# Assisting international medical graduates applying for their first post in the UK: what should be done?

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**ABSTRACT – The number of international medical graduates (IMGs) passing the Professional and Linguistic Assessment Board (PLAB) examination was six times greater in 2004 than in 2000.This has resulted in unprecedented numbers of applicants for junior posts, with some attracting over 1,000 overseas graduates. The Royal College of Physicians working group on IMGs was established in 2004 to address the problems that face newly qualified IMGs. The group has ascertained and now publishes current levels of competition for junior posts in order to inform overseas graduates of the levels of competition they are likely to encounter. The group is seeking ways of selecting applicants when such large numbers apply for posts and is looking at ways of improving clinical attachments. The paper considers these and other difficulties that IMGs face when they first seek employment in the UK and discusses possible solutions.**

**KEY WORDS: clinical attachments, international medical graduates, junior doctor posts, overseas doctors, PLAB**

## Key Points

**In 2004, 6,392 international medical graduates (IMGs) passed the PLAB examination compared to 1,120 in 2000**

**The result has been unprecedented numbers applying for junior doctor posts, with at least eight posts attracting over 1,000 applicants in the past six months. The average number of applicants for medical senior house officer posts is now 288, and for medical pre-registration house officer posts 481**

**Publishing this information allows IMGs to make an informed judgement about when and whether to come to the UK**

**There is considerable scope for improving clinical attachment posts and for improving the selection of IMGs for definitive posts**

**The UK welcomes and will always welcome overseas graduates who constitute one-third of the junior NHS workforce, but they should not be disadvantaged because of lack of information on the current high level of competition for junior posts and the possibility of unemployment.**

The problem started around five years ago.[1] Remarkably, until then the supply of non-EU international medical graduates (IMGs) in the UK approximately matched the number of available junior posts. But no more. Since then there has been a six-fold increase in the numbers of IMGs passing the Professional and Linguistic Assessment Board examination (PLAB), with 6,392 passing in 2004, compared to 1,120 in 2000 (Fig 1). The reasons are not entirely clear. The Department of Health's (DH) overseas recruitment campaign for senior doctors, the opening of the General Medical Council's (GMC) PLAB examination centre examining up to 10,000 candidates per year, and the favourable pay and conditions of UK junior doctors compared to those overseas may all have played a part. The unprecedented numbers of applicants for junior posts, some now attracting more than 1,000 applicants (Fig 2), have resulted in considerable disquiet amongst overseas doctors.[2]

The UK has a duty at least to ensure that any period of unemployment for overseas doctors is kept to a minimum. Our survey of 870 curricula vitae of applicants for a pre-registration house officer (PRHO) post in February 2004 showed that IMGs spent on average 11 months unemployed between stopping work at home and obtaining their first post in the UK; half of this time was pre PLAB, half post PLAB.[3] Applicants for this one PRHO post alone had wasted 800 'doctor years'. One projection suggests that there will be between 3,500 and 6,000 unemployed overseas graduates in the UK by December 2005, compared to 500 in 2003.[4]

The GMC now surveys doctors one year post PLAB and, using the date of registration as a marker of the date of first employment and knowing the date PLAB was passed, can calculate the length of time unemployed.[5] Their figures, slightly more optimistic than ours (although of necessity reflecting events one year ago), show that 67% obtain a post within six months of passing PLAB. However, for many this first post may only be a locum post.

International medical graduates in 2002 made up 28% of hospital medial staff (Table 1),[6] and their welfare particularly concerns physicians. The GMC's post-PLAB survey found that 30% of IMG respon-

