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Employment and integration of refugee doctors in Scotland

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Global Commission on International Migration

In his report on the 'Strengthening of the United Nations - an agenda for further change', UN Secretary-General Kofi Annan identified migration as a priority issue for the international community.

Wishing to provide the framework for the formulation of a coherent, comprehensive and global response to migration issues, and acting on the encouragement of the UN Secretary-General, Sweden and Switzerland, together with the governments of Brazil, Morocco, and the Philippines, decided to establish a Global Commission on International Migration (GCIM). Many additional countries subsequently supported this initiative and an open-ended Core Group of Governments established itself to support and follow the work of the Commission.

The Global Commission on International Migration was launched by the United Nations Secretary-General and a number of governments on December 9, 2003 in Geneva. It is comprised of 19 Commissioners.

The mandate of the Commission is to place the issue of international migration on the global policy agenda, to analyze gaps in current approaches to migration, to examine the inter-linkages between migration and other global issues, and to present appropriate recommendations to the Secretary-General and other stakeholders. The Commission's report was published on 5 October 2005 and can be accessed at www.gcim.org.

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Potential contributors to this series of research papers are invited to contact the GCIM Secretariat. Guidelines for authors can be found on the GCIM website.

Introduction[1]

UK integration policy

In 2000, the UK Home Office demonstrated its commitment to refugee integration by publishing the document 'Full and Equal Citizens'. Since then the Home Office has spearheaded a series of National Integration Conferences across the UK. A number of research projects investigating integration have also been commissioned by the Immigration Research and Statistics Service (IRSS). In 2005, the 'Full and Equal Citizens' document was superseded by a new integration strategy, 'Integration Matters'. A subsequent Home Office Integration Conference (Edinburgh, 2005) included consultation with refugee community organisations (RCO's), academics and practitioners to further inform the strategy. Alongside this new strategy sits the DWP's employment strategy 'Working to Rebuild Lives'. These developments demonstrate the Home Office's desire for refugees to fully integrate in UK society.

Nevertheless, within the UK a number of legislative frameworks present challenges to refugee integration. National policies which preclude asylum seekers from working render the goal of integration difficult, especially in the area of employment (Bloch and Schuster, 2005). The UK dispersal policy, instituted by the 1999 Immigration and Asylum Act, also results in the forced dispersal of asylum seekers to multiple destinations. The largest dispersal site in the UK outside of London is Glasgow city, which now houses some 10,000 refugees. This creates challenges in terms of providing specialised services for individuals, such as employment advice for health professionals.

This paper examines, through the lens of employment, ways in which international organisations can contribute to integration at the local level through funding local research projects. Specifically, the paper is based upon an innovative research project which involved collaboration between the author (an academic researcher) and a local development organisation (Glasgow North Ltd). The research conducted is put forward as one example of good practice in relation to the integration of refugees and asylum seekers.

The integration 'process'

In terms of academic research there has been an analytical separation of forced migration into two distinct spheres: the asylum move and integration. Theorists have identified 'indicators' of integration such as the functional and social domain (Zetter *et al.*, 2002). However, this factor-based approach has been challenged and replaced by a focus upon the integration 'process'. Indeed, integration is conceptualised as a legal, economic and social process (Crisp, 2004; Higgitt, 2000). Integration as 'process' also suggests that this should begin at the point of arrival and not be

[1] The project was funded by the European Social Fund (ESF) and EQUAL funding programme. This project is part of the European Employment Strategy which seeks to help asylum seekers and refugees integrate through education, training, advice and employment.
Special thanks go to Kirsty Cameron and Kim Murphy (Glasgow North Ltd) who also worked on this phase of the project and who have provided invaluable assistance. Also, this research would not have been possible without the generous help of various HR managers and medical staffing officers/advisors in the following Trusts across Scotland: Glasgow Trusts (located at Gartnavel, Yorkhill, Southern General and Stobhill), Tayside, Argyll and Clyde, Grampian, Ayr, Fife, Dumfries and Edinburgh.

deferred until leave to remain is granted (Refugee Council, 2004). Increasingly, then, the focus has been upon identifying processes rather than solely on measurable variables.

