MEDICAL SERVICE WITHIN THE COMMONWEALTH AND OTHER COUNTRIES OVERSEAS

BY

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1. The following communication, in the main, embodies a new deal for doctors going from the United Kingdom and other Commonwealth countries to serve for a period in the developing countries within the Commonwealth and also outside it. The biggest contribution which employing authorities, such as regional and hospital boards, universities, and general practice, can make is in applying a code of secondment and in treating a period of overseas service as an asset to promotion prospects in the medical services rather than the reverse. Acknowledgment is made to the Commonwealth Education Conference, and the Ministry of Education (Circular 10/60, 1960) for many of the ideas concerning recruitment of teachers for overseas that have been incorporated herein.

The Challenge

2. All look forward to the day when the greater part of the traffic of medical officers within the Commonwealth (and other countries) will be on the basis of full reciprocity, and when each country will be able to develop its own medical services to a point independent of outside help. However, at the present time short-term assistance is required by the underdeveloped countries both in the training and in the supply of medical personnel and auxiliaries, which needs are complementary. In order to ensure that the resources available are used to the best advantage, it is recommended that efforts should be diverted primarily to (a) filling some key posts in developing countries with personnel from other countries more favourably placed, and (b) training in the latter countries postgraduate and undergraduate students who would themselves fill key posts on their return to their own countries.

3. The Commonwealth, and particularly the United Kingdom, has both an opportunity and a duty to help, not only on grounds of humanitarianism and brotherhood, but as part of a policy leading to the further development of the Commonwealth idea and all that that implies. The Government of the United Kingdom (and other favourably placed governments such as those of Australia, Canada, and New Zealand) should offer more undergraduate and postgraduate places at university and technical level, with bursaries for the students filling them. On the supply side the Government should stimulate the recruitment of United Kingdom medical officers for service overseas and, in particular, should take financial and other measures to encourage recruitment. Apart from university posts, the need is largely for general-duty officers, both in hospitals and in polyclinics, on short-term contracts for from two to five years.

4. In addition to the Commonwealth, the continuing needs of foreign countries must be borne in mind. It is very much in this country's interests to help some of the countries which are trying to build up their medical services and wish to recruit British doctors—for example, Iraq, Persia, Sudan, Egypt, Colombia, Indonesia, etc.

The Difficulties

5. The call to give help comes at a time when there is a substantial shortage of doctors to meet the immediate needs of the people of the United Kingdom. At the present time many foreign nationals are employed as house-officers and registrars in the non-teaching hospitals owing to the shortage of suitable British personnel, and the Willink Report has induced a climate of retrenchment rather than of expansion of the numbers to be medically trained in this country. Notwithstanding this position, however, a small number of recruits to the key posts of the medical services overseas would represent an accretion to the strength of such services that could make an impact out of all proportion to the number involved, whereas such a number in the United Kingdom is marginal in relation to the total; it should be remembered that in the United Kingdom there is 1 doctor to 900 of the populace, whereas in Uganda it is 1 to 18,000; in Tanganyika, 1 to 22,000; and in Ghana, 1 to 25,000.

6. It should be possible to find some additional doctors by a redeployment or a stimulation of existing efforts. A substantial number of doctors have been going annually to take up posts in the Commonwealth overseas, but most of them have gone to one or other of the older independent countries. There will always be scope for exchange schemes and other forms of two-way traffic within the Commonwealth, but it is hoped that these countries will recognize that their need to recruit doctors from the United Kingdom is now *less urgent* than that of the developing countries.

7. Perhaps the main difficulty lies in giving doctors a feeling of confidence that if they serve for a period overseas their interests will be safeguarded before, during, and after their service, and they and their families will receive recognizably fair treatment. Examples are as follows:

(a) Expatriates overseas lose their place in the queue for promotion. The "out of sight, out of mind" attitude unfortunately prevails.

(b) Expatriates are not given time in which to apply for posts in the United Kingdom. Examples which can be culled from the medical press are of regional and hospital boards who require only two to three weeks for the receipt of applications after the appearance of the advertisement.

(c) Facilities for interview of short-listed applicants who are expatriates are almost non-existent. Indeed, in several cases the short-listed applicant has been out of pocket to the tune of several hundreds of pounds. Further, the fact that an applicant is an expatriate has on occasion militated against his being short-listed.

(d) If an expatriate is successful in obtaining a consultantship in the United Kingdom, no matter his seniority or high professional status overseas, he can only be credited with a maximum of four years' seniority with the National Health Service, and that as a matter of grace.

8. Although some provision for the continuation of technical aid by the transference of Commonwealth Development and Welfare Funds, etc., to emergent colonial territories has now been made, territories such as Ghana have been cut off without any continuing assistance such as they enjoyed when dependent territories. This would seem harsh.

