The Squibb Travelling Fellowship

Report on a trip to the United States to do research

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Getting there

In 1986 I was awarded the Squibb Travelling Fellowship by the Royal College of Psychiatrists. The funding this provided, combined with funding provided by the Henry Hutchinson Stewart Scholarship in Psychiatry awarded by Trinity College, Dublin, enabled me to spend a three month period in the summer of 1987 at the Children's Hospital Medical Center, Boston, doing research in the area of emotional adjustment in adolescents with chronic physical illnesses. The research will be the subject of a future paper. The purpose of this communication is to outline some of the steps en route between winning the Fellowship and starting on the project at Children's Hospital. The amount of paperwork involved was time consuming, confusing and, at times, overwhelming, and I hope that other doctors planning to travel to the United States to carry out research will benefit from my expeience.

Entering the Squibb Travelling Fellowship involved preparing a protocol of the proposed study and finding a hospital or unit in which it would be suitable and possible to carry out the study. These steps were relatively straightforward. I decided to aim for Children's Hospital, Boston because I had done a medical student externship in Boston many years ago, and I knew how stimulating and exciting the medical scene is in Boston. There was no difficulty in establishing contact with the Department of Psychiatry in Children's Hospital, and through that department with the various paediatricians whose patients I wished to study. The study protocol took several weeks to prepare but having done that and having won the Fellowship, I felt I could relax. The Fellowship was awarded in August 1986 but for professional and family reasons I decided not to go until summer 1987. I had nine months in which to get organised which seemed plenty of time. The paperwork involved in arranging the trip fell into seven categories:

1. protocol application to the committee on Clinical Investigation (The Hospital Ethical Committee)
2. housestaff application form
3. communication with staff paediatricians about subjects and controls for the study
4. application for Limited Licensure to the Board of Registration in Medicine
5. ECFMG certification
6. visa application
7. miscellaneous

1. Protocol application to the Hospital Ethical Committee

This was a useful, if daunting exercise. It consisted of an in depth description of the proposed study using the following outline: introduction, specific aims, experimental protocol covering clinical material and sample protocol, interpretation of data, risks, potential benefits, funding, references, and copies of the proposed consent forms for subjects and controls. Looking at specific aims, risks and potential benefits to subjects and controls was an area to which I had not given much thought. Having to think about these areas and describe them in detail made me look at the study from a different perspective, and was very useful. The consent form was so detailed that I doubted if anyone, having read it, would agree to participate! The completed protocol had to be submitted to the Committee on Clinical Investigation and, in my case it was passed. Many protocols have to be revised, sometimes extensively, to conform to the Hospital's ethical guidelines.

2. Housestaff application form

This was a fairly standard job application form requesting information about training, previous experiences, and referees. It had to be accompanied by an ECFMG Certificate. It led to my appointment as an Affiliating Fellow in Medicine for the duration of my Fellowship.

3. Communication with staff paediatricians

This involved trying to identify in advance of my arrival which patients I would have access to, and

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whether or not I would be able to find sufficient numbers of selected patients who were the correct age, sex, intellectual level and with the correct physical diagnosis. I was reasonably confident about finding the right patients, but controls presented a problem and I decided to leave that until arrival.

4. **Application for limited licensure**

To carry out any work which involves face-to-face contact with patients it is necessary to have a limited licence issued by the Board of Registration in Medicine of the Commonwealth of Massachusetts. 'Limited' means that the licence is given for a set period of time, that medical practice is limited to a named hospital, and that clinical work is carried out under the supervision of a staff member holding a full licence. The licence application covers in great detail the applicant's pre-medical, medical school and clinical clerkship experience and must be accompanied by official transcripts from the medical school and hospitals where undergraduate training was carried out. The applicant must also write a 'detailed narrative' of his/her clinical study in medical school to satisfy the Board that all clinical training is substantially equivalent to the minimum standards required of United States Medical School graduates. The official transcript from the applicant's medical school must show that the applicant has attended and completed a required period of instruction in the full range of preclinical and clinical subjects. A copy of the applicant's medical school degree — translated if not originally in English — is also required. I was able to get all the above documents thanks to the goodwill and efficiency of the staff of the Dean's Office of University College, Dublin where I attended medical school. Documents must be sent in the form of notorised copies of originals, and any statements made on the application form must be in the form of an affidavit. This requires the services of a notary public. Most medical schools can advise about how to find a notary public. The application must be accompanied by an ECFMG Certificate. The Board strongly advises giving six months for licensure to be processed after they have received all the documents. In my case, processing took three months.

5. **ECFMG certification**

I had passed the ECFMG examination several years ago but had not applied for my ECFMG Certificate. Getting this certificate from the ECFMG Office in Philadelphia costs $50.00 and takes time. It requires sending a copy and translation of your medical degree and a copy of your Certificate of Full Registration as a Medical Practitioner. The medical degree is then returned by the ECFMG Office to the Dean's office of the issuing medical school for authentication, returned by that office to the ECFMG Office who finally issue the ECFMG Certificate. This drawn out process takes several weeks, and, as the ECFMG Certificate is a prerequisite for items 2 and 4, I would advise anyone who is thinking of going to the United States in the future to get their ECFMG Certificate now. People who have taken the VQE (Visa Qualifying Examination) rather than the ECFMG, should check the steps necessary for them.

