

Insights into obtaining FRCR and beyond: Obstacles, opportunities and post-relocation dilemma - An Indian perspective

Siddharth Thaker^{1,2}, Rajesh Botchu³, Harun Gupta⁴

¹Department of Radiology, Kettering General Hospital, Kettering, ²University Hospitals of Leicester NHS Trust, Leicester, ³Department of Musculoskeletal Imaging, Royal Orthopaedic Hospital, Birmingham, ⁴Department of Musculoskeletal Imaging, Leeds Teaching Hospital, Leeds, UK

Correspondence: Dr. Rajesh Botchu, Department of Musculoskeletal Radiology, The Royal Orthopedic Hospital, Bristol Road South, Northfield, Birmingham, UK. E-mail: drbrajesh@yahoo.com

Abstract

Indian radiology trainees and radiologists are interested to have FRCR (Fellow of the Royal College of Radiologists) qualification for various reasons including academic career progression, subspecialty interest and other socioeconomic factors. The path for acquiring FRCR qualification is adventurous yet onerous and exhausting. Perseverance, meticulous planning and clarity in the vision are essential prerequisites for an Indian graduate aiming to complete FRCR qualification, and one may require to invest an average of 1.5–2 years even if there is no reattempt in this tripartite examination. Indian doctors including radiologists are considered amongst the finest across global medical fraternities. However, the Indian medical education is skewed and variably distributed over the subcontinent due to organisational inability to provide single radiology curriculum-based education to all radiology training programmes. Parallel educational boards and a variety of institutions such as government, trust-funded and private organisations provide radiology training to further complicate the grand picture of radiology education in India. Conversely, UK radiology education is uniform nationally and rigorously enforced by deaneries based upon state-provided guidelines. UK training opportunities are essentially academically rewarding experience but they require herculean efforts to gain access to one. One should constantly focus on building a resume at par with that of a UK trainee by obtaining experience required to fulfil checklist for such opportunities. Alongwith addressing local (UK) competition thoughtfully, hard work, diligence, and high standards of work ethics are absolute musts to build a great resume, to obtain training opportunity and, in turn, to satisfy the ultimate goal of carrier advancement.

Key words: Challenges; Fellow of the Royal College of Radiologists; India; UK; UK fellowships

Introduction

Fellowship of Royal College of Radiologists (FRCR) is one of the most sought international radiology postgraduation qualifications which interests Indian radiology-trainees and

radiologists alike.^[1] According to RCR clinical radiology UK workforce census 2017, 30% of radiologists working in

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

For reprints contact: reprints@medknow.com

Cite this article as: Thaker S, Botchu R, Gupta H. Insights into obtaining FRCR and beyond: Obstacles, opportunities and post-relocation dilemma – An Indian perspective. Indian J Radiol Imaging 2020;30:70-6.

Received: 03-Nov-2019

Revision: 05-Dec-2019

Accepted: 11-Feb-2020

Published: 30-Mar-2020

Access this article online

Quick Response Code:



Website:
www.ijri.org

DOI:
10.4103/ijri.IJRI_438_19

Table 1: Stark contrasting features of Indian and British radiology training, professional education and socioeconomics

	United Kingdom	India
Training duration	5 years (6 years for IR)	3 years (Degree) or 2 years (Dipl.)
Curriculum	Highly structured and rigorously enforced	Not uniformly enforced
Regulating body	GMC	MCI (now NMC) or NBE
Higher specialty training included in training schemes	Yes	No
Documents including MSF, audits, logbooks, appraisal	Yes	No
Continuing Medical education, Clinical research and academic radiology	Widely prevalent	Minimal
Access to continuous professional development activities	Yes, includes variety of activities including clinical skills, further training, communication skills, governance, leadership and teamwork	Yes, Predominantly focused on clinical skills
Work life balance	Maintained	Skewed, depends upon individual
Working hour regulations	Regulated (40 hours per week for trainees and consultants)	Not regulated
Workplace safety for doctors	Very high, enforced by law	Recently plummeted
Competitive work environment	Non-existing	Cut throat competition in private sector
Spirit of collegueship and patient-doctor relationship	High-spirited	Recently declined
Family related expenditure	Very high	Low
Cost of living	Very high	Low
Take home salary	Plateau - Earn more, Pay tax more (further hit by adjusted income after certain amount)	Depends upon individual preference
Family life	Very tricky to maintain	Excellent

the UK have obtained their primary medical qualification abroad, amongst them 9% were from the European economic area (EEA) whereas 22% were from the rest of the world (non-EEA). Graduates from India, Egypt, Italy, Greece and Pakistan contributed to half of the new clinical radiology consultant posts from outside the UK between 2012 and 2017.^[2] Consultants in clinical radiology in the UK remain on the 'United Kingdom Short Occupation List' along with a few other speciality medical professionals, which means easier norms and no cap for Tier 2 visa/work permit making a relocation to the UK relatively easier as compared to other countries.