Advancing this notion, recent research has indicated that the integration 'process' is influenced by the institutional environment of the receiving society as well as the personal capacities of the settling population (Valtonen, 2004). This strand of academic literature can be usefully employed in relation to the example of refugee doctors. It can suggest ways forward in understanding and tackling the problems faced by this group. Indeed, the approach suggests that in order to fully utilise this untapped resource, efforts should not merely focus upon the re-qualification of the individual. Rather, the employment environment in which refugee doctors aspire to gain employment must also be considered. This was the basis of the research project, namely to investigate the medical employment environment in Scotland. This is discussed further in the following section, which focuses upon refugee employment.

Refugee employment

Official studies have concluded that employment is fundamental for refugee integration, independence and social inclusion (Charlaff *et al.*, 2004; Home Office, 2000; Social Exclusion Unit, 2004). Nonetheless, a major study found that fewer than one third of refugees were in employment compared with 60 per cent of the ethnic minority population (Bloch, 2002). Well-educated refugees have been found to be under-employed, often taking low-skilled jobs (Bloch, 2000). Indeed, the rate of refugee unemployment (36 per cent) is around six times the national average (Hurstfield *et al.*, 2004). So, despite the knowledge and skills of highly qualified asylum seekers and refugees, structural barriers force highly motivated professionals to undertake menial jobs. This can lead to economic destitution and downward occupational mobility (Al-Rasheed, 1992; Hope, 1997).

Over the past four years the government has provided £2 million for the Refugee Doctors Project (Department of Health, 2003; Gavin and Esmail, 2002). The Department of Health has also funded and instituted a number of programmes such as the Refugee Doctor's Database (2000) which was established by the Refugee Council and British Medical Association. In addition, the General Medical Council (GMC) now waives the fee for IELTS[2] and PLAB[3] for refugee doctors. It also offers a reduction in the cost of limited registration. But despite these positive steps, all the evidence points to skills being wasted and under-utilised. Over the past five years, the professional, financial and cultural obstacles facing refugee doctors have been well documented (Adams and Borman, 2000; Berlin *et al.*, 1997; Cheeroth and Goraya, 2000; Easton, 2003; Stewart, 2002; 2003; Tayal, 2003).

It is at this juncture that the integration literature can suggest ways forward. As indicated earlier, to theorise integration as 'process' would indicate that it is not the individual refugee doctor who is solely responsible for integrating economically. The employment environment into which doctors wish to integrate (namely the NHS) is equally important. Indeed, it has been demonstrated elsewhere that if migrants are unfamiliar with the rules of the labour market and workplace conventions this can be a barrier for newcomers (Bauder, 2005). The main aim of the research project was

[2] International English Language Testing System.
[3] Professional Linguistic Assessment Board.

therefore to investigate the medical employment environment in Scottish hospitals, with a view to advising refugee doctors.

Investigating employment issues

The research design was based around previous academic research (Stewart, 2002; 2003) and anecdotal evidence from the local development organisation. It was decided that two issues needed further investigation. First, debates have typically focused on the under-utilised supply of refugee doctors in the UK with little attention paid to employers' demand. Second, the majority of studies have focused on re-qualification of refugee doctors (i.e. by passing IELTS and PLAB I and II) rather than on long-term employment outcomes. Mutual consultation on these issues led to the identification of specific research questions. These included quantifying the shortages in Scotland's hospitals, as well as establishing the interview procedures for junior doctors and the perceived essential candidate requirements. The objective of the research project was to focus upon providing career advice to individuals seeking their first substantial post in Scotland by drawing upon direct consultation with employers. This would then be used to produce a careers guidance resource for careers advisors.

A number of tasks contributed to the research project and resulted in the production of the careers guidance resource. These took place from December 2003 until December 2004. A discussion of each follows before reflection on the methodology is presented. First, key players were consulted. A series of meetings were conducted with the main organisations which provide services for refugee doctors in Glasgow. This included consultation with a representative from the Bridges Project as well as a meeting with the Dean of NHS Education Scotland. The consultation was also carried out in conjunction with the associated partners of the project, the New Glaswegians Project (run by the Glasgow Chamber of Commerce). This phase provided accurate and up-to-date information on the existing services provided for refugee health professionals in Glasgow. Discussions also focused upon identifying practical ways of further improving employment opportunities in the city. Although direct consultation was not arranged with the Scottish Executive, the new Baseline Findings on the Scottish NHS WorkForce and Future Plans (2004) were consulted extensively.