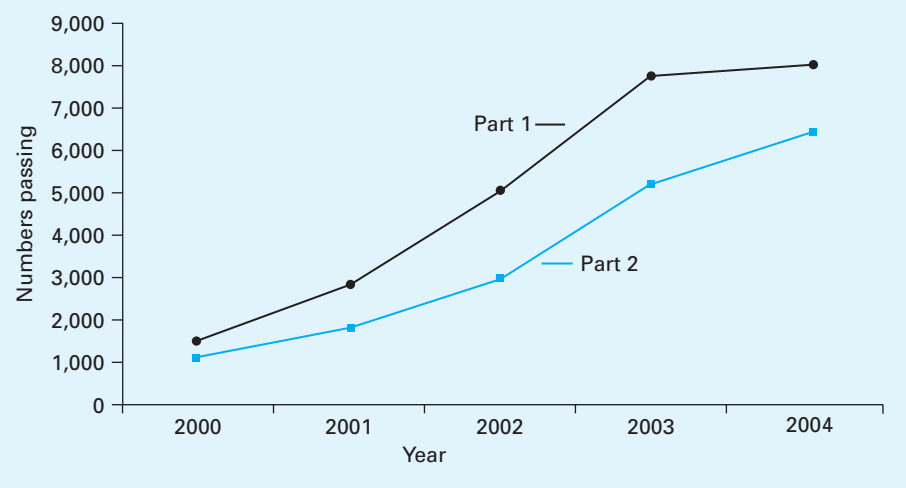


**Fig 1. Numbers of candidates passing PLAB part 1 and PLAB part 2 examinations between 2000 and 2005 (courtesy of General Medical Council Registration Directorate).**

dents obtained their first post in medicine and that, of the posts advertised as suitable for recently qualified IMGs, there were twice the number for medicine than for any other specialty[5] (Table 2). Our survey of applicants for a medical PRHO post showed that 76% of those who listed obtaining a postgraduate diploma as a reason for coming to the UK wished to take MRCP. Data from the examination office of the Royal College of Physicians show that 46% of those taking the final MRCP PACES exam in 2003 were IMGs.

In June 2004, the Royal College of Physicians set up a working group to address the problems facing newly qualified IMGs coming to the UK. This paper focuses on four issues discussed by the working group:

- competition for posts
- selection for shortlisting
- specific posts for IMGs
- clinical attachments.

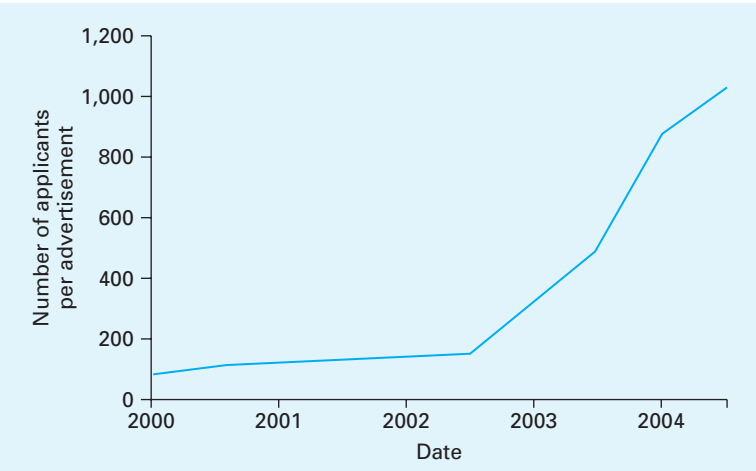


**Fig 2. Number of applicants for medical PRHO posts advertised in Darlington between January 2000 and October 2004.**

## Competition for posts

Here there has been improvement, at least in publicising the current levels of competition. The GMC's website emphasises that PLAB is not linked to appointment and now states that it could take a year or longer to find a first post.[5] The RCP working group obtained numerical data on current levels of competition for all posts suitable for post-PLAB IMGs. The results (Tables 2 and 3) are now available on the BMJ Career Focus website (www.bmjcareers.com/juniorcomp) and are regularly updated. A doctor will send off on average 227 applications if applying for a senior house office (SHO) post, 430 applications if applying for an advertised PRHO post. Competition is greatest for posts in Wales (Table 3). Posts in medicine, accident & emergency (A&E), and surgery are the most sought after (Table 2). Eight advertisements have attracted more than 1,000 applicants, 80 more than 500. A grant from the DH has enabled these figures to continue to be published regularly. When combined with the GMC figures for unemployment available on www.gmc-uk.org/register/default. htm, they should alert overseas graduates as well as employing authorities and the DH to trends in the number of unemployed graduates and the current competition for posts.

