A training course for the UEB examination

The case for retaining an examination for overseas doctors excluded from practising in the UK

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ABSTRACT - Background: Some overseas medical graduates choose to take the United Examining Board (UEB) examination to achieve UK registration; others have no other option. We have devised a course for overseas doctors who wish to re-qualify via this route.

- The course: Eighteen doctors enrolled during 1995–1997; all passed the UEB examination. Regular formative assessment allowed us to identify students adequately prepared to pass the examination. The main predictor of examination outcome was performance in a mock examination. Gender, residential status and interval since original qualification were not predictive. The eight doctors whose primary medical course was conducted in a language other than English did not seem to be disadvantaged.

- Outcome: Successful examinees obtained pre-registration house officer posts without delay; one has since passed the full MRCP(UK) and another MRCP Part I. All but one of them intend to pursue their medical careers in the UK.

- Summary: After a structured course (average 9.5 months) at this medical school, selected overseas doctors can reach a standard appropriate to a UK primary qualifying examination. These findings have implications for overseas doctors living here and not practising, as well as for those concerned with expanding the UK medical workforce.

To practise medicine in the UK, medical graduates need to be registered with the General Medical Council (GMC). For graduates of UK medical schools, provisional registration occurs at qualification, followed by full registration on satisfactory completion of approved pre-registration house officer (PRHO) posts. Provisional and full registration are also available to EC medical graduates provided they are also EC citizens. While university graduation is the preferred route to registration for UK students, there has always been a non-university avenue.

In October 1992 the GMC encouraged the three non-university licensing boards (the Society of Apothecaries of London, the Examining Board in England and the Scottish Triple Management Board) to combine by 1 January 1994. The United Examining Board (UEB) was formed on 5 October 1993 and the first examination held in February 1994 in London.

The examination is held three times a year and the diplomas granted are LRCP (Lond), LRCS (Eng), LMSSA (Lond) for the London examination and LRCP (Edin), LRCS (Edin), LRCPS (Glasg) when the examination is held in Edinburgh or Glasgow. The standard and scope of the examination are intended to be the same level as for university medical degrees. Administrative responsibility lies with the Society of Apothecaries of London, whilst the Royal College of Physicians of Edinburgh co-ordinates the production and analysis of the written papers.

In addition to overseas medical graduates, candidates for the UEB examination include UK undergraduates, and overseas undergraduates who have been prevented from qualifying by reason of local civil disorder.

The GMC requires that prospective entrants for the UEB examination be attached for a period to a UK medical school and certified as prepared for the examination by the Dean or Authorised Officer of the medical school. At this medical school, a Sub-dean (JBE) was appointed in 1994 to set up a course for prospective UEB students, and certification was delegated to him.

We report our experience of introducing a flexible structured course for overseas doctors taking the examination of the UEB.

UEB examination and candidates

The UEB examination assesses performance in eight subjects: medicine, surgery, obstetrics and gynaecology, paediatrics, psychiatry, public health, pathology and clinical pharmacology. There are five parts to the examination: short written answer papers, a multiple choice paper, an oral and two clinical examinations. Satisfactory completion of the first three parts allows candidates to proceed to the clinical examinations. No more than four attempts are allowed and these must be taken within two years of the first attempt.

On the formation of the UEB in 1993, the Registrar of the Board compiled a register of individuals – all graduates of
overseas medical schools – seeking a medical school attachment prior to taking the Board’s examination. The list is updated and circulated to medical school deans every four months. The first list in 1994 contained 62 names; a peak of 472 individuals was reached in November 1996. In December 1997, 54 of the 420 were refugees or asylum seekers; the majority (60%) of the remainder had right of permanent residence in the UK, often as a result of marriage to nationals of the UK or European Union.

In 1994, around 75% of applicants for the UEB examination had not taken, or were ineligible to take, the Professional and Linguistic Assessments Board (PLAB) test; this total has remained roughly constant despite the GMC having adopted the WHO list of recognised medical schools in place of its own restricted one.

In the first three years of the United Examining Board examination (up to March 1997), 187 overseas graduates and 50 undergraduates of UK medical schools took the examination. The former came from widely dispersed medical schools: Africa 27, Americas 6, Europe 40, Far East 9, Indian subcontinent 95, Middle East 10. A proportion had taken their degree in a language other than English, usually French, Russian, Polish, Serbo-Croat or Arabic.