Interest in the FRCR qualification amongst Indian graduates is multifactorial. FRCR is radiology only curriculum-based examination, unlike the United States Medical Licencing Examination (USMLE) which involves qualifying through all non-clinical and clinical subjects. Structured and robust examination patterns, clinical knowledge reinforcement, globally-recognised qualification and English as a common academic language in medical education are other contributing factors. Academically, direct placement to consultant posts and other academic positions, access to subspecialty training and clinical skills development opportunities as well as a variety of continuing professional development activities not limited to clinical skills but also extending to radiology-related soft skills like leadership and management, quality improvement, business and finance in radiology are the other reasons for making FRCR attractive. Worklife balance, flexible working hours, decent pay scales, national health service (NHS) benefits including childcare benefits, pensions and NHS discounts

are few socioeconomic factors that require consideration. Amongst all, subspecialty training access and clinical skills development are the most sought factors which attract the Indian graduates to the UK.

Although subspecialty training and clinical attachments in the UK are lucrative opportunities for catapulting career graph; in reality, they are extremely competitive. For every training post, there are almost four applicants and training posts are consistently filled as per RCR clinical radiology UK workforce census 2017.^[2] For obvious reasons, UK graduates are given priority. Overseas trainees, unfortunately, may have to opt for service posts; viz. locum consultants, trust grade (TG) and speciality and associate specialist (SAS) doctors or global fellows which make them 'NHS contributor' and increase their chances to qualify for such posts.

In this perspective article, we will discuss differences between Indian and UK systems, their advantages and disadvantages, [Table 1] factors driving specialists overseas, hurdles while moving to the UK and after. We aim to provide a mix of perspectives and facts which may help Indian radiology graduates to make informed decisions about obtaining international radiology qualification and subsequent emigration.

Moreover, the article also acts as a generic guide and the reader should try to understand, reflect and utilise the information provided according to one's discretion based upon individual circumstances and needs.

Why Do People Go Overseas?

According to Sreekar *et al.*, for 78% of the Indian graduates, India was their most preferred postgraduate training location, while 7% wanted training in the United Kingdom, 6.4% in the United States and 3.7% in Australia. Career options and family were the most common reasons stated for staying back in India whereas lacking high-end hospital infrastructure was the prime concern for those who were wishing to go abroad.^[3]

As depicted in the WHO regional health forum, 2006, the exodus of health professionals from developing countries to the developed world are not new; however, its magnitude and implications are unprecedented due to rapid globalisation. Medical professional emigration including radiologists can be attributed to both external 'pull' and internal 'push' factors.^[4]

Globalisation, free-market economy and international flow of doctors from the eastern hemisphere, especially south-east Asian regions—including India, Pakistan, Bangladesh and Nepal having relatively logistically deprived healthcare system—to the west, act as the external 'pull' factors. This also explains international medical professional movement from the United Kingdom and Canada to the United States of America, and from south-east Asia region countries to the Gulf, the United Kingdom and the United States.

Amongst the 'pull' factors, opportunities for further professional training, higher wages and other perks and better living conditions are the most sought, relatively excess production of health professionals, corporate influence including target-based salary packages, carrier stagnation, cut-throat competition, horrendous work-life balance and underemployment coupled with lack of proper healthcare infrastructure act as major 'push' factors. These factors are often exacerbated by political influence, bureaucratic hurdles and insecurity including a threat to life at the workplace in the home country in certain circumstances.

