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Clinical attachments in psychiatry

This article discusses the history of clinical attachments in psychiatry and recent changes in this area, including work permit regulations, which can make it increasingly difficult to obtain an attachment. The advantages and disadvantages of clinical attachments are considered for both the clinical attaché and the UK health service. Good practice points for clinical attachés and their supervisors are presented. The future of the scheme is discussed and potential solutions to difficulties are suggested.

What is a clinical attaché (sometimes known as honorary senior house officer (SHO), clinical fellow, or honorary fellow)? One commonly held view is that clinical attachés are overseas doctors who gain unpaid work experience in the high-quality National Health Service, in the hope of then gaining paid employment and training and skills to eventually bring back to their country of origin. An alternative view is that they are doctors, wealthy in their home countries, who desert their needy compatriots in order to earn lots of money and settle permanently abroad, working in a system that is happy to asset-strip poorer countries. Similar arguments rage regarding the NHS International Fellowship Scheme (Khan, 2004; Holsgrove, 2005). The reality may be somewhere in the middle of these polarised views.

The exact number of doctors seeking clinical attachments is unknown, but many hospitals and consultants receive hundreds of applications annually. This high figure is because of the potential rewards if successful, and perceptions abroad that the NHS is short of junior doctors (advertisements in foreign newspapers for doctors in the UK may encourage this view). Changes in registration procedures and to the Professional and Linguistics Assessments Board (PLAB) examination (including overseas sittings) by the General Medical Council (GMC), and profits made by the GMC and some trusts may be factors in encouraging applications.

Anecdotal evidence suggests that many aspiring clinical attachés are unaware of the true picture in terms of how difficult it is to be successful; 'failed' doctors are reluctant to give the true reasons for their return home, and doctors may be blinded to the reality by their own hopes (Alcock, 2004).

Currently, clinical attachments in psychiatry are obtained predominantly through personal contacts in the UK. Doctors also try their luck by sending curriculum vitae to unknown consultants or medical staffing departments. There is much variability among hospitals and consultants; some take no clinical attachments (and may have policy accordingly), some take a few, some perhaps take too many. There are no national standards, although there are guidelines (Cheeroth & Berlin, 2001). In some hospitals there may be formal or informal procedures, waiting lists, or structured schemes for clinical attachés.

Benefits for clinical attachés

The primary purpose of clinical attachments is to provide overseas doctors with experience of the NHS and how psychiatry is practised in the UK. They are also opportunities to enhance curriculum vitae, thereby improving the attachés' prospects of getting paid employment (Berlin *et al*, 2002). Clinical attachments give overseas doctors opportunities to improve aspects of practice that may be emphasised more in the UK than in overseas training systems.

The benefits for individual doctors in terms of career prospects in the UK and elsewhere, remuneration, opportunities for family members to live in the UK, etc. must also be borne in mind.

Benefits for trusts, the NHS and others

Any experience and skills gained by clinical attachés benefit patients in the UK if those doctors go on to work in the UK. More tangible benefits for trusts include the ability to recruit into SHO posts from current and past clinical attachés; it is clear that the informal knowledge of these candidates gained during their time as clinical attachés by members of interview panels can affect who is called for interview or offered a post. Another clear benefit for trusts is that clinical attachés constitute a pool of doctors willing, indeed often desperate, to do locum work. This helps trusts fill service gaps and adhere to the European Working Time Directive, and provides cover for leave taken at short notice. There are cost savings for the state, as the NHS can increase the medical workforce quickly and relatively cheaply.

Problems for clinical attachés

Getting an attachment is largely a result of persistence, luck and help from consultant or junior doctor friends. Many doctors lament that they had to wait months to secure an attachment, or that responses to enquiries to medical staffing departments were usually discouraging.

The difficulties continue even after securing an attachment; there is ongoing uncertainty owing to the short-term nature of contracts offered, periodic visits to the Home Office for expensive visa extensions, pressure to get paid employment and get accepted onto a training scheme, and financial pressures. Attachments are by no means guarantees of future employment. The cost of living (especially accommodation) in the UK is high, and people with short-term visas and no employment contract find getting a private rental contract difficult. The practice in some trusts of charging for attachments is in our opinion undesirable, especially as the quality of the experience offered is often no better as a result, although

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Box 1. Comments from clinical attachés and those who work with them

Comments from clinical attachés

- I have sent applications to at least 100 or 200 consultants
- I'm living on borrowed money
- I paid £400 for a 4-week clinical attachment in London
- One of the reasons for charging may be to use it as a deterrent for many people sending their applications
- I spent most of my time travelling to out-patient clinics and meetings and hardly any time speaking to patients on the ward or understanding the functioning of the multidisciplinary team. There were no learning objectives or plans and thus no feedback or any meaningful educational supervision was possible
- I spent most of the time in the hospital library
- I was asked to do an audit by my supervising consultant during a 6-week attachment . . . I reviewed roughly around 900 case notes working for 9–10 hours a day [and] successfully completed the audit. However, the consultant refused to give me a reference, stating that he did not observe any clinical skills!