Second, relevant material was collated. Throughout the duration of the project, data and relevant material were collected for inclusion in the careers guidance resource. This included gathering information to produce a glossary of terms. Illustrative and helpful diagrams were identified for addition to the careers booklet. Data was also obtained from ISD Statistics Scotland. This provided extensive, quantitative data on the Scottish NHS WorkForce and was analysed in relation to the composition of the WorkForce as well as vacancy data. Careers advice supplied to overseas doctors in the UK was also examined and adapted for application to refugee doctors.

Third, in-depth interviews were conducted with human resource directors of NHS Trusts. An in-depth interview was conducted with a representative of each of the four NHS Trusts in Glasgow. This provided interesting qualitative information which was summarised for inclusion in the careers resource. The results from these interviews also informed the construction and refinement of the postal questionnaire. A further seven in-depth interviews were conducted across Scotland, taking the total sample to 11 in-depth interviews. These included the following Trusts: Glasgow Trusts (located at Gartnavel, Yorkhill, Southern General and Stobhill), Tayside, Argyll and

Clyde, Grampian, Ayr, Fife, Dumfries and Edinburgh. Although a small sample numerically, this can be considered representative of the situation in Scotland.

Finally, postal questionnaires were distributed to all human resource departments in NHS Trusts in Scotland. A total of 27 questionnaires were distributed across Scotland. Each department was subsequently sent a reminder letter. The departments were then contacted on at least two subsequent occasions to increase response. The distribution of the questionnaire unfortunately coincided with the implementation of the New Consultant Contract which may have reduced the response rate. Nonetheless, there was a total response of 30 per cent (11 questionnaires) which is the expected rate for this type of survey. Further, some departments had recently undergone restructuring and amalgamation which rendered some questionnaires void. Thus the actual response rate was probably higher than that stated above.

Reflections

The research was somewhat delayed by the difficulties in contacting and arranging meetings with human resource representatives in the NHS. The low response rate to the postal questionnaire also resulted in additional time being spent in reminding individuals to respond and re-sending copies of the questionnaire. The amalgamation of NHS Trusts in April 2004 led to initial difficulties in identifying appropriate individuals to be interviewed. Finally, the full impact of Modernising Medical Careers, which will begin in August 2005, still remained unclear at the time of the research. Nonetheless, the in-depth interviews produced extensive, qualitative material which provided useful insights into employment procedures in Scotland. Finally, the project was geographically limited in scope. Some personnel shortages highlighted were specific to Scottish hospitals. The project nonetheless indicates the potential for future research in this area. There could be a comprehensive analysis of vacancies UK-wide in order to advise refugee doctors. Despite these limitations, the employment procedures highlighted during the interviews should be considered as applicable to most NHS working environments, thereby stressing the value of this project.

The substantive 'product' of the research project was a careers resource guidance booklet. The booklet is structured into various chapters including: background information, organisations, accreditation and employment procedures. The main results included exposing myths about medical personnel requirements in Scotland (i.e. there is an oversupply of junior doctors with most shortages in the middle grades and for certain specialities). The in-depth interviews also uncovered requirements for CVs, candidate specifications, interview and employment procedures as well as the assumptions of the workplace. Two of these areas are discussed below in more depth. This includes personnel shortages in Scottish hospitals and the route to employment for refugee doctors.