## Problems in selection

How does one select a shortlist from 1,000 applicants all with near-identical CVs? A recent SHO advertisement in BMJ Career Focus specifically stated in their advertisement that random methods might be used, and five trusts replying to the RCP questionnaire stated that only the first 100–200 applicants received were considered for shortlisting, the remaining CVs being discarded. Such methods are not satisfactory and will disadvantage talented UK graduates as well as IMGs. Could the mark IMGs obtained in PLAB part 1 be used as an indication of merit? Candidates not in the top 25% of PLAB part 1 might be less inclined to come to the UK if they were aware of the current very high number of applicants for posts and knew that their score would form part of the shortlisting process. However, the GMC are reluctant to change PLAB, arguing that it is a pass/fail exam to assess minimal competencies needed to work at SHO level, not to grade candidates. Nevertheless, if it were possible to give grades above pass reflecting the top 10 or 20% of marks at each sitting, it would offer one possible way of grading IMGs for the purpose of shortlisting. The grade may not be a fair way of judging whether an IMG will be a capable and caring doctor but would be preferable to the random methods currently used.

Could the first part of a postgraduate diploma be used as a mark of aptitude and knowledge? Our survey found that 10% of applicants for a medical PRHO post had already passed MRCP part 1 and a further 20% were taking the exam at the next sitting before the post commenced. Charges of discrimination could be levelled if the same criteria were not applied to UK graduates. In reality, for PRHO posts this situation rarely arises as there are few UK applicants for unfilled PRHO posts (the 1,090 applicants for PRHO posts advertised in Darlington starting in February 2005 did not include a single UK-trained graduate).

If the PLAB exam is not to be graded, then other ways of ranking IMGs on merit must be sought. One such method would be a more formal assessment of clinical attachments. For an able doctor, demonstration of skills during a clinical attachment often swings the balance in favour of appointment if a post becomes available in their hospital. However, this may just put the selection barrier back from definitive job to clinical attachment and still begs the question as to how one chooses candidates for clinical attachments.

If the trend of increasing numbers of applicants per post continues and if no solution to grading applicants is found, then, in the interests of transparency, the random methods of selection currently used in shortlisting applicants must be publicised. If random methods or any other method for shortlisting are used, then ideally these should be applied before graduates give up their jobs at home. This must be an important long-term goal. To achieve it would require a central regulatory body for IMGs, which is up-to-date on current job competition and likely vacancies, similar to that proposed by NHS Professionals (see below). Such an organisation would need to be respected by IMGs and employing authorities alike to prevent doctors bypassing it and applying straight to trusts. The equivalent in the USA, the National Resident Matching Programme (NRMP), has run for 52 years as a private not-for-profit corporation covering all resident programmes. Linked to this would be the desirability of holding the PLAB 2 exam (or equivalent exam) in the candidate's home country, to prevent candidates having to give up their posts at home to take the exam in the UK.[7]

**Table 1. Numbers and percentages of hospital medical staff who qualified outside the European Economic Area, September 2002.**

| | |
|---|---|
| All grades | 20,147 |
| *% of all grades* | *28* |
| Consultant | 4,712 |
| *% of all consultants* | *18* |
| Associate specialist | 1,057 |
| *% of all associate specialists* | *62* |
| Staff grade | 3,379 |
| *% of all staff grades* | *66* |
| Registrar group | 3,986 |
| *% of all registrar group* | *30* |
| SHO | 5,518 |
| *% of all SHOs* | *33* |
| House officer | 539 |
| *% of all house officers* | *14* |

Data from 2002 Department of Health *Statistical Bulletin 2003/04.*[7]

The financial implications of any central scheme need to be considered. A joining fee from IMGs could cover the costs with or without a surcharge on PLAB fees or on employing authorities. But should not the UK taxpayer fund the scheme? Ten thousand IMGs, all trained at the expense of overseas taxpayers, currently work for the NHS in training grades (Table 1). At today's prices, the UK taxpayer has saved over £500 million in medical school costs for these doctors alone. A small fraction of this spent on a central support scheme for IMGs would hugely improve their lot.

