Editorials

Global health partnerships

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Christopher J M Whitty, Chair of science, education, and training committee (c.whitty@lshtm.ac.uk)[1], Linda Doull, director of health and policy[2], Behzad Nadjm, UK specialist registrar[3]

Author affiliations

Changes to training and revalidation may impede the UK's support of health care in developing countries

The *Global Health Partnerships* report by Lord Crisp,**1** commissioned by the prime minister, aims to find ways to strengthen the United Kingdom's contribution to health care in developing countries. The report acknowledges the UK's "remarkable intellectual and practical leadership in international development" and recommends that the UK facilitate and support the "very valuable work already being done by so many UK organisations and individuals." The report goes on to describe the potential benefits of such activities both to developing countries and to the individuals involved. All people who have experience of the research, teaching, emergency support, and many other activities that UK health workers undertake in support of developing countries would concur.

Warm words are welcome, especially when backed up by practical measures. Lord Crisp makes excellent recommendations for new departures, ranging from explicit ministerial support for National Health Service staff to spend time working in developing countries, to making it easier for aid workers to maintain NHS pension contributions. However, recent changes to the NHS are making it more difficult for UK medical staff to engage positively in three important areas. Lord Crisp notes all three, if occasionally indirectly; unless rapid action is taken these changes will erect new barriers to the UK supporting health care in developing countries.

The first area is allowing medical staff in developing countries to undertake higher training in the UK. Recent changes in immigration policy and their probable impact have been widely discussed, but it is worth noting that Lord Crisp repeatedly found that doctors in developing countries wished to undertake some specialist training in the UK. Finding mechanisms to achieve this without stripping developing countries of medical staff should be possible, but it is getting more difficult.

The second area is revalidation. Doctors from the UK undertake work in developing countries in a variety of ways, but most of them wish to practice in the UK afterwards. Such overseas work includes repeated short term deployment in emergencies or longer term deployment in complex emergencies

with non-governmental organisations such as Merlin and Médecins Sans Frontières; medium or long term periods providing medical services or training medical staff; and periods of often many years spent undertaking research in the tropics. The General Medical Council has tried to be flexible in designing ways to allow doctors doing overseas work in these varied work patterns to undertake revalidation, or to relinquish but then regain the licence to practise with the minimum additional bureaucracy and the maximum speed. It is essential that this flexibility survives the recent white paper on revalidation.[2] In his initial report[3] and foreword to the current proposals, the chief medical officer stated that humanitarian work by NHS staff should not be disadvantaged by the new system, but this does not seem to have been taken into account of in the government's subsequent proposals.

The greatest threat to the ability of UK doctors to undertake work in the developing world, however, is the modernising medical careers (MMC) initiative. Those who designed this initiative did not intend to make it difficult or impossible for doctors in training in the UK to work in the developing world, but that is what they have achieved. This is particularly disappointing as the Department of Health is simultaneously stating how important our engagement in global health is for the UK, and that joined-up government is the key to this, most recently in a major report released by the chief medical officer.[4] Lord Crisp optimistically states that “the introduction of MMC could provide the opportunity to reconsider how international medical training and overseas work might be included in the higher medical training posts both in the foundation years and within specialist training.” This is an aspiration all would support, but the immediate priority is to prevent MMC accidentally destroying what already exists. Currently, most UK doctors who go on to spend some of their career working in the developing world get their first experience at the senior house officer stage. If they go earlier they have too few skills to be of use to their host country, but later on most are already embarked on medical specialisation. The current model of MMC makes a break from the career pathway at this point extremely difficult.

We need to match the warm words about the importance of assisting the developing world with a serious attempt to build flexibility into the MMC, revalidation, and licensing structures to allow the varied patterns of work that are needed for short term work in humanitarian non-governmental organisations, spells of teaching or medical service, and medical research of varying lengths. If this does not happen doctors will be able to choose to train in the NHS, or to assist the developing world, but not both. This would be a great shame. As Lord Crisp points out, currently the UK has much to be proud of in this area, and it would be a tragedy to destroy it by accident. He recommends that the Postgraduate Medical Education and Training Board, deaneries, and the royal colleges need to take action regarding this problem. The need to do so is even more urgent than he implies.

Footnotes

- **Competing interests:** None declared.

- **Provenance and peer review:** Commissioned; not externally peer reviewed.

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