Student selection*

Source of students

The UEB register enabled us to select students for interview. Individuals who had qualified recently or, if not, had had continued exposure to clinical medicine, were felt to have the best chance of benefiting from the course and were therefore interviewed. Other students who approached us direct were also interviewed and asked to register with the UEB if they had not already done so. During 1995–1997, 114 students were contacted and 75 offered interviews; 52 attended. Twenty-three interviewees were offered places and 18 accepted; three of the five who declined a place did so for financial reasons. Of the 52 interviewed, 13 were refugees or asylum seekers. Of the 18 enrolled, 6 were refugees or asylum seekers; 8 of the 18 had obtained their primary qualification in a language other than English. The date of original qualification ranged from 1985 to 1997.

In course assessment

The eight subjects of the UEB examination are assessed together. Although unsuccessful candidates receive feedback through the Registrar of the UEB on their performance in the different sections of the examination, this can offer little information as to which subjects were weak. For this reason we held 'mock' UEB examinations. These resemble the UEB examination itself and consist of written papers, MCQ, orals and two clinical examinations.

The mock examinations have been useful in two ways. First, they have enabled specific areas of weakness to be identified, so that remedial teaching could be instituted. Second, in the written paper, any problems of legibility and fluency could be ascertained. This formative assessment has been especially important for those whose primary medical degree was taken in a language other than English, especially those with non-Roman scripts.

Financial aspects

The charge for the course is that charged by the medical school to undergraduate students ineligible for public funding (£14,100 in the period concerned) and is payable in advance. Usually, the students required financial help. A number of sources of funding have been available including career development loans, discretionary local authority grants and charitable funds. Occasionally, individuals have obtained private sponsorship and some were able to support themselves. The Sub-dean assisted students as much as possible in their fund-raising efforts.

Entering for the UEB examination

Once the tutors are satisfied that the students have both reached a satisfactory standard in the eight subjects and performed adequately in a mock UEB examination, they are signed up by the Sub-dean for the UEB examination. The Sub-dean has to confirm the duration of the medical school attachment, proficiency in English and satisfactory assessment of competence in certain gynaecological examinations as well as in cardio-pulmonary resuscitation.

*Supplementary information covering the interview, health clearance, course structure, delivery, and enrolled students' demographic details and relationship with St George's Hospital and Medical School, is available on request from the authors.

Key Points

Overseas doctors (including refugees and asylum seekers) whose long-term future is in the UK but whose primary qualification does not entitle them to full registration need a secure career path

We have devised and implemented a structured but flexible course as preparation for the eight sections of the UEB qualifying examination

We report the first group of 18 doctors enrolled on the course, all of whom passed in 4–24 (mean 9.5) months

A number of our students have now taken higher examinations; one has passed MRCP Part I and another the full MRCP(UK)

There is an untapped pool of overseas doctors living in the UK but unable to practise; financial assistance would enable greater numbers to requalify and contribute to the UK medical workforce at little cost to the taxpayer
Outcome and current status

All 18 students passed the UEB examination, 13 at their first attempt. Students were encouraged to take part in the PRHO matching scheme; they compete on equal terms with the MBBS students. They all (apart from the one who did not wish to do PRHO posts) obtained at least one PRHO post through the St George's matching scheme, 8 at St George's itself and another two at the associated teaching hospital, St Helier Hospital; 17 of the 18 intend to pursue their medical career in the UK.

Three have taken a specialist examination; one having passed MRCP Part I and another the full MRCP(UK).

Predictors of the outcome in the UEB examination

Mock examinations

The mock examination has proved to be a useful predictor of performance in the UEB examination and we have found that students generally perform better in the latter. No individual who passed the mock examination failed the real UEB examination (Fig 1); on the other hand, 6 of the 10 who had failed our mock examination passed the UEB examination when they took it a month later.

On only one occasion out of 24 attempts at the UEB examination was a student signed up who it was felt was unlikely to pass. This was at the beginning of the first course before we had devised mock examinations. He is the only individual not to have gained sufficient marks in the UEB examination to proceed to the clinical examinations; he passed at his next attempt, six months later.

