

The Postgraduate Medical Education in U.K. - The System and Its Relevance to Training and Medical Practice in Pakistan

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Introduction

Pakistan like many other developing countries has relied heavily upon European countries especially UK and United States for higher education in almost all fields of science and technology, in the field of medicine, most of the highly qualified professionals came from U.K. till very recent years. Although exact figures are not available, more than 90% of the foreign qualified specialists in different branches of medicine in Pakistan had qualifications from U.K. There is, however, a lack of information regarding the system of postgraduate medical education in U.K. and more significantly its relevance for the doctors working in Pakistan. The present article sets to explore the following issues:

- The system of the postgraduate medical education and training in U.K.
- Does this system provide relevant training for doctors who are ultimately going to work in a developing country like Pakistan.
- How the training opportunities in U.K. can be best utilised by the doctors from Pakistan.

These issues are discussed in the light of recent literature on medical education and our joint experience of more than six years on Overseas Doctors Training Scheme of the Royal Colleges of Psychiatrists and Surgeons in U.K.

National Health Service (NHS) - The Model for Training and Care

Britain prides itself in having one of the best health care systems in the world, known as the National Health Service (NHS), supported by highly qualified and devoted experts in different fields of medicine. This, not only provides health service to the citizens which is free of cost, but also provides training to the doctors. It is therefore important to give a brief introduction of the NHS. The basic unit of NHS is the community based service provided by the General Practitioners. The general practice in U.K. embraces 98% of the medical needs of the whole population. It is based on precisely defined list of registered patients², which ensures that a doctor or a group of doctors practising from a base, commonly referred to as "Surgery" provides health care and also analyzes health problems of a well defined population. Almost all the patients, except dire emergencies which may directly present in an Accident and Emergency Department of the hospital, are first seen by their GPs. Therefore, the General Practice acts as a strong filter for all the referrals to the specialists. The specialised services are provided by the consultants in the hospitals. The consultants maintain close liaison with GPs who provide follow up service when patient is discharged from the hospital. This helps to maintain the continuity of care. NHS has been through tremendous changes recently but the basic structure described above remains the same. The U.K. has the longest training programme for GPs which lasts upto three years. It is also one of the few in the world to have a professional examination and the diploma, Member of the Royal College of General Practitioners (MRCGP), which has been shown to benefit the patients². The importance attached to general practice can be gauged from the fact that the first chair of general practice in the world was established in U.K. in 1963 and currently there are several academic departments of general practice in medical schools led by the professional chair¹.

The Specialist Training

The training required to become a consultant in U.K., the subject of this article, is much more complicated. Postgraduate medical education (PGME) is organised and supervised by the Medical Royal Colleges, postgraduate deans and the universities, while the General Medical Council (GMC) is

responsible for registration and professional standards. it would be interesting, at first to look at the development of the Postgraduate Medical Education (PGME) before discussing the present structure of PGME in U.K. Although efforts to organise PGME started at the turn of 20th century, the most significant impetus came from the Christ Church Conference held in Oxford in 1961.^{3,4} The scenario of PGME in U.K. at that time was perhaps not much different than the present situation in Pakistan.

Around the same time, Prof. George Smart described the whole situation in PGME as “chaotic”⁶. Similarly, Pickering and McLachlan commented that the average young graduate received little help or advice from an organised source. There was little or no attempt to arrange teaching in the large non-teaching hospitals⁵. (Unlike Pakistan much of teaching in U.K. takes place in District general hospitals not attached to the university departments). The Christ Church conference concluded that PGME should be regionally organised in association with regional universities. The hospitals were recognised as units of delivery for PGME and regional postgraduate deans were endowed with the responsibility to establish an infrastructure for PGME⁷. Christ Church conference was followed by many reports and changes in the system. Twenty-five years since then, PGME has evolved gradually and now two levels of postgraduate training can be identified. One is called General Professional Training (OPT) and the other is recognised as Higher Specialist Training.