In India, where almost 70% of healthcare is provided by private medical practises, the ground reality has become worse in recent years. In the words of Tan, mentioned in the Regional Health Forum, 2006, *'the medical profession is under siege. The public increasingly distrusts us because we are too condescending to listen, to mediocre to keep up and too greedy to truly care about their welfare'*.^[4] The doctor used to enjoy great trust in India but now more and more people are questioning the practise and the 'second-to-God' type of blind trust is fading away, especially amongst the educated who have realised patient's rights in clinical decision-making. Unethical advertisements by doctors, continuous debate by alternating systems of medicine proclaiming their superiority over others, dichotomy and

other incentives to lure referrals, prescribing fashionable and expensive investigations and media trials and incendiary comments by journalists having little understanding of healthcare aggravates growing distrust between the doctors and the patients.

Indian Training

Length of postgraduate training and parallel boards

Length of radiology training in India is variable, including a postgraduate diploma qualification (DMRD – Diploma in Medical Radio-Diagnosis or DMRE – Diploma in Medical Radiology and Electrology) which can be obtained after 2 years and postgraduate degree qualification, MD – Doctor of Medicine or DNB – Diplomate of National Board, both of which span over 3 years. DMRD is a nationally recognised postgraduate certification recognised by all medical councils of all states; DMRE, on the other hand, is a state-approved diploma, conferred upon to the candidate by a non-university body and is valid only in the specified state granting the certification. While NBE (National Board of Examinations) accredits and gives the qualification, the Medical Council of India (MCI) only accredit the institution and the degree is granted by the university to which the colleges are affiliated.

Wide variation in training standards

Indian doctors are well-known for their clinical skills and decision-making. Essentially, these qualities are ingrained in them during their radiology training. For there is wide geo-demographical variation in the availability of radiology equipment and services, radiology training itself varies significantly which is essentially inseparable from the former. For example, largely, trainees from institutions in metro cities may have access to cutting edge radiology technology including high-field strength MRI, multislice CT scanner, high-end ultrasound machines, digital radiography equipment whereas trainees from rural institutions and small trust-owned or independent centres in Tier 2 or Tier 3 Indian cities lack those to a significant extent. Sustainable interventional services and radionuclide imaging are scarce throughout India.

On the other hand, with the technological revolution, Indian radiology education is undergoing an expeditious transformation. Utilising an efficient combination of internet, social media platforms along with traditional academic conferences, courses and outreach training activities, radiology education and services are now far-reaching even into the remotest rural institutions and trust hospitals, successfully breaking demographic barriers of the vast Indian subcontinent. Indian radiology societies remain cornerstones for providing these which balance lack in such opportunities in certain institutions, including some of the well-equipped urban units. While Indian fraternities including radiology societies and

consortiums have successfully revolutionised health services catering to more than one billion lives and medical education, clinical research is largely overlooked even though Indian healthcare has immense potential to translate gigantic clinical data into substantial clinical research and publications. One of the core reasons for this because Indian doctors tend to concentrate more on developing clinical prowess hindering other skill-mix such as leadership, management, administrative capabilities, clinical research and quality improvement activities.

Unequal exam patterns

Each of the diploma (DMRD or DMRE) or degree (MD or DNB) qualifications can only be obtained after completing exit examination at the end of the postgraduate term. The exit examinations lack universal standardisation across the country. Although, such examinations contain written components, OSCEs, table vivas and radiology physics questions similar to FRCR examination; they, however, are not tethered against national standards and depend heavily upon examiners' discretion.

No structured curriculum

As mentioned before, two different education boards oversee the radiology curriculum. Further to complicate this matter, central government-funded institutions, Centres of excellence, state-sponsored academic institutions, deemed universities and smaller private colleges modify curriculum according to their own need and will. Sheer numbers of such institutions and lack of manpower and IT support make enforcing a single curriculum virtually impossible.

Furthermore, the lack of in-training data capture including electronic logbook, clinical audits, reporting statistics during training, appraisals, multisource feedback and in-training performance evaluation make a resume of Indian trainees weaker as compared to their UK counterparts. Lack of rigorous documentation for trainees makes potential foreign employers question the credibility of clinical experience provided by Indian applicants.

No nationally-recognised subspecialty training

Radiology training itself is curtailed for the maximum of the 3 years aiming to produce general radiologists at the end. Barring a few central government-funded institutions offering a 1-year fellowship and fewer offering DM (superspecialty) courses in neuroradiology, for most of the qualifying radiology graduates, the journey of academic radiology ends here! For those who are keen to have further subspecialty training in such institutions, up to 3 years of the senior resident experience, gruelling competition from local candidates and the high rejection rate is disheartening factors.^[5]

UK Training

Overview foundation and core radiology training

After completing medical school, all graduates are expected to undertake a 2-year Foundation Programme (FY1 and FY2) to be able to work and practise as a doctor in the UK. It is then possible to apply for clinical radiology training directly after foundation training.