Measures Proposed

9. A fresh examination must be made of the needs of the medical services in the developing countries, so that

the extent of the problem can be assessed. Concurrently, an investigation into the needs of doctors going overseas, and into the difficulties of regional and hospital boards and universities in releasing them and in giving a firm undertaking about re-employment on return, must be instituted.

10. These investigations, which together should form an integrated scheme, should incorporate: (a) A Commonwealth medical council for the supply of officers overseas, with a secretariat in London. (b) National councils in the various countries of the Commonwealth. (c) A code of secondment. (d) A code for terms of appointment overseas. (e) Special allowances to augment where necessary the emoluments provided by the overseas employer and to cover additional expenses incurred in going and living overseas. (f) Terminal grants at end of contract, to provide a lump sum on return to this country. (g) A fund to assist doctors to return to the United Kingdom (or native country) for interview if they are short-listed for posts due to fall vacant at about the time that their overseas service will end.

The main outline of the above is given schematically as follows:

11. A Commonwealth Medical Council for the Supply of Officers (and Auxiliary Personnel) Overseas

(a) It would seem essential that some central machinery be instituted through which the interested bodies can regularly discuss common problems, work out solutions, and co-ordinate action. The Council will bring together the main partners concerned in recruitment and resettlement. It will not itself undertake recruitment but will assist recruitment in a variety of ways and seek to promote a climate of opinion in which a period of service is regarded as an asset by the various employing authorities in the constituting countries. As the Council's terms of reference are in the field of policy-making and inspiration, and are to be likened to the Crusades of former days, it would perhaps be appropriate to suggest the President of the British Medical Association as its Chairman and instigator. Other members would be representatives of other Commonwealth countries, including the Presidents of the various Royal Colleges.

(b) Initially, a secretariat consisting of a full-time secretary and staff should be instituted in London. The duties will be the bringing together of the interested parties, and the implementation of the policy of the Council so that secondment to underdeveloped countries and training of nationals from these latter countries may be expedited.

12. National Councils for the Supply of Officers Overseas

Such councils will co-ordinate policy and action at the national level and will be constituted by representatives of the Ministry of Health, the universities, and the

various Royal Colleges, including the College of General Practitioners and other interested bodies. Initially, the secretariat mentioned in 10 (b) may be used in the United Kingdom.

In the United Kingdom the National Council should co-operate with the Inter-University Council for Higher Education and the British Postgraduate Medical Federation with a view to co-ordinating the training of Commonwealth and foreign nationals in this country in the field of postgraduate, undergraduate, and technical education.

13. A Code of Secondment

This should be a code of the terms which would allow the release of doctors for service overseas and their re-employment on return. It is suggested that the code should embody the following proposals:

(a) The employing body will second the doctor concerned for a period of two to three years (with possible extension up to six years), and will undertake at the end of that period to secure his reinstatement, if desired, in his former post or a post comparable to it, with consequential increase in salary and promotion in accordance with the passage of the years overseas.

(b) Where a doctor on secondment while still overseas applies for a post, his application will be considered fairly without interview on the basis of reports obtained from his former employers and also his overseas employer, on equal terms with applicants who are available for interview, unless the doctor's absence has greatly exceeded three years.

(c) In the case of senior posts, such as consultantships in the National Health Service and university senior lectureships, the applicant, if short-listed, should be assured of a return passage for the interview (by air).

(d) Although employers in this country will attempt to reinstate the returned doctor in his former post or one comparable to it (with due incremental salary or promotion consistent with the passage of the years), it may be impossible to guarantee this. Until this is done the returning doctor should be guaranteed for a period of up to two years the salary (with due increments) he would have been receiving had he remained in this country throughout.

14. A Code of Terms for Applicants Overseas

The code of secondment suggests ways in which employing authorities in the United Kingdom may help doctors before, during, or after his service overseas. It is no less important that the overseas employer should play his part by providing satisfactory conditions, both personal and professional, while the doctor is in his overseas post.

The United Kingdom cannot directly exercise control over employers in other countries, but the Commonwealth Medical Council should be able to help by drawing up a code as a guide both to the doctor and to the overseas employer, setting out the points that ought to be covered in contracts and conditions of appointment, and the points on which information should be available to doctors before they accept appointments.

Particular subjects which come to mind are: (a) Up to date and accurate estimates of the cost of living. (b) Guarantees of free time and facilities for research in the case of university personnel. (c) Specific arrangements for housing doctors' families and accurate assessment of the local facilities for education. If the latter are deficient, generous allowance for the education of children in the United Kingdom (or native country) and arrangements for annual leave to the United Kingdom of family (by air). (d) Possible special allowances to cover expenses incurred in going and

living overseas. (e) Possible terminal grants at the end of contract. (f) Generous but clearly defined contracts concerning money allowed to be sent back to this country and generous income-tax arrangements such as are enjoyed by United Nations personnel.