General Professional Training (GPT)

The details of OPT vary between different royal colleges, depending on how a college defines adequate training for the purpose of GPT. The following account will give a broad picture of the organization of OPT. The GPT usually lasts for three to four years and comprises of training in the Senior House Officer (SHO) and Registrar grades (SHO in U.K., unlike Pakistan is a training grade after house job). Training during OPT is obtained under the different rotational schemes. These training schemes are organised separately for each speciality. Each training scheme is approved by the respective Royal College, which inspects it regularly to ensure the maintenance of certain standards (some colleges e.g. The Royal Colleges of Physicians do not have approved/recognized training schemes for OPT). The OPT culminates in the membership i.e., MRCP or the fellowship i.e., FRCS of the concerned college. The OPT and the subsequent examinations are aimed at recognising and preparing the trainees who are suitable to go on to the higher training. The main objective of the OPT is acquiring clinical skills with a broad grasp of the subject. The training is mostly under the supervision of a consultant in a medical or surgical team.

The Higher Training

This will be discussed in more detail as this is not a well known entity in our country. It must be realized that the qualifications like MRCP or FRCS are not recognized as a specialist qualification in U.K. as such, a fact clearly mentioned, for example, in the MRCP prospectus⁸, which states “The MRCP (UK) is not a specialist qualification. The examination may also be taken by those who do not intend to pursue a career in hospital medicine and this is one of the reasons why the colleges have not followed the example of other countries in only awarding their fellowship or membership once specialist status has been obtained”. These qualifications serve to mark the end of OPT and are essential requirement for achieving a senior registrar post to start the higher training. A specialist status in UK can only be achieved at the satisfactory completion of the higher training, which usually lasts for three years. In some of the specialities like Psychiatry, even the post-membership experience, gained at a registrar post, is not recognised as higher training for obtaining a Specialist status. It must be in a recognised Senior Registrar post⁹. Each major medical speciality has got a committee for higher training, comprised of the representatives from the main educational bodies in the speciality. In Psychiatry, for example, the Joint Committee on Higher Psychiatric Training (JCHPT) comprises of the representatives from the Royal College of Psychiatrists and the Association of the University teachers of Psychiatry. The committee has the responsibility of supervising the higher training, which, like GPT, is organised in the form of rotational schemes for the posts specifically recognised for the same

purpose. The consultants supervising the higher training are usually more senior and have more academic experience than those supervising the trainees in the GPT. A similar joint committee for Higher Medical Training (JCHMT) overlooks higher training in Medicine. At the end of four years, higher specialist training in approved posts, trainee is eligible to apply to the Higher Training Committee for accreditation as a specialist.

What is the purpose of higher training

The period spent in the higher training provides a unique opportunity for a trainee to look for new horizons in his field of interest without the pressure of the examinations. The objectives of the higher training were best described by Prof. Copeland⁹ (an ex-chairman of JCPHT) as follows: I)

Consolidation of skills and knowledge learnt during GPT

II) Preparation for consultantship which involves learning team coordination, the attributes of leadership, decision making, service planning and training of junior doctors and medical students.

HI) Training in a sub-speciality of the subject for example, Old age Psychiatry or Paediatrics Orthopaedics.

The End Point

The completion of higher training marks the end of formal training in a speciality. The whole training period lasts for seven years and at the end of it the doctor is eligible to apply for a consultant or an equivalent post. This is not the end of informal training. Continuing Medical Education (CME) is now becoming mandatory for the consultants in some specialities. The Royal College of Obstetricians 'and Gynaecologists, for example, requires that 200 CME credits to be earned from different academic activities over a five years period. If a specialist does not achieve this target, his or her name will not appear on the College's role of trained specialists¹⁰. This, however, is not the subject of our study and we come back to our next question.

Is it relevant?

Britain has traditionally provided us trained personnel in every field of medicine, some of whom provided leadership and helped to establish the major institutions for training and patient care.

Therefore, it seems strange now to raise the question whether this training is relevant for the trainees from Pakistan. Interestingly, however, the usefulness of this training in U.K. for the trainees who will ultimately work in a developing country, has increasingly been questioned in U.K. itself recently¹¹⁻¹⁵.

This is not surprising. The training system in every country, whether UK or Pakistan, reflects the peculiarities of health care system of that country. It will be naive to expect that British postgraduate education will cater to the needs of the doctors who are going to work in Pakistan. It would, therefore, be pertinent to see in the light of experience of eminent trainers and trainees the type of training available to the majority of overseas trainees in U.K.

Training in U.K., What does it offer to overseas trainees?