![Graph](attachment:image.png)

Fig 1. Comparison of overall marks in the St George’s mock examination and the UEB examination. Twenty pairs of marks are shown for 16 students. The pass mark is 15.

Gender, age, residential status, age and years since primary medical qualification

The 18 who accepted places on our course comprised 6 men and 12 women. Of the five who failed the UEB examination on at least one occasion, two were men and three women. The mean age of these five individuals was 31.0 (range 28–33) at enrolment; that of the 13 who passed first time was 28.7 years (range 24–35). The five individuals who failed at least once had all been qualified two, two, four, six and eight years (mean 4.4) respectively. The 13 passing first time had been qualified for a mean of 5.0 years (range 0–12); they included all four asylum seekers and one of the two refugees.

Language of primary medical course

Of the 13 passing the UEB examination first time, 7 had been taught their primary medical degree in a language other than English (Arabic 3, Polish 2, Serbo-Croat 2). Of the five who did not pass first time, only one had been taught in a foreign language (Russian).

Underperformers

Careful scrutiny of the work of all students has identified those who need special attention. Such students may need a full 12 months or more before they can be confidently entered for the UEB examination. Given the financial, geographical, cultural and social hardships that they had to contend with, it is not surprising that some of the students have academic difficulties. We regard assistance with these problems to be a responsibility of the Sub-dean.

Who needs the UEB examination?

At entry to our UEB course all students, with the exception of the four asylum seekers, had permanent right of residence in the UK. This is important because all the students but one intend to pursue their medical career in the UK. For this reason, a secure career path is required by which they can obtain full rather than limited registration. This is why some of our students who were eligible to take the PLAB test did not apply but chose instead to re-qualify via the UEB route and so have the chance to integrate (at PRHO level and subsequently) with UK graduates. By passing the UEB examination and obtaining provisional registration, they join a peer group who will support each other as they pursue their medical careers.

It is these overseas doctors living in the UK, whether or not they are eligible to take the PLAB test, for whom the UEB examination is particularly important, as it is the only satisfactory route to continuing their medical careers.
Others for whom the UEB examination can lead to resumption of their careers are those individuals whose studies have been disrupted by civil unrest. Final year students, who may also be refugees, have the UEB (but not the PLAB) route open to them.

Two other groups also depend on the UEB examination. Individuals who have completed no more than PRHO posts in their own country are unlikely to pass the PLAB test. It is not surprising that many individuals will not wish to take an examination designed for those of senior house officer grade, when they themselves are at the level of a PRHO. Second, asylum seekers who have often experienced considerable personal upheaval are likely to have difficulty with the PLAB test; they may also have unavoidable gaps in their careers. Both these groups benefit from the medical school attachment preceding the UEB examination; indeed, without it they are likely to make little progress as aspiring members of the UK medical workforce.

Discussion

The results described here show that it is possible, by delivering a structured course for carefully selected overseas medical graduates, to enable them to re-qualify in Britain within a reasonable length of time. Our 18 students have passed the UEB examination in a mean of 9.5 months (range 4–24). Currently, however, there are only about 35 UEB registrants on medical school courses in the UK; yet the most recent list issued by the Registrar contains the names of 399 doctors wishing to re-qualify here.

Last year the government accepted the recommendation of the Medical Workforce Standing Advisory Committee (Third Report 1997) that by the year 2000 a further 1,000 new doctors a year need to be trained over and above the current target of 4,970 per annum in order to maintain the UK medical workforce. The report estimates that the extra burden of medical students will necessitate ‘additional gross recurrent costs’ of about £200m per annum. It should be remembered that the doctors who have qualified overseas, have often done so at the expense of the government of the country concerned. When attached to a UK medical school, they are expected to fund themselves; so when they re-qualify and join the NHS they have done so at no cost to the British taxpayer.