Comments from consultants

- I get a few applications every week. They go straight in the bin, I don't even read them
- Five consultants [of a total of 50] are willing to supervise the clinical attachés
- No 'these poor doctors'. They've had volition enough to get and pay for a flight and leave their country and get on a plane and find somewhere to live and tout around by letter. They take a chance but sometimes it doesn't work out

Comments from others

- I get very annoyed by clinical attachés constantly asking to 'sit in' when I'm seeing patients; they never contribute anything and I have to spend lots of time answering their questions, never mind the doctor–patient relationship, or what the patient thinks! (specialist registrar)
- He fell asleep in one ward round (specialist registrar)
- I was on placement with a firm that had a couple of clinical attachments. It was rubbish for me because they wanted to do everything that I was supposed to be doing and learning (medical student)

we accept that such fees are legal and are dictated by market forces.

Attachments vary in quality; there are many instances of attachés being mistreated in various ways (see Box 1), not least because of their dependence on the sponsoring consultant. Some consider that even the best attachments are not meaningful experiences, owing to limitations on patient contact, inadequate teaching from SHOs and senior doctors, the pressures noted above and the steep learning curve in general.

Problems for trusts, the NHS and others

Many mental health trusts are reluctant to accept clinical attachés because of the costs of processing applications, providing accommodation and pre-employment screening. Clinical attachés are sometimes perceived as unreliable, for example not turning up when expected, leaving with little notice and not paying bills. Trusts may be reluctant to provide training for a doctor without guarantee of any reciprocal benefit.

Medical and other students may receive fewer educational opportunities if clinical attachés are also present (bearing in mind that clinical attachés should not see patients alone).

Individual consultants may have little experience of clinical attachés, or may have ethical objections to recruiting from poorer countries. Doctors from different countries may not have equal opportunities to gain an attachment. Some believe there is an 'old boys network'; there are reports of consultants accepting as attachés only doctors who have graduated from the consultant's own alma mater.

Impact of recent changes in immigration regulations

Until 3 April 2006 doctors in training did not require work permits to train in the UK. From this date the only doctors who will be covered by the permit-free arrangements are those who have completed their medical degree in the UK and have been appointed to a 2-year foundation programme. In making appointments, doctors from other European Economic Area (EEA) countries must be considered for posts along with UK applicants. A post must be offered to an adequately qualified UK or EEA doctor even in preference to a better-qualified overseas doctor. If recruiting overseas doctors, NHS trusts will have to show that a sufficiently qualified UK or EEA national was not available to fill a post. These measures introduce a two-tier system of recruitment, heralding the demise of the meritocracy in appointing doctors.

Doctors who have leave to remain under the Highly Skilled Migrant Programme can still take up any posts offered, without the need for Home Office permission.

Following discussions with the Department of Health, the Home Office has decided to limit the amount of leave granted for clinical attachments to 6 weeks at a time and 6 months in total, in line with the purpose of these posts, to allow overseas doctors to familiarise themselves with UK working practices and prevent overseas doctors remaining in the UK when there are no suitable posts available.

Predicting the future is difficult in the light of these changes, but it is clear that opportunities for overseas doctors will be fewer because of increased competition from EEA doctors. The current flood of applications for clinical attachments is likely to become a trickle, but is unlikely to dry up completely in the immediate future.

Solutions

Clinical attachés and supervisors would benefit from some of the good practice points suggested below.

Good practice for clinical attachés

- Think carefully before you come to the UK.
- Do an induction course for international doctors (e.g. the 1-day course conducted by the Royal College of Psychiatrists and Institute of Psychiatry in London

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(for details contact the Overseas DoctorsTraining Committee, Royal College of Psychiatrists).

- Be clear from the start about what you want to achieve during the attachment.
- Understand what you are not allowed do.
- Develop social networks for support, among other attachés as well as SHOs.
- Shadow doctors and other team members.
- Conduct an audit project and present the results.
- Attend and present at teaching sessions (e.g. case presentations, journal clubs).
- Learn about the structure of psychiatric training in the UK.
- Prepare for job interviews.
- Work hard to ensure that you gain a good reference from your supervising consultant.

(see Prabhu, 2004; Mahboob, 2005).

Good practice for supervisors

- Consider why you are accepting a clinical attaché.
- A named consultant should take responsibility for the clinical attaché; experience and understanding of the needs of overseas doctors is obviously beneficial.
- Prior to the commencement of the attachment, meet the attaché for an informal interview to ensure that both have clear shared expectations.
- Set clear tasks, goals and learning objectives.
- Give regular structured feedback.
- Ensure that the doctor gets a depth and breadth of opportunities for learning.
- Consider organising formal teaching or weekly supervision directed towards the attachés' training needs (these might range from pastoral care to learning about the Mental Health Act 1983 to writing a curriculum vitae).

(see Department of Health, 1995; Turya, 2004).

A system of placements administered centrally by the Royal College of Psychiatrists would make the application process simpler (and cheaper). The College could monitor supervision and run some form of appraisal, perhaps using systems similar to that which is currently in place for SHOs. This would ensure some quality control and prevent some of the problems listed. Alternatively, and more simply, the College could maintain a register of attachés (who have passed the PLAB examination) and a register of consultants willing to take attachés.

If the system of clinical attachés is worth maintaining, there should be formal incentives for those consultants involved.

The NHS could draw up clear guidelines regarding charging for attachments; placements should be free for medically qualified refugees (Department of Health, 2000).

Information is required on what happens to these doctors (i.e. how many come to the UK annually, what proportion enter training schemes, what proportion return home disappointed, etc). The College could consider research in this area.

Declaration of interest

R.O. is the Immediate Past Chair and S.N. was a member of the Psychiatric Trainees' Committee, Royal College of Psychiatrists at the time of writing.

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