Personnel requirements in Scotland

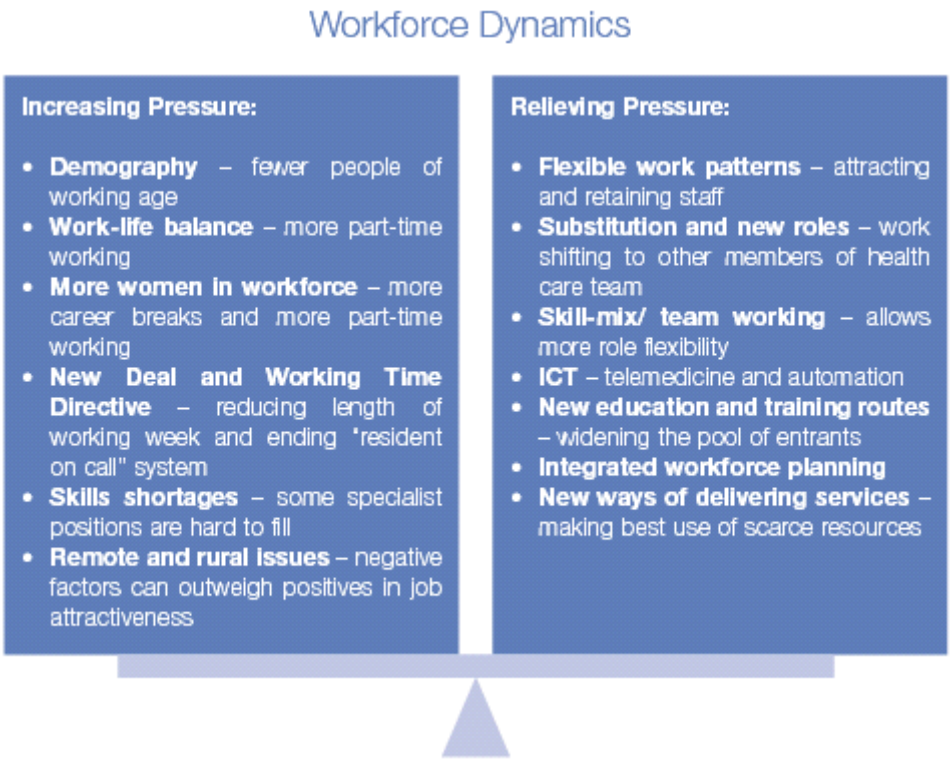
Within the UK inaccurate or ambiguous information about the shortage of doctors abounds. This can lead to unrealistic expectations amongst refugee doctors. The majority of opportunities are only for fully trained doctors in certain specialities. In the UK, demand for training posts is extremely high, particularly in popular specialities like paediatrics and surgery. This means that competition can be

extremely fierce (Constable, 2004). A number of factors have contributed to the current demand for training posts:

- 10 new member states have joined the European Union meaning competition for jobs is more intense.
- increased numbers of overseas doctors are coming to train in the United Kingdom, e.g. from India and Pakistan.

The situation is also similar within Scotland. The NHS is one of Scotland's major employers, accounting for around 6 per cent of the workforce in Scotland (147,000 staff). In Scotland the National Workforce Committee was established early in 2003 to provide leadership for the workforce development agenda. More recently, this group published the Health Workforce Plan (2004). Within this Baseline report a number of 'workforce dynamics' (figure 1) were considered to influence demand in Scotland for doctors. A few of these are discussed below (Scottish Executive, 2004).

Figure 1: Workforce dynamics in Scotland (Source: Scottish Executive, 2004)



Demography

A key shift is the increasing proportion of women in the workforce. Some 60 per cent of the medical student intake in Scotland is now female. This has major implications for medical workforce numbers, given the greater tendency of women to seek flexible working patterns. Further, the decline and ageing of Scotland's population means there will be challenges in attracting staff to work in the NHS amidst competition in a shrinking labour market.

Integrated team working

In the future there will be increasing numbers of integrated multi-disciplinary teams. These will cover a variety of new clinical roles that go beyond the traditional reliance on doctors and nurses. For example, patients may be advised by an NHS24 nurse by telephone. This will increase demand for diverse medical personnel in the NHS.

New Deal and EWTD

The hours limits introduced by the New Deal contract and the European Working Time Directive (EWTD) are reducing the amount of service provided by hospital-based doctors-in-training. This means that work traditionally done by doctors-in-training will increasingly be carried out by specially trained healthcare professionals. Again, this will probably increase demand for diverse health professionals in NHS Scotland.