Training for clinical radiology takes 5 years to complete and is called as ST1 to ST5 upon yearly progression. There is a further year, ST6 for those trainees wishing to specialise in interventional radiology. The first 3 years of training involve general radiology training (called core training) where trainees also rotate in subspecialties of radiology. This is followed by 2 years of higher special interest training in the candidate's chosen subspecialty (called specialty training). The training is highly structured, uniform across the country and according to the curriculum laid down by RCR. The trainees have to maintain electronic logbooks, require regular assessments and yearly appraisals.^[6]

During training, the trainees take the examinations leading to FRCR. At the end of this training, the trainee receives the Certificate of Completion of Training (CCT) and will be eligible to be on the General Medical Council (GMC) Specialist Register. One can then apply for substantive consultant posts.

Salient features of UK radiology training

The medical training in the UK, in general, has a key focus on good communication skills, team working, leadership, ethical practises and always putting the patient's interest first. The 'duties of a doctor' are defined by the General Medical Council of the UK and doctors are required to strictly adhere to it. In general, the medical profession including radiology in the UK is one of the most highly regulated in the world. There is complete accountability for reports and opinions with a regular discussion of 'misses and errors' as part of departmental educational meetings.

Problems while Preparing and after Obtaining a Qualification

Yet the journey to obtain international qualification is rewarding and leads to a feeling of professional accomplishment. It is full of challenges that remain inseparably attached to the career aspirations and related decision-making process not just up to but well beyond relocating and settling into entirely different sociocultural norms and the healthcare system. We have divided possible challenges into three parts: (1) hurdles faced by Indian radiology graduates up to having FRCR qualification, (2) Peri-relocation period and (3) problems for those having 'settled status'.

Each of these phases has special sets of challenges, generic enough for all Indian aspirants but still unique depending upon personal circumstances and requires individualised and pragmatic approaches to circumvent them.

(1) Pre-FRCR impediments

Poor medical imaging physics education and its applications, lack of examination centres in India further aggravating exam costs which include airfares, stay and transportation charges in local currencies in the United Kingdom, Singapore or Hong Kong, low conversion rates of Indian rupee to such countries and lack of understanding of NHS clinical management pathways as compared to the British counterparts are a few of the challenges which hinder interests of Indian radiology graduates towards the examination. Increasing numbers of Indian FRCR preparatory courses including those being run by UK-based consultants now successfully mitigating a few of these challenges.

Currently, there is a delay in getting a slot for writing the FRCR part 1 physics or anatomy for which RCR runs the waiting list reaching to hundreds. This uncertainty is still remaining at the time of writing this article. There was a long wait for part 2B which is now partly addressed by the additional FRCR final exam sessions being conducted only for Indian Radiologists by RCR since last year onwards.

(2) Peri-relocation pessimism

The battle is far from winning once the FRCR qualification is obtained. Being non-EEA candidates, Indian radiology graduates have to satisfy criteria including educational (validating primary medical qualification and FRCR via EPIC – Electronic Portfolio of International Credentials), linguistic (IELTS – International English Language Testing System or OET – Occupational English Test) and judiciary (PCC-police clearance certificate from Ministry of external affairs in the home country and DBS-disclosure and barring services from the United Kingdom) prerequisites for General Medical Council registration. Similarly, visa process is also cumbersome and requires enormous documentation including satisfying financial prerequisites through certificate of sponsorship (COS) for Tier II Visa, academic linguistic prerequisites through UKVI IELTS (academic), OET or UK NARIC (National Agency for Recognition and Comparison of International qualifications and skills) and pre-employment health checks in both, in India (by the means of TB certificate) and in the UK (by the means of occupational health services check, including TB, hepatitis B, HIV, varicella-zoster, influenza and MMR titres and immunisation).

Cultural shock, accommodation and transportation-related problems, differences in clinical decision-making and

management pathway, unpredictable weather conditions and entirely new work environment may pose significant barriers to newly immigrated one to foreign health systems including the UK.

