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Migrating doctors

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Thirty-six percent of doctors working in the UK obtained their primary medical qualification outside the UK,[1] a greater proportion than any other European country. International medical graduates (IMGs) offer extraordinary service to the NHS; but how is it is that the world's fifth richest country by GDP[2] is so dependent on international doctors trained in countries whose health needs far exceed ours, whose GDPs are way below ours and who have contributed at least £15 billion to the UK economy in saved medical school fees.[3]

History provides clues, particularly with regard to migration from the Indian subcontinent. During World War I, 4,700 Indian medical officers and nurses were recruited along with 1.3 million soldiers (urged by Gandhi 'to share the responsibilities of the membership of the Empire').[4] Some stayed, and small numbers of doctors started to migrate to the UK from India and other British colonies. A significant turning point was withdrawal of General Medical Council (GMC) recognition of Indian medical colleges in 1930 following long-standing disagreements.[5] Without GMC recognition, Indian graduates could not work in the UK or British Empire. Recognition was re-negotiated but at the expense of Indian schools aligning their curricula with western practice even though this was seldom appropriate for the health needs and culture of the majority rural poor. Doctors could not fulfil their aspirations locally so emigrated to practice the medicine they had been taught and recoup costs. Migration led to more migration as students studied medicine specifically to work overseas.[5] By 1947, 1,000 Indian doctors were practising in Britain.[4]

In the 1950s, perhaps as now, there was disillusionment in the NHS and many UK-trained doctors emigrated; 7,000 left for the USA, Canada and Australia between 1952 and 1968.[6] The gaps, particularly in general practice and geriatrics, were filled by IMGs. By 1968, 88% of registrars in geriatric medicine were IMGs often with very poor training conditions. In 1961, Lord Taylor, himself a doctor, speaking in the House of Lords said:

> *They are here to provide pairs of hands in the rottenest, worst hospitals in the country because there is nobody else to do it… There is no nonsense about teaching in these places. Oh no!… the conditions are very often so bad for the residents that you cannot expect Englishmen to work there. That is a terrible state of affairs.*[6]

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Many were uneasy about the dependence of the UK on IMGs.[7] However, economic and professional factors continued to drive doctors from developing to developed countries and so long as UK junior posts were filled, there was little incentive to train more doctors.

The situation changed dramatically in 2002 when the number of IMGs coming to the UK rose exponentially, driven by exceptional UK salaries and an increase in graduates qualifying from overseas medical schools. Remarkably, the GMC rather than restricting places for the Professional and Linguistic Assessment Board (PLAB) exam, opened a new centre capable of processing 1,000 candidates a month. This resulted in IMG unemployment on an unprecedented scale. By 2005, IMGs were spending on average 16 months unemployed in the UK, and experienced graduates were having to make more than 500 applications to obtain a single pre-registration house officer post. Applicants for one post had wasted in total 800 'doctor years'; wasted in terms of professional development and time denied to their home country.[8] It was a shameful period for the leaders of a caring profession and a bleak one for IMGs.

The Department of Health's eventual response was to withdraw the permit-free training visa. Doctors would need to apply for a 'Tier 2' visa, which would only be issued if no UK or EU resident or doctor with 'leave to remain' satisfied the person specification for that post, regardless of merit. Applied retrospectively, it resulted in hardship to many – especially those who were part-way through their training – but it did end IMG unemployment.

What is the situation now? In 2012, surprisingly and despite a further decrease in permitted working hours, the Health and Education National Strategic Exchange recommended a 2% reduction in medical school places.[9] Taken together with today's Brexit fallout and the threatened exodus of junior doctors, the demand for non-EU international graduates is likely to increase substantially, sadly reminiscent of the medical carousel of the 1950s.

If our health needs are to continue to increase, we must train more doctors and also nurses, for whom the situation is even more critical. The recent promise from the Secretary of State of 'up to 1,500 extra graduates per year from 2018' is most welcome;[10] but how to manage for the next 10 years? Our current policies are unsustainable and risk harming fragile international health economies. The Department of Health developed a code for the international recruitment of healthcare professionals in 2001, reaffirmed in 2016.[11] However, few seem aware of the code, particularly in the private sector, and Public Health England's *Global Health Strategy 2014 to 2019* makes no mention at all of medical migration.[12]

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Doctors from lower and middle income countries have as much right as UK doctors to be trained and exposed to a high standard of medical practice. Our primary objective should not be limitation of mobility *per se*, but to ensure equity of healthcare. For junior doctors, the Medical Training Initiative scheme (MTI) set up by the colleges and Department of Health after withdrawal of the permit-free training visa is one such scheme. [13] Doctors are recruited into paid UK training posts under a time-limited 2-year 'Tier 5' visa. The Royal College of Physicians' (RCP) International Department facilitates the visa and GMC recognition without PLAB. Candidates are promoted by their home institution and interviewed overseas to assess clinical and communication skills and ensure, as far as possible, that it is their wish to return home after 2 years in the UK. Currently, 320 IMGs are sponsored and mentored by RCP under this scheme; a recent positive development has been the establishment of a university-based diploma in UK medical practice to give due recognition to the IMG's time in the UK.[14]

The drivers behind the MTI scheme are training and experience for IMGs, but the scheme also brings huge benefits to NHS trusts. It is a win-win scheme as reflected by the comments and deeds of international graduates on returning home, and by comments from employing trusts. In October 2016, a cap on the number of visas threatened to derail the scheme and drive trusts to recruit yet more doctors under the Tier 2 visa. Fortunately, the cap was lifted and the scheme continues, but many trusts still need to recruit under the Tier 2 visa. Doctors on Tier 2 visas can apply for indefinite leave to remain after 5 years, the opposite of the government's intention when it capped the Tier 5 scheme. Those on Tier 2 visas are also disadvantaged because their visa is dependent on them remaining in a paid post, and unlike Tier 5 doctors on the RCP-sponsored MTI scheme, they are outside the educational system, with no guarantee of training, supervision or career progression; a true lost tribe of doctors. Perhaps now is the time for Health Education England and the royal colleges to bring these doctors out of that educational wilderness.

As part of a responsible migration policy, UK doctors should be encouraged to volunteer to work or teach in resource-poor countries. Gaps in the service could be filled by doctors on the MTI scheme. Volunteering received a boost from the 2007 Crisp report[15] and many trusts have established links with resource-poor countries. The RCP's links with the West African College of Physicians, Myanmar, India, Pakistan and the Middle East provide opportunities for volunteer teachers. The benefits to the volunteer and the wider NHS are self-evident but the rigidity of the UK's training system has not lent itself to volunteering. Health Education England and the Department of Health have recognised this and established an NHS Volunteering Group to deal with revalidation, career progression and insurance.

Finally, we must recognise that doctor migration is not limited to movement between countries. The preference of doctors to work in cities leads to precarious under-provision in many rural areas. The financial rewards and kudos of, for example, an interventional cardiologist are likely to far exceed the pull of being a rural primary care physician even though globally the need for generalists far outweighs the need for specialists. It is the same in the UK where the GP and consultant doing the acute on call, on whose shoulders the health of the nation and the future of the NHS depend, are under threat because of recruitment problems. Whether by coercion, education, financial reward or medical student selection, we must address this perennial mismatch of human medical resources to patient need. At the same time we musts focus on our ethical responsibilities to international recruitment, particularly over the next 10 years before the new cohort of medical students comes on stream. ■

Conflicts of interest

The author declares that he has no conflicts of interest.

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