In reality, there is little prospect of a central regulatory authority in the short to medium term. The alternative, which the RCP working group is pursuing, is to publish a 'Black Box', warning of the current situation with regard to job opportunities in the UK. This factual warning (Fig 3) could be regularly updated, so that IMGs thinking of coming to the UK are at least informed of current job prospects.[8]

## Designated posts for IMGs?

Which posts should IMGs apply for? Some argue that they are too experienced to apply for PRHO posts but many do apply and in 2002 IMGs made up 14% of PRHO posts (Table 1). PRHO posts are seen as an excellent introduction to the NHS and give IMGs an advantage when applying for SHO positions. Hospital posts at all grades offer exposure to patients, their pathology and care. This bedside experience remains the great strength of UK medical education. Flexibility in the delivery of the additional formal teaching required should still allow PRHO posts (and Foundation Year 1 posts) to be of excellent educational value even for more experienced IMGs.

Numbers of trust posts (at both PRHO and SHO level) have mushroomed in recent years. Many are outside the umbrella of the Colleges and postgraduate deans, although often are of the same standard as recognised posts and rotate with them. Increasingly, IMGs are appointed to these posts and more may be appointed from 2005 when foundation posts will subsume most recognised junior SHO and PRHO posts into two-year training programmes. Few foundation programmes are advertised in the *BMJ* and application has to be made through individual deaneries' websites. It is disappointing that IMGs, who fill 30% of all training grades (Table 1), receive so little attention in published discussions on foundation posts. None of the postgraduate deaneries' websites cite examples of how and whether IMGs should apply. The West Midlands deanery has stated that they will provide opportunities for second-year foundation posts,[9] but to date this information does not appear on their website. Foundation posts must of necessity cater mainly for newly qualified UK graduates but allowances must also be made for the 30% of IMGs currently filling training posts.

The pragmatic approach is to accept the likely further increase in trust posts so as to maintain ward-based clinical services but to regulate them and designate them as stand-alone or linked posts tailored specifically for the educational needs of IMGs. Compared to UK graduates, there are many more IMGs in non-

consultant than in consultant, career grades posts, which is a significant pointer to the need for better training posts for IMGs (Table 1).

Historical manpower considerations have capped the numbers of approved SHO posts, but the recent growth of trust posts makes this totally anachronistic. Trust posts need to achieve the respectability they deserve and be awarded the educational rights and privileges so amply (and aptly) awarded to established SHO posts.

The UK medical school output is set to increase by 2,000 per year to 5,400 by 2008.[10] It is not known to what extent this will further squeeze the number of posts available for IMGs and indeed to what extent the UK will move to self-sufficiency in junior doctors. In 2002, there were 6,000 IMGs in SHO and PRHO grades (Table 1). Two thousand extra UK graduates per year would substantially reduce the posts available for IMGs if the numbers of SHO and PRHO posts stayed constant at 2002 levels. However, this is unlikely, as since 2002 extra demands caused by enforcement of the European Working Time Directive, part-time working and career breaks associated with rising numbers of female doctors, and increased numbers of acute hospital admissions, have significantly increased the need for junior doctors. In particular, numbers of trust SHO and trust PRHO posts not mentioned at all in the 2002 statistics have increased. However, if the number of posts available to IMGs does shrink it is even more important to monitor the competition for posts to prevent the number of unemployed IMGs rising still further.

## Clinical attachments

Clinical attachments are essential in introducing IMGs to the NHS. IMGs at present apply by letter, e-mail, telephone and in person, sometimes to hundreds of trusts and consultants without success.