A quarter of SHO and more than a 3rd of registrars working in UK obtained their qualifications outside Britain or European Community (EC) countries¹¹. Some receive excellent training¹⁶, but for a significant proportion, the quality has been poor and much criticised¹¹. The situation has been aptly summarised by Sir David Innes William, an ex-director of British Postgraduate Medical Federation, "For many years some overseas doctors have been forced to find employment in the narrower specialities such as ENT surgery, Geriatrics or Mental handicaps, which is almost always inappropriate to their training requirements." The long term Senior house Officers from overseas compelled to do locum jobs here and there with little or no structured training is, therefore, all too familiar scene in U.K.". The training experience, even in the best centres in U.K. may not be relevant for practice in Pakistan. The nature of medical problems and disease pattern vary so enormously between the two settings that Gibney¹³ described the training of doctors from developing countries in Britain, except in some highly specialized fields, as 'illogical'. The usefulness of such a training is further limited by the peculiar structure of N.H.S. One of the implications of highly developed general

practice system in NHS is that the specialist in U.K. unlike in our country, see what they are supposed to see i.e., more uncommon, complicated and serious conditions which cannot be handled at primary level of medical care. The impact of this 'filter' system operating at the level of general practice is well documented in medical epidemiology but its effect on the training of doctors is less well studied.

The net result is that a doctor on return to Pakistan after completion of training in UK may commonly face problems which he may not have at all or rarely encountered during his training in Britain. It is not surprising therefore, that an eminent Professor of Psychiatry in Pakistan said of his six years training in one of the best centres in U.K., "when I returned to Pakistan, I felt cheated because of the inappropriateness of the training I had received". Psychiatry is not unique due to cultural variations, similar problems are faced in subjects such as orthopaedics. Expressing his own worries and those of some of the members of World Orthopaedic Concern, Rowley (1990) noted about the Orthopaedic training in U.K. that "having travelled extensively abroad it is quite clear that the type of practice (in orthopaedics) abroad and that in U.K. differs widely. The type of technology available in this country will simply not be available to these trainees in their home countries. Moreover the emphasis on arthritis and other degenerative diseases in U.K. is completely replaced by the problems of infections and the late management of trauma and its complications in developing countries like ours. Cases we regard as a 9-day wonder in the U.K. are common place in other countries and vice versa¹⁴⁻¹⁶. The situation for overseas trainees has been made worse by the recent changes in the immigration laws. Under the new rules doctors seeking the postgraduate training in U.K. can only stay in Britain for a maximum of four years¹⁷.

While previously it was possible for the overseas trainees to muddle their way through to the higher training, it is now impossible to go beyond general professional training (OPT). The GPT, as we discussed earlier, is limited in its nature and scope. An overseas trainee, is therefore, unlikely to get more than the basic training, which in many cases is available in most developing countries in any case.

What is the way forward for us

Modern medicine in Pakistan cannot exist without an international exchange of ideas, data and technology. This is true of not only U.K. but also of other countries. Our historical links and the advantage of sharing English as a common language means that we can gain a lot from U.K. It is a great pity that while we have not even considered this subject seriously, a supplementary report considering the implications of Calman report for overseas doctors in U.K. has already been published". (The Calman report¹⁸ is a major document on the training of all the hospital doctors in U.K. which is set to radically change the postgraduate training in U.K. and will be fully implemented by the end of year 1996). This supplementary report to Calman's Report is an important contribution to the training of overseas doctors in U.K. It needs to be studied by the policy makers in postgraduate medical education in Pakistan. An editorial commenting on this report in British Medical Journal¹¹ emphasized its main points as follows. "At the heart of report is the recommendation for planned coordinated training for overseas trainees which should be tailored to the trainees' need. While their job necessarily entails a service commitment, the whole point of postgraduate training is to prepare these doctors for life time practice in their own country and our training is failing if it does not achieve this." The editorial concludes as "doctors from overseas have served the NHS well and we owe it to them to provide first rate postgraduate training." This poses a challenge for us. How should we respond to this call for planned and coordinated training tailored to trainees' needs preparing them for practice in Pakistan. In our view we need to set our priorities and objectives for postgraduate training of doctors from Pakistan on the following principles.

What training?