Conclusion

15. Many authorities in this country are endeavouring to stimulate recruitment among doctors for overseas service, and many hospitals, both teaching and non-teaching, are helping in the training of Commonwealth and foreign nationals.

Due acknowledgment of the very fine efforts of the Missionary Societies, W.H.O., the British Council, the universities, the Inter-University Council for Higher Education Overseas, the Overseas Committee of the B.M.A., the Overseas Medical Service, the Overseas Settlement Bureau, the British Postgraduate Medical Federation, the various Royal Colleges, and the various regional and hospital boards is hereby given. However, their efforts are not enough and are extremely uncoordinated.

16. It would seem that some impetus should be given at a high level so as to infuse nationally a spirit of service and dedication to Commonwealth development, so that service overseas (as of yore) was part of the pattern of the national life, as reflected in Medicine. To do this it is felt that a crusade should be started with its head the ex-president of the B.M.A., the Duke of Edinburgh, and its convener, the present President, with the co-operation of the Presidents of the various Royal Colleges.

Medical practice overseas means more than giving essential services to developing countries; it embodies the development of a culture which, dearly wrung from the past centuries, may afford a signpost for a new world.

APPENDIX A—A CODE OF SECONDMENT

17. Universities

Universities may second under various schemes which are inter-related.

(a) By the provision of supernumerary personnel to departmental staffs so that there may be a procession of lecturers to similar departments overseas. This would remove the fear of insecurity with regard to promotion and re-employment on return to this country. This was recommended by the University of London in 1951 but has never been implemented.

(b) By secondment from within the existing establishment of university departmental staffs. This has already been done at the Royal Free Hospital School of Medicine by appointing two lecturers at the same time for a combined lecturership to be held at the Royal Free and at University College, Ibadan. One candidate has proceeded to Ibadan for two years and the other works in London; after two years they interchange; on the fifth year they both work in London. Because of the numbers of staff employed and long-term planning of similar secondments overseas, no difficulty will be experienced in the re-employment of the "extra" lecturer returning for the fifth year.

(c) Proleptic appointment: It would seem appropriate with quinquennial estimates formulated some years ahead to arrange for the redeployment of members of the existing staff who have been earmarked for promotion. For example, a junior lecturer who has all the hallmarks of the future senior lecturer within the department may be seconded overseas for two to three years prior to his promotion to that post which has been proposed and accepted within the

quinquennial estimates. There should be no difficulty in filling his lecturer's post in the interim.

(d) Universities may adopt universities in the developing countries *in loco parentis*. This is already taking place in the American sphere of influence—for example, Indonesia—and also in the British—for example, Birmingham and the University of Rhodesia and Nyasaland. Further, departments can adopt departments *in loco parentis*. This is being done partially at the Great Ormond Street Hospital for Sick Children, which regularly sends a registrar to Makerere College, Uganda.

18. Hospital Service

Although a scheme is in existence for the secondment of N.H.S. personnel to countries overseas, in only a few instances have these facilities been taken up. The reason for this is the general climate of insecurity mentioned in paragraph 7, and the reluctance on the part of regional and hospital authorities to concern themselves with matters other than those within their immediate sphere of influence.

It would seem that if there was a spirit of real endeavour to help within the N.H.S., such as is at present inspiring the Ministry of Education in this country (Appendix B), then modifications of secondment (supernumerary and within the establishment), proleptic appointment, and adoption *in loco parentis*, as is suggested for the universities, may be effective.

19. General Practice

At present in this country it would seem that the pattern of recruitment for general practice is the appointment of trainee general practitioners immediately after the pre-registration appointment of newly graduated doctors. It would seem not unreasonable if newly qualified doctors may be allowed to serve a period of two to three years after pre-registration in polyclinics or in hospitals overseas. This would gain support if they were assured of posts on their return to this country.

Although it may be said that these newly qualified doctors are inexperienced, this is only relatively so, and the situation should be judged on the grounds that the needs of the developing countries are desperate.

The overseas countries would be helped until such times as they have sufficient of their own nationals to man their own services, and British medicine would be the richer on the return of those young doctors after a period overseas.

It is suggested that recruitment for general practice may be organized under the aegis of the College of General Practitioners so that there is a "pool" of young postgraduate general practitioners either serving overseas or having returned to this country after a period overseas. Admittedly the difficulties embodied in this proposal are many, but they are not impossible of solution.

APPENDIX B

20. The Commonwealth Education Conference held at Oxford in 1959 drew attention to the shortage of teachers in some Colonial territories and other developing countries of the Commonwealth.

In 1960 the Ministry of Education allocated a sum of £700,000 annually for the recruitment of 400 teachers for overseas and instituted a National Council for the Supply of Teachers Overseas (in conjunction with similar authorities in Scotland and Northern Ireland). In 1960 Circular 10/60, incorporating details of a

suggested Teaching Service in the Commonwealth and other countries, was published.