Many physicians view clinical attachments as a drain on departments. They do, however, give consultants an oppor-

**Table 2. Mean number of applicants per advertisement and per post divided by specialty and grade of the post.** The figures apply to advertisements with closing dates between 1 June 2004 and 1 January 2005. Available on www.bmjcareers.com/juniorcomp

| Grade | SHO | | | Trust SHO | | | Foundation posts | | | PRHO | | | Trust PRHO | | | Average across all grades | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Specialty | No of adverts analysed | Average per advert | Average per post | Adverts analysed | Average per advert | Average per post | Adverts analysed | Average per advert | Average per post | Adverts analysed | Average per advert | Average per post | Adverts analysed | Average per advert | Average per post | Adverts analysed | Average per advert | Average per post |
| Medicine | 84 | 288 | 159 | 71 | 241 | 137 | 0 | – | – | 12 | 481 | 253 | 3 | 324 | 324 | 170 | 283 | 159 |
| Surgery | 59 | 240 | 137 | 37 | 117 | 80 | 0 | – | – | 8 | 241 | 152 | 4 | 484 | 401 | 108 | 207 | 128 |
| A&E | 19 | 631 | 350 | 17 | 315 | 118 | 0 | – | – | 0 | – | – | 0 | – | – | 36 | 482 | 240 |
| Anaesthetics | 34 | 156 | 74 | 9 | 62 | 23 | 0 | – | – | 0 | – | – | 0 | – | – | 43 | 136 | 63 |
| ENT | 27 | 139 | 95 | 8 | 74 | 64 | 0 | – | – | 0 | – | – | 0 | – | – | 35 | 124 | 88 |
| Haem/oncology | 11 | 132 | 105 | 9 | 116 | 114 | 0 | – | – | 0 | – | – | 0 | – | – | 20 | 125 | 109 |
| Inf diseases | 2 | 7 | 7 | 0 | – | – | 0 | – | – | 0 | – | – | 0 | – | – | 2 | 7 | 7 |
| ITU | 5 | 103 | 64 | 7 | 83 | 55 | 0 | – | – | 0 | – | – | 0 | – | – | 12 | 91 | 59 |
| Neurology | 1 | 32 | 32 | 3 | 14 | 14 | 0 | – | – | 0 | – | – | 0 | – | – | 4 | 19 | 19 |
| O&G | 47 | 130 | 77 | 13 | 110 | 62 | 0 | – | – | 0 | – | – | 0 | – | – | 60 | 126 | 74 |
| Ophthalmology | 14 | 129 | 92 | 2 | 40 | 40 | 0 | – | – | 0 | – | – | 0 | – | – | 16 | 118 | 86 |
| Orthopaedics | 30 | 249 | 159 | 45 | 201 | 105 | 1 | 40 | 40 | 0 | – | – | 2 | 182 | 120 | 78 | 217 | 125 |
| Paediatrics | 58 | 192 | 108 | 18 | 144 | 107 | 0 | – | – | 1 | 291 | 291 | 0 | – | – | 77 | 182 | 110 |
| Pathology | 8 | 93 | 80 | 0 | – | – | 0 | – | – | 0 | – | – | 0 | – | – | 8 | 93 | 80 |
| Plastic surgery | 5 | 215 | 148 | 4 | 55 | 39 | 0 | – | – | 0 | – | – | 0 | – | – | 9 | 144 | 100 |
| Psychiatry | 21 | 283 | 93 | 8 | 161 | 131 | 0 | – | – | 0 | – | – | 0 | – | – | 29 | 249 | 103 |
| Rotating posts | 5 | 412 | 126 | 2 | 157 | 157 | 8 | 478 | 63 | 5 | 613 | 91 | 0 | – | – | 20 | 463 | 95 |
| Urology | 4 | 253 | 253 | 12 | 100 | 82 | 0 | – | – | 1 | 552 | 552 | 2 | 275 | 275 | 19 | 174 | 163 |
| **Average across all specialties** | **436** | **227** | **128** | **268** | **171** | **101** | **12** | **396** | **45** | **27** | **430** | **205** | **11** | **347** | **306** | **754** | **219** | **122** |

A&E = accident & emergency; ENT = ear, nose and throat; Inf diseases = infectious diseases; ITU = intensive treatment unit; O&G = obstetrics and gynaecology.