Experts in medical education as well as international organisations like WHO now agree that basic postgraduate medical education in almost all specialities should be carried out in trainees' own country^{13,15,19}. What we need therefore, is higher training for our doctors, who have completed their

basic postgraduate training in Pakistan²⁰. Sir Ian Todd who formerly ran the Overseas Doctors Training Scheme of The Royal College of Surgeons has put it succinctly for us, “In my view, we should move away from offering training at Senior House Officer and Registrar level and provide more higher specialist training to a few, carefully chosen, well qualified and experienced graduates who are going to be in position to implement what they have learnt and teach others when they return home¹⁵.”

For Whom?

It is clear from above that only those doctors who have completed postgraduate training in Pakistan, preferably with a postgraduate qualification should have higher training in U.K. They must concentrate on gaining experience and skills that are unavailable in Pakistan. The appointments should be made to a specific training programme instead of succession of random allocation of jobs that may not be appropriate for their training needs. Attainment of a membership or fellowship of a royal college would not be appropriate for a majority of these trainees^{11,13} as it will repeat much of what they have already learnt in their own country. This is something we would recommend from our personal experience as well. Free of any concerns to pass the examinations, we found opportunity and flexibility that was needed to gain experience and training which was not available in Pakistan.

For How Long?

The trend to stay in U.K. for an unlimited period needs to be discouraged. If training is organised on the above lines, a training period of two to three years should suffice. This would include six months induction period to tune the candidate to the medical practice in U.K., followed by the training in a field in which the higher training is desired.

The Opportunities

The two major developments in U.K. over the last two decades have brought welcome changes for overseas trainees. If we can adopt a coherent and comprehensive postgraduate medical training policy, a lot of opportunities exist for our graduates to find the appropriate training. The overseas doctors training schemes of various Royal colleges offer a unique opportunity in this regard. This scheme requires at least two years experience in the concerned speciality and some of the Royal colleges require a postgraduate qualification from the home country. The candidates are placed in the recognised posts for training. The Royal College of Surgeons, also operate a higher training programme called Overseas Doctors Higher Training Scheme (ODHTS). Although ODTS has also been criticised recently but it can still provide an opportunity for experienced trainees to gain useful experience in some specialities. Another major development relates to the implementation of Calman's Report²¹. This report proposes a major innovation suitable for overseas doctors, i.e., ‘fixed term training appointments’. These would be appointments for six months to two years duration, available to those who have got no permanent resident rights in Britain. Such appointments are aimed at providing planned programmes of specific training at a level equivalent to that of specialist registrar grade, a new grade proposed in Calman's report. University departments, sub-speciality units and others keen to offer training are expected to seek the participants through international competition²¹. These are the two major avenues, other arrangements which can also provide limited but useful opportunities include:

- a) Exchange Programmes: Many of U.K. educational institutions are recognising the value of experience in the developing countries. In exchange, we can send our trainees for shorter periods to benefit from the opportunities in the relevant institutions.
- b) Support for indigenous training programmes: Realizing the need for proper training in their own countries, the International Health Consortium (IHS) provides support for training programmes in the developing countries²². The IHS has representatives from a wide range of professional associations and disciplines. The consortium supplements these programmes by providing visiting teachers in the areas or subjects in which skills are deficient in the developing countries. The consortium has provided considerable help to countries like Tanzania and Ghana across many specialities.

- c) Arrangements between the individual consultants for trainees working with them.
- d) Scholarships provided by government, British Council and other agencies.

Conclusions

Increasing realization in U.K. of the inappropriate training received by the overseas doctors, changes in British Postgraduate Medical Education System, amendments in the immigration rules for overseas doctors and availability of basic postgraduate training in Pakistan, all mean that we need to develop a comprehensive policy for training our postgraduate trainees in U.K. Such a policy should be structured along the following guiding principles.

1. We should aim for higher specialist training in the fields in which adequate training facilities are not available in Pakistan.
2. The training should be planned and coordinated before a doctor takes up appointment in U.K. The training should be tailored to the trainee's need and should last for a limited duration.
3. To use Lowy and Cope's words "The trends to merely acquire examination or rather non-specific Western veneer" should be discouraged¹². The nature and type of experience gained in Britain or for that matter in any developed country should be given priority rather than a particular qualification. As is widely recognised, our doctors have served the NHS well. Now they need to be trained properly to serve our own population. This is the task ahead for us, can we take the challenge? A golden opportunity is knocking at our doors. Shall we keep our ears shut?

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