Much of the material covering this memorandum on the proposed "Medical service within the Commonwealth and other countries overseas" has been based on this Ministry of Education Circular 10/60. Acknowledgment with thanks is here given.

POSTGRADUATE EDUCATION IN THE FIELD OF RHEUMATISM AND ARTHRITIS IN THE U.S.A., 1960

BY

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This review is based on a period of four months in the U.S.A., spent for the most part at Bethesda by invitation of the National Institute of Arthritis and Metabolic Diseases and with visits to research centres and university departments of medicine in Washington, Pittsburgh, New York, Baltimore, Durham, Birmingham, Dallas, New Orleans, Boston, Cleveland, Chicago, and Los Angeles, undertaken with the assistance of the Wellcome Research Travel Fund and the centres concerned.

Comparison with the educational programme in Great Britain must take into account two major differences between the countries: firstly, the rather different structure of undergraduate and graduate education in the two countries; and, even more important, the very great difference between the two countries in the organization of medical services to the public.

Undergraduate and Graduate Education

Before receiving a doctorate of medicine, the American student has usually spent four years in university and four years in medical school: his school-days have not in general resulted in as quite a high level of education as do English private schools, but this difference is made up by the time of entry to medical school. After the M.D. examination he may spend a year as an intern (house-physician) before taking his State examination. For intending specialists there follows five years' training in an approved centre or centres before he is allowed to take his specialty board examinations (corresponding to our M.D. or M.R.C.P.). This is made up of two to three years as resident (registrar) and then two to three years as a research fellow or in specialty practice. The 19 specialty boards are composed of representatives of the American Medical Association and of the National Specialist Societies. There is no specialty board in rheumatism, which is included mainly with the specialty of internal medicine. Although many members of the American Rheumatism Association do not have specialty board qualifications at all, a number possess these in the fields of internal medicine and a few in the fields of physical medicine, pathology, or orthopaedic surgery.

A specialty board qualification is not necessary for appointment to academic or hospital posts, particularly in the more renowned centres, but it is desirable in any event and usually necessary for appointments to smaller

hospitals, etc. There are large differences between the calibre of students accepted at different universities, but in general the just-qualified M.D. is probably similar to his M.B., B.S. counterpart in England, knowing perhaps a little less of clinical evaluation and a little more of laboratory diagnosis. Demand for doctors as a whole is increasing fast because of the increase in population.

Organization of Medical Services

The second major difference between the two countries is in the organization of care. In England this is a Government responsibility; in the States, consultant services are sponsored by individual consultants themselves (private practice) often with part-time hospital appointments, by private hospitals and clinics, by private or State university hospitals, and by Government agency only in small part (in the Veterans Administration Hospital and the Public Health Service). The majority of consultants are therefore chosen by private hospital or university boards, and there is no overall control of specialty categorization or of the numbers of specialists in any one specialty field or in any one area. In this system of private enterprise, therefore, the outlet for specialists in any particular field depends primarily upon demand and usefulness.

Rheumatism has become very much more important over the last 10 years as a specialty field: although not being rigidly defined, the university specialists are usually to be found within the department of medicine, but they may also be in paediatrics, pathology, or biochemistry. Thus membership of the American Rheumatism Association has increased from 876 in 1955 to 1,283 in 1959. In 1960 there are 1,350 members in 44 states. These numbers are related to a total population of 180 million and a total medical population of 210,000. In 1955, American Rheumatism Association members were found in 40 of the 48 States (as well as in D.C., Puerto Rico, and eight Canadian provinces) and in 228 cities within the United States. Some centralization in New York was inevitable (112 out of 876 members were listed therein in 1955). There are now active rheumatism units in most of the 86 universities of the U.S.A.: 45 of these are in receipt of research training grants from the National Institute of Arthritis and Metabolic Diseases (as well as some other hospitals, such as Mount Sinai, New York), as compared with six in 1946. In view of the ever-increasing funds voted by Congress for expansion in this and other fields, it is clear that there is and will continue to be many posts available in the U.S. over the coming years for people well trained in the field of rheumatism and arthritis.

By contrast, in Great Britain, with its more rigid and centralized control of consultant appointments, the great advances made in the rheumatism field have not been reflected in the recognition for appointment purposes of specialization in this area of the field of internal medicine. There tend, therefore, to be few entrants for training in this field, and they are correspondingly difficult to place when their training has finished. Many of them emigrate, some find appointments in physical medicine, and a few find posts, against very strong opposition, in general medicine. In most universities and hospital centres, rheumatism patients are bandied between the orthopaedic surgeon, the medical consultant, and the physical medicine consultant, whereas in the U.S.A. the rheumatologist,