**Table 3. Mean number of applicants per advertisement and per post divided according to geographical region of advertised post.** The figures apply to advertisements with closing dates between 1 June 2004 and 1 January 2005. Available on www.bmjcareers.com/juniorcomp

| Grade | SHO | | | Trust SHO | | | Foundation posts | | | PRHO | | | Trust PRHO | | | Average across all grades | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Region | Adverts analysed | Average per advert | Average per post | Adverts analysed | Average per advert | Average per post | Adverts analysed | Average per advert | Average per post | Adverts analysed | Average per advert | Average per post | Adverts analysed | Average per advert | Average per post | Adverts analysed | Average per advert | Average per post |
| East Anglia | 29 | 137 | 87 | 20 | 120 | 82 | 0 | – | – | 6 | 327 | 168 | 2 | 600 | 600 | **57** | **167** | **112** |
| London | 37 | 284 | 115 | 44 | 150 | 79 | 0 | – | – | 1 | 300 | 75 | 0 | – | – | **82** | **213** | **95** |
| Midlands | 66 | 227 | 131 | 51 | 165 | 79 | 2 | 425 | 38 | 3 | 652 | 271 | 2 | 375 | 210 | **124** | **217** | **113** |
| Northern | 108 | 248 | 146 | 68 | 175 | 123 | 4 | 394 | 43 | 8 | 470 | 206 | 3 | 361 | 361 | **191** | **236** | **142** |
| N Ireland | 5 | 97 | 42 | 0 | – | – | 0 | – | – | 0 | – | – | 0 | – | – | **5** | **97** | **42** |
| Scotland | 85 | 180 | 104 | 6 | 149 | 116 | 0 | – | – | 2 | 421 | 191 | 0 | – | – | **93** | **183** | **107** |
| South | 50 | 215 | 137 | 33 | 258 | 137 | 4 | 465 | 73 | 4 | 368 | 78 | 4 | 197 | 166 | **95** | **246** | **133** |
| South West | 27 | 255 | 133 | 30 | 151 | 87 | 0 | – | – | 2 | 256 | 256 | 0 | – | – | **59** | **202** | **114** |
| Wales | 26 | 340 | 191 | 12 | 189 | 110 | 0 | – | – | 1 | 804 | 804 | 0 | – | – | **39** | **305** | **182** |
| **Average across all regions** | **436** | **227** | **128** | **268** | **171** | **101** | **12** | **396** | **45** | **27** | **430** | **205** | **11** | **347** | **306** | **754** | **219** | **122** |

tunity to observe the skills of doctors and judge their suitability for locum or definitive posts in their own hospital. With the current number of IMGs passing PLAB, access to clinical attachments must be improved.

NHS Professionals for Doctors and the postgraduate deans have explored managed clinical placements for post-PLAB graduates with proposed four-month supernumerary attachments and a central clearing house for all graduates.[11] This initiative could allow a hands-on introduction to the NHS which would compare favourably with the present *ad hoc* 'observerships'. This vision, although ideal, will certainly not be in place to embrace the 7,000 graduates passing PLAB in the coming year. In the short term, clinical attachments must stay and, because of our dependence on IMGs, should remain *pro bono* (although some trusts are starting to charge).

A contentious issue is whether under existing arrangements post-PLAB clinical attachments should be offered fixed-term honorary SHO posts. If offered, GMC registration would follow and allow the doctor to be assessed in the workplace. Some members of the RCP working group felt that trusts should be encouraged to set up trial schemes with job plans similar to those shown in Fig 4. Some felt they could be exploitive. However, the posts would be supernumerary and time limited, and the benefit to the SHO would be that

**Fig 3. 'Black box' advice to prospective PLAB candidates.**

**The following information is important for all medical graduates thinking of coming to the United Kingdom to take part 2 of the PLAB examination.**

**It is issued on behalf of the UK Academy of Medical Royal Colleges.**

1. Competition for house officer and senior house officer posts in the UK is currently very high.
2. 36% of overseas graduates who passed PLAB part 2 in June 2003 were still unemployed 6 months later.
3. Your first post in the UK may only be a non-training, locum or honorary post.
4. There are on average 219 applicants for each junior doctor advertisement in the UK. Eight recent advertisements have attracted over 1,000 applicants.
5. Because of the very large numbers of applicants, varying, sometimes random, methods of selection are used to shortlist candidates.
6. There are on average 430 applicants for each house officer advertisement. Graduates who have not completed their house officer posts (or equivalent) in their home country may find it very difficult indeed to obtain a post in the UK.
7. The UK welcomes and will always welcome overseas graduates. However, it does not wish them to be disadvantaged because of lack of information on the current very high level of competition for junior posts and the long periods of time that they may spend unemployed.