(3) Problems for those having settled status

Substantive consultant position in the NHS: The most desirable settled status designation is the consultant position. It is best to avoid any long term middle grade position as it can lead to career stagnation and frustration. Consultants are required to have leadership qualities and take up management, teaching, academic or research responsibilities apart from a clinical position. They are required to maintain their RCR CPD (continuing professional development) logbook, undergo mandatory yearly appraisals, job planning process and revalidation every 5 years. The overall paperwork is tedious and time-consuming. The NHS remains cornerstone UK healthcare provider including various hierarchical levels of hospitals varying from teaching hospitals – performing most specialist work, large district general hospitals (DGH) to small DGH. Consultants are also required to provide on-call services but their patterns and types vary on the NHS trust basis.

Private radiology services: Private work opportunities are very limited and highly competitive as they are predominantly insurance-dependant and more suitable for larger and more populated cities.

Cost of living and family life in the UK: The cost of living for a family is very high and UK consultant pay scales are one of the lowest in the developed world. Pension rules have changed and are complex and essentially can only be redeemed at the age of 67 years which is again likely to go to a higher age.

Families often struggle to survive on the single salary which builds frustration over a period leading to the ‘mid-career crisis’ as one enters the 40s. A large number of well-settled radiologists have been relocating back to India or immigrating to other countries such as Australia, Canada and Singapore in the last few years.

Typical helping hands from maids, relatives, drivers available in India is non-existent in the UK forcing working parents to look after all needs and activities for the children by themselves including all educational, curricular and entertainment. Another gigantic challenge is ageing parents and related health issues when they are back home. The inability to help parents and family in times of need can be an extremely unpleasant experience leading to remarkable despair and emotional turbulence.

Advantages

Even though NHS is undergoing an unprecedented financial, logistical and manpower crisis, it can uphold

the finest ethical practises and quality of care standards compared to other healthcare systems. Patients are entitled to receive a similarly high standard of healthcare irrelevant to their financial capabilities or social status. The NHS has successfully demonstrated that nuisance-free healthcare provision is achievable and it has proudly provided a safe, clean and positive environment to healthcare workers and the patients. This is reinforced by stable and uniform law and order at NHS institutions, lack of corruption and dichotomy in the healthcare and strong belief of UK patients in NHS.

Suggestions

Have a clear vision before embarking upon FRCR examination

Having a clear understanding of the ultimate goal, whether being academic, financial or sociocultural is of utmost importance before starting preparation for the examination. Individual, family and social and economic circumstances should also, be considered during decision-making. We have provided a model illustration for approaching FRCR but it should be customised according to one's own need [Chart 1].

Previously most Indians who became consultant radiologists in the UK had their training in the UK but the option of entering radiology training in the UK is very difficult now. Most opportunities now for anybody intending to enter UK radiology are for post-FRCR overseas-trained radiologists. It is, however, important to understand that FRCR does not equate to the job of one's choice in the UK.

If anyone has UK plans, one has to obtain GMC registration as this is mandatory for any work in the UK. On Indian training, the GMC does not give direct entry to its specialist register and therefore, one cannot take up a substantive consultant position. One can take up fellowship, temporary consultant position or staff grade position. If there is a desire to take up a long-term consultant position then one has to undergo a rigorous process of obtaining a 'certificate of eligibility for specialist registration (CESR)'.

All NHS jobs are advertised on www.jobs.nhs.uk. It is useful to try for a short few weeks of clinical observership in a radiology department, which enables one to acquaint with

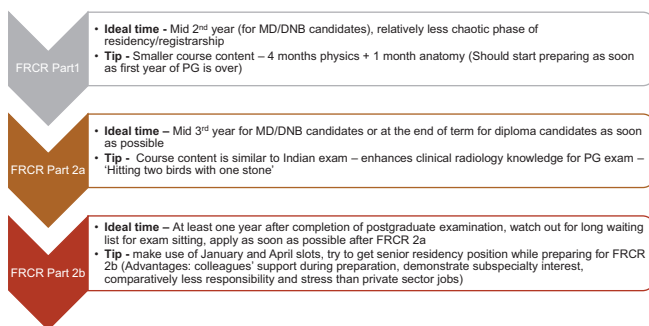


Chart 1: Model illustration for approaching FRCR examination while in postgraduation

the actual working of the NHS and radiology departments. Obtaining FRCR still no guarantees that you will get a suitable job or fellowship in the UK.