These developments are driving major service redesign and key changes within Scotland, which include:

- An expansion of consultant numbers and non-medical staff (nurses and Allied Health Professionals), as activities traditionally carried out by doctors-in-training is redeployed to those staff groups.
- A continuing increase in doctors-in-training (to ensure continuing supply for an expanding consultant cohort).
- The introduction of new contracts for doctors-in-training, consultants and GPs designed to accommodate the working time limit of 48 hours per week, address the burden of extended out-of-hours/on-call commitments, underpin and extend the role of primary care, and enable more efficient delivery of safe and effective services (Source: Scottish Executive, 2004 #591].

Recruitment challenges within Scotland

At the UK level, Scotland is competing in an increasingly competitive NHS labour market. Scotland risks losing more healthcare staff south of the Border than it gains. Scotland generates a good supply of doctors-in-training, but it does less well in retaining doctors-in-training as they progress in their career. This leads to shortages at consultant level because doctors move elsewhere. Further, many doctors in training are English-domiciled and therefore move south of the Border when they complete training.

There are also particular and perennial challenges in recruiting and retaining staff to work in rural and remote areas. The large city teaching hospitals in Glasgow and Edinburgh have few problems in recruiting. The competition for jobs in these hospitals is therefore greater. Nevertheless, there are geographically 'harder to fill' areas such as Greenock, Forth Valley, Lanarkshire and Elgin. For example, the number of applicants will be significantly less for posts in Argyll and Clyde or Ayr than for a job in Greater Glasgow. Nevertheless, there is universal competition in popular specialities (such as A&E) that have a good training reputation, regardless of location.

Within Fife Trust, training posts are rotated from the Deanery in Edinburgh. This results in gaps as doctors are less likely to desire training in certain geographical locations. Consider the following quote:

> It is easier for us to attract people to Queen Margaret (Dunfermline) than it is to attract people to Kirkcaldy … specifically because Queen Margaret is a new build, people were attracted to going there because it was a new hospital and had all the state of the art equipment, and it is closer to Edinburgh, that is an obvious pull to a lot of the trainees … Kirkcaldy as you can see is an old tower block, it doesn't have the same facilities. (Medical Staffing Advisor, Fife)

So there are locational preferences within areas covered by Trusts and Deaneries. This results in training grade posts remaining unfilled. If this occurs after the matching scheme[4], then the Trust has the responsibility to recruit.

Vacancies in Scotland

Discussions of vacancies in the NHS are often couched in vague terms, so they can be somewhat misleading. A consideration of recent UK targets (below) provides an insight into the types of vacancy in Scotland. These are mainly within the higher grades of consultant or AHPs, so there are shortages of qualified senior medical staff and at consultant level. There are no significant shortages at the junior training grade levels.

Targets

- To increase the number of consultants in the NHS by 600 by 2006 and continue to build on that increase thereafter.
- Ensure a total of 1,500 extra Allied Health Professionals (AHPs), such as radiographers, physiotherapists, dieticians and chiropodists (Scottish Executive, 2004).

At the same time Scotland is experiencing shortages in specialist areas such as oral and maxillofacial surgery as well as obstetrics and gynaecology. A detailed list of specialist vacancies at consultant level is outlined in Table 1 (pages 16-17). This illustrates percentage vacancies for Scotland as a whole but also for each Trust in 2003.

During the interviews the following specialist shortages were indicated by Scottish Trusts. Again, it should be stressed that the majority of shortages were in the middle grades or at consultant level:

- *Southern General* had experienced difficulties with gastro-entomology and neurophysiology posts.
- *Stobhill* indicated that renal transplants was a big problem for medical posts. There were shortages in consultant posts in oncology and haematology for junior posts. There were further shortfalls in radiographers at oncology clinics, pharmacists and dieticians. Finally, medicine for the elderly was highlighted.
- *Tayside* experienced few shortage areas but indicated that the radiography shortage reflected the national trend.
- *Dumfries* also indicated shortages in radiography. Obstetrics and gynaecology had also proved a problem in this Trust.