**This information is accurate as of January 2004. Further up-to-date details on unemployment and competition for junior doctor posts are available on http://www.bmjcareers.com/juniorcomp and http://www.gmc-uk.org/register/default.htm**

the post would provide more training and experience than clinical assistant posts currently do. A formal UK reference could be obtained and at the end of their time candidates could progress straight to FY1 or FY2 posts according to ability. If a short-term locum post were to come up in their hospital, the probationer, already with existing GMC registration, could apply and if appointed be remunerated. The service commitment, especially at the beginning of the post, would be small and less than that offered by an experienced SHO and would be little more than that necessary to assess competence and application.

The advantage to trust and deaneries would be that SHOs could be much more fully assessed in the workplace and at the end of the post placed appropriately according to their ability. Only by testing such a scheme would one know whether there would be demand for it and whether it would be successful in its educational objectives.

Extrapolating from the RCP 2003 Census,[12] around 3,000 consultants have regular on-call commitments. Even if all newly registered IMGs did a medical rather than surgical attachment each consultant need only have two clinical attachments per year and fewer if the numbers of IMGs decreased. We should encourage our colleagues and trusts to take on clinical attachments and explore the issue of honorary probationary SHO posts.

**Fig 4. Suggested framework for honorary clinical probationary posts.** ACLS = Advanced Cardiovascular Life Support; ALERT = Acute Life Threatening Events – Recognition and Treatment.

1. Time limited to three months.
2. Named consultant educational supervisor.
3. Named SHO mentor.
4. Tailored induction programme.
5. Educational structure as for existing SHOs with learning portfolio and self-directed learning agreement with attendance expected at departmental educational meetings.
6. Agreed trust- or deanery-financed study leave to attend local ACLS and ALERT courses, and local courses for post-graduate exams and deanery introductory courses for overseas doctors.
7. Duties of the post to be timetabled with expectation of attendance.
8. Formal assessment at the end of the post.
9. Typical duties for a medical post to include:
   - a Clerking, diagnosing and managing patients on the medical admission unit in the role of supernumerary SHO.
   - b Undertaking procedures with level of supervision tailored to candidate's experience (eg venesection, arterial puncture, etc).
   - c Clerking new outpatients under consultant supervision.
   - d Attending ward rounds.
   - e Attending procedures relevant to training needs (eg endoscopies, exercise testing, echos, radiological tests).
   - f Attending multidisciplinary meetings.
   - g Attending and assisting at cardiac arrests.
   - h Defined on-call commitment with SHO cover.
   - i Continuing responsibility at junior level for a cohort of inpatients within a firm based structure; to include their admission, management, discharge arrangements and discharge summary.

## Conclusion

International medical graduates face many difficulties when applying for their first post in the UK. They have no central advisory body to turn to before leaving their home country; they are shortlisted (or not shortlisted) by random methods of selection; and they spend long periods of time unemployed while waiting for their first post in the UK.

There are no easy solutions. In the short term, publicising lengths of unemployment and levels of competition for junior posts should give a more realistic view of current job prospects in the UK. In the medium term, the establishment of structured clinical attachments would allow post-PLAB IMGs to be assessed in the workplace and would be preferable to the present unstructured clinical observerships suitable mainly for pre-PLAB candidates. Honorary probationary SHO posts should be considered and tested in trial situations. Trust posts should be developed with the same educational structure as SHO posts and the flexibility to suit the varying educational requirements of IMGs.

In the longer term, consideration should be given to a central body to assist IMGs at all stages, from the time that they first consider coming to the UK through their application for PLAB to obtaining their first post in the UK. Who should run or fund such a body needs much discussion. What is not acceptable is for IMGs to give up their posts at home and commit considerable financial outlay only to face an uncertain future and the likelihood of long periods of unemployment.

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