and document-dependent tools and methods described are augmented with state-of-the-art information technology (IT). In this way, not only will the HCSE for CAS potential to achieve cost-effective healthcare improvement be realised but so also will significant opportunities for case outcome optimisation and medical mistake mitigation (medical mistakes being currently the third-leading cause of preventable patient deaths in the United States of America).¹

I posit that because the root cause of medical mistakes is 'clinician cognitive overload' created by medical practice requirements executed in chaotic healthcare venues and because

traditional medical mistake mitigation methods (eg checklists and other heuristics promulgated by patient safety organisations)^{2–4} exacerbate cognitive overload, therefore IT in the form of mobile applications, 'apps', is needed to provide real-time and cost-effective cognitive support. Furthermore, healthcare subject matter experts now can create and operate these apps using commercially available cloud-based software solutions known as mobile app development platforms (MADP) as described by the global business analyst firms such as Gartner and Forrester. ■

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- 3 Armstrong Institute for Patient Safety and Quality. *CUSP tools and resources*. The Johns Hopkins University. www.hopkinsmedicine.org/armstrong_institute/training_services/workshops/cusp_implementation_training/cusp_guidance.html
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Non-training clinical fellowships

Editor – We read with interest the paper by Jalal *et al.*¹ Sherwood Forest Hospitals, has provided non-training clinical fellowships since 2002.² An account of how it addresses the issues raised in the paper by Jalal *et al.* has been reported.³

Many overseas doctors are trained through traditional undergraduate medical curricula which do not emphasise communication and leadership skills, in contrast to significant emphasis on communication and leadership skills in the UK. It is a significant cultural shift for them to make the transition to settings where skills of communication and teamwork are given high priority in the clinical setting and assessed through work place based assessments using an electronic portfolio.

Our programme addressed this challenge through 8 weeks of a supervised supernumerary period in a supported environment, designed to expose the clinical fellows gradually to the work environment through an extended period of induction mentoring and coaching with a gradual transition to the new work environment to enable the fellows overcome language, communication, clinical and work-cultural challenges and adapt to the UK healthcare system.

Overseas doctors, who are employed in non-training positions, do not by right receive the training and educational opportunities offered to trainees in the National Training Programme and are not monitored by the Guardian for Safe Working Hours. Our programme addressed this issue by providing a study leave allocation, protected time for personal and professional development as well as deployment of the *gripes* tool.⁴

Leadership, management and educational governance of the Clinical Development Fellowship Programme is through a committee comprising the executive medical director, director of postgraduate medical education and senior human resources staff.

The success of the programme was reflected in the programme outcomes which showed that 49% of fellows gained a training