There is also a humanitarian aspect in responding to the challenge posed by overseas doctors living here that places a responsibility on medical schools and licensing bodies alike. Medical refugees have a long tradition of contributing to British medicine, both clinically and scientifically. Fifty-four (13%) of the 420 individuals wishing to re-qualify are refugees or asylum seekers. However, these probably represent only about a quarter of the 200 or so medically qualified refugees and asylum seekers in Britain. Professionals are over-represented among refugees and asylum seekers. Some take jobs well below their educational attainment and experience a sense of loss and frustration at being unable to use their professional skills. Why so few have registered with the United Examining Board is not clear, but low morale and lack of appropriate advice and help could be important factors. There may also be a sense of hopelessness, because of lack of access to a medical school course designed to meet their educational needs. For some, the additional expense of preparing for the UEB examination may also be a deterrent. In a recent study of 37 refugees and asylum seekers, it was found that all 37 had had a college or university education and that medical professionals were the largest group.

About 65% of the 399 overseas doctors on the UEB list are already resident in this country so it would be cost effective to provide financial support to enable them to join the UK medical workforce. The government might welcome this additional contribution in trying to correct the current shortage of doctors. The existence of government funds would probably encourage other overseas doctors, currently unknown to the UEB, to seek re-qualification.

With regard to the UEB examination itself, it is important for medical schools taking overseas doctors to realise that candidates can only take the examination four times. It is incumbent on Deans of medical schools to ensure that high quality training is provided for these graduates and to monitor it by student feedback and formative assessment. Individuals should not be signed up for the UEB examination unless they have a realistic chance of passing. Certainly, virtually all examinees should be capable of at least passing the written and oral sections of the examination and proceeding to the clinical examinations. We have demonstrated that the potential to achieve the standard required in the written paper, MCQ and orals is easily measured. Information from the UEB shows that of 261 overseas entries (1994–1997) to the examination, only 182 individuals (69.7%) reached the clinical examinations. Among the St George’s course students, 23 (96%) of 24 attempts at the examination have resulted in progression to the clinical examinations after an attachment of no more than one year in most cases. Unless a high success rate is achieved, some individuals will unnecessarily waste attempts (and precious funds) and may not achieve an adequate standard by their fourth attempt. Failure at this juncture means giving up one’s chosen profession, an outcome that must have an enormously detrimental impact on the individual as regards both earning capacity and personal self-esteem. It wastes a resource the medical profession and the people of the UK should both appreciate and utilise.

In the Spring of 1998, the Education Committee of the GMC advised the Privy Council of its view that the UEB examination does not conform to the standard of proficiency required by the Medical Act 1983. We have commented recently on the serious repercussions of putting a stop to the UEB examination for several categories of overseas doctor, particularly refugees and asylum seekers. The need in the UK for a primary qualifying examination that would suit the needs of doctors whose degrees are not recognised in the UK, appears self-evident to us. Since
many of the doctors will remain in the UK, any route to primary medical qualification needs to contain educational goals consonant with the principles contained in the GMC’s documents *Tomorrow’s doctors* and *The new doctor*. To this end the UEB examination needs to be modified and strengthened. What alternative will emerge if the UEB route to full registration were to be blocked remains to be seen.

Currently, the UEB examination is not superfluous: it caters for needs different from PLAB; it is not wasteful because those who pass it remain in the UK, and it does not result in the certification of sub-standard doctors, all our graduates having made solid career progress.

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**NEW TITLE**

**Clinical management of overweight and obese patients**

*With particular reference to the use of drugs*

A report of a working party of the Royal College of Physicians

There is an urgent need to address the major problem of obesity which doubled in the period 1980–94 and which exacerbates a large number of health problems — both independently and in association with other diseases. In general, obesity should be treated with a weight loss programme combining diet and exercise, but where this fails and there is medical risk from obesity, the use of drugs may be considered. This report sets out the requirements of a weight loss programme, the circumstances in which anti-obesity drugs should be considered and includes guidelines for their use. The characteristics of three drugs used in weight loss are described with a clear warning that such drugs should be prescribed only by doctors as part of a gradual weight loss programme which can be sustained in the longer term.

This report is a revised version of a report published by the College in 1997 and builds on the general recommendations made in that report by adding new information and guidance.

**Recommendations**

- Background and introduction
- Body mass index as a determinant of fatness
- Aims for a weight loss programme
- Appropriate interventions
- Guidelines for the drug management of obesity
- Types of drug treatment for obesity
- Criteria to judge the success of anti-obesity drugs and their long-term use
- Guidelines for continuing care of obese patients treated with anti-obesity drugs
- Pharmacotherapy of obesity — appropriate settings
- Glossary of anti-obesity drugs
- References

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