A large number of candidates have a desire for fellowship. Fellowships in subspecialty are of 1-year duration and are considered post-CCT posts. Getting a training fellowship is tougher than a consultant or visiting fellowship post, as the local candidates mostly take those training ones. These are competitive and candidates are expected to be able to work as a consultant with overall good skills in all modalities and such posts of 1 year are mainly for enhancing the specialist experiencing as a 'fine-tuning' post rather than learning all from the beginning. It is, therefore, useful to have good first-hand experience in specialty one is looking for and make their CV as strong as possible for such jobs. Never exaggerate skills on a CV as it can backfire and make further jobs difficult due to loss of trust as the country has a high moral referencing system for any job.

Teaching hospital consultant jobs are prestigious and highly competitive and often have fellowship-trained candidates. These jobs are easily filled as compared to those in DGH and smaller DGH and therefore one needs meticulous planning to define their career path.

Jobs in so-called areas of need and smaller hospitals are comparatively easier to get but one has to be careful as these may not have specialist work, different working pattern and demographic and pathology difference and can lead to de-skilling of previous experience which can be detrimental if the plan is to go back to India. In the last decade, for there has been better availability of equipment, the opening of more corporate and teaching hospitals and improved pay scales in India, one needs to think clearly about their expectation when entering a new country and system as it can take years to establish oneself.

Get maximum out of your job in the UK

Typically, the NHS job provides a plethora of clinical, leadership, management, quality improvement and educational opportunities. One should select them according to the need for keeping intermediate and long-term professional goals in mind. The NHS is renowned globally for excellent collegueship and professional courtesies.

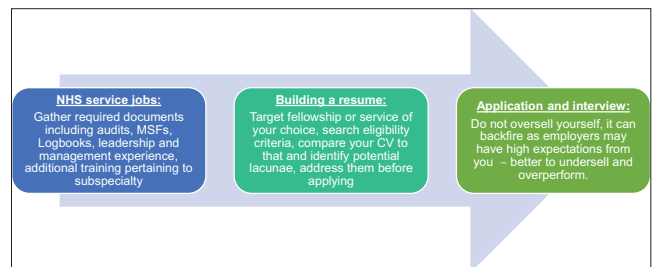


Chart 2: How to prepare for the dream fellowship or academic post while working in the UK? – An example

Ideally, one should take maximum advantage from having discussions with senior clinical colleagues from the NHS trust who employs one and colleagues from different NHS trusts.

Focused pursuit towards fellowship or higher education of your choice

Each of such training opportunities or attachments carries a specific job and person specification which can rarely be met while applying from overseas. Criteria for such posts are stringent and enforced rigorously. Resume and personal qualities needed varies significantly from post to post and 'one size fits all' the approach is not recommended. One should invest ample time and effort in building resume specific keeping training opportunities in mind [Chart 2]. We recommend talking to previous fellows and trainees from the institute of interest and visiting the institute informally before applying and interview.

Deciding a permanent job

Family life and finances once obtained 'ILR – indefinite leave to remain' status or citizenship, again remains a centre stage question. Good transportation, nearby entertainment facilities and access to child education and kids clubs are a few amongst the factors to be considered.

Summary

In this article, we provided insight into the opportunities, challenges, advantages, and obstacles in obtaining FRCR

and subsequent relocation to the UK. Although this article is largely based upon experiences of UK-based consultants, the same holds while immigrating to any foreign healthcare system.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest

References

1. Therakathu J, Keshava SN, Thippeswamy PB, Chandramohan A. Overseas exams - Perception of audience in a conference symposium: A survey. *Indian J Radiol Imaging* 2015;25:206-7.
2. https://www.rcr.ac.uk/system/files/publication/field_publication_files/bfcr185_cr_census_2017.pdf.
3. Sreekar H, Nithya R, Nikhitha R, Sreeharsha H. Career intentions of medical students trained in India. *Educ Health* 2014;27:64.
4. Adkoli BV. Migration of Health Workers: Perspectives from Bangladesh, India, Nepal, Pakistan and Sri Lanka. In: *Regional Health Forum*. 2006. p. 49-58.
5. Mohan C. Subspecialization in radiology – Is it time to hatch out of the cocoon? *Indian J Radiol Imaging* 2017;27:261-2.
6. Clinical radiology curriculum [Internet]. Available from: <https://www.gmc-uk.org/education/standards-guidance-and-curricula/curricula/clinical-radiology-curriculum>. [Last cited on 2019 Nov 03].