6. **Visa application**

I was advised by the United States Embassy to apply for a J-1 Visa. In order to get this it was necessary to supply the Embassy with a completed Form 1AP-66 together with my passport and other visa requirements. The 1AP-66 is sent from the hospital to be visited, and is not issued by the hospital until it has satisfied itself that the prospective visitor is a bona fide doctor, properly trained and visiting for a legitimate purpose. This 1AP-66 is not issued by the hospital until the housestaff application form has been processed. My 1AP-66 arrived two days before I was due to leave for Boston, causing considerable anxiety. Luckily, having queued outside the Embassy for two hours on the morning prior to departure, I got my visa in time.

7. **Miscellaneous**

Domestic

Finding accommodation, making travel plans, arranging medical insurance and banking facilities, and getting an International Driver's Licence, have all to be remembered.

Work-related

It was not difficult to arrange leave of absence and transfer of patient care while I was away. Thanks to the support of colleagues, cover for my three month absence was provided with no fuss.

In retrospect the various steps seem logical and necessary. It did not seem like that at the time. There seemed to be a great deal of overlap and duplication. I spent many hours form-filling, writing letters, telephoning the USA, visiting the medical school, the notary public, the bank, the US Embassy, the Automobile Association.

'Getting There' is difficult but, as I hope to show in 'Being There', it was well worth it.

Being there

Having done all the background paperwork I arrived in Children's Hospital Medical Center, Boston in June 1987 for a three month stay. My objective was to carry out a study looking at emotional adjustment in young people with Duchenne muscular dystrophy and spina bifida. Children's Hospital is a 350 bed

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teaching hospital attached to Harvard Medical School. It covers the whole spectrum of paediatric care, acting both as a community hospital to the local population and as a referral centre for children with complex disorders from other states and other countries. There is a huge out-patient service. It was from the out-patient clinics for patients with neuromuscular disorders and for those with myelodysplasia (spina bifida) that I had already arranged to recruit patients for my study. Getting the study off the ground presented few problems and some of the factors which contributed to this ease were:

Resources

Photocopying, rooms to interview patients, library facilities and secretarial staff were fully available. The Squibb Travelling Fellowship enabled me to provide car parking passes and cafeteria passes to subjects and controls which in some small way acknowledged their participation in the study. I discovered that this practice is widespread in the USA and is sometimes accompanied by more tangible rewards such as small cash payments, tee-shirts etc.

Telephones

It seemed that the vast majority of patients had telephones and these are used more readily than in Ireland. It was thus possible to contact patients by telephone prior to their scheduled clinic visits to explain the study to them. This prepared them to spend the extra time at the clinic that participation in the study involved. It seemed that communication by telephone is used far more freely in USA than in Ireland and seems to be part of a more informal approach to communication in general.

Computerisation

Patient demographic data were available on the hospital computer system as well as all scheduled out-patient clinic visits. This facilitated planning patient appointments well in advance. It also enabled a comparison of patients seen in the study with those with the same diagnosis but not seen, thus giving some idea of how representative the study group was of all clinic attenders. To do this by looking through charts would have been very time consuming. The computer was 'user-friendly' so that with minimal instruction I was able to use it.

Goodwill

The vast majority of medical, nursing and secretarial staff were extremely helpful and supportive. Part of this has to do with the frequency with which they encounter people passing through the hospital doing short pieces of work. It is familiar to them and thus non-threatening. A bigger part has to do with the openness and friendliness of the American people. Being Irish in Boston gives one an almost automatic stamp of approval!

Difficulties

Timing

I chose to spend the three summer months in Boston for predominantly family reasons — I could bring the children without them missing school at home. I was under pressure to recruit as many subjects as possible for my study in a three month period and had set a target of 75. Summer is vacation time and the out-patient clinics were not as busy as during the rest of the year, and many patients I tried to contact were either going on vacation or already away and non-contactable. However, I did manage to see 45 subjects and 22 controls and thus I almost made the target set.

Controls

The ideal control group for my study would have been obtained through the school system, thus ensuring a random non-patient control group. It was school holiday time when I was there and any students doing summer programmes at school tended to either have learning disabilities or to be 'gifted' and thus getting special tuition. Neither group was suitable. The nearest I could get to a non-patient control group were children and adolescents attending either Well Child Programmes or Paediatric Practice Programmes run by the hospital. These healthy young people were attending mostly for physical examinations which are routinely required before entering summer camp or high school. Some controls were recruited through the Sports Medicine Department and were healthy young men with sports-acquired injuries.

Other activities

Areas of particular interest to me in child psychiatry include paediatric liaison, child abuse and in-patient treatment. It was possible to organise spending one half day each week with the teams working in these areas. This provided much stimulation and clinical interest which nicely complemented the research.

The Fellowship provided a marvellous opportunity to combine a clinical research project with gaining new experience in areas of clinical practice of particular interest to me. Contacts were established with other psychiatrists working with young people with chronic physical disorders, and these contacts will be ongoing and will lead to sharing of information. The ten weeks were most stimulating, exciting and encouraging and I wish to thank the Royal College of Psychiatrists, and Trinity College, Dublin for making this possible.