[4] All training posts are 'matched', or recruited, by the Deanery and assigned to Teaching Hospitals.

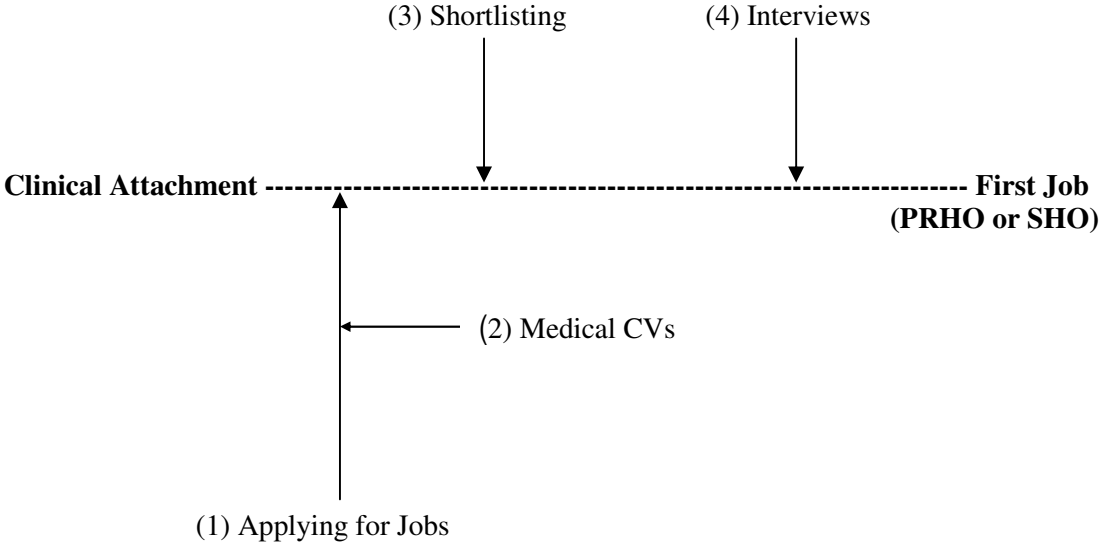
- *Argyll and Clyde* stated that radiography, laboratory specialities, paediatrics and obstetrics and gynaecology had proved difficult recruitment areas.
- *Grampian* had experienced shortages at SpR level in obstetrics and gynaecology, dermatology, trauma and orthopaedic surgery and psychiatry.
- *Ayr* indicated shortages at consultant level in child and adolescent psychiatry as well as genito-urinary medicine.
- *Fife* had problems recruiting SpR level paediatrics.
- *Edinburgh* had experienced difficulties in the middle grade specialities such as pathology and microbiology.

By examining the Workbase Plan and ISD statistics it has been found that the majority of doctor shortages in Scotland are not at the junior doctor level but at consultant and middle grades. There was also clear evidence of geographical differences and variations by speciality. News headlines proclaiming doctor shortages therefore need to be qualified in light of this data - and this accurate information about shortages need to be provided to refugee doctors seeking employment. This will result in individuals becoming fully informed and realistic about opportunities. This section has therefore demonstrated the importance of examining quantitative data both to challenge common myths about shortages and to advise refugee doctors. The following section will examine the equal value of qualitative data in relation to understanding the current Scottish employment environment.

Route to employment

This section explores important steps refugee doctors must take to obtain their first substantial medical post in the UK, after gaining a clinical attachment (figure 2). Four different areas are discussed including applying for jobs, preparing medical CVs, shortlisting procedures and interview tips. Drawing upon the in-depth interviews conducted, there is a discussion of each area below.

Figure 2: Route to employment



Applying for jobs

Refugee doctors are advised that they are unlikely to obtain an SHO[5] post against current competition without having done a PRHO post first. The majority of PRHO posts are reserved for local graduates and are 'matched' well in advance by the Deanery. This was confirmed by medical staffing advisors:

> None of the HO jobs we fill unless when we are allocated HOs from the university they cannot fill all our requirements, then we have to find our own doctors to fill those jobs. But the majority are filled on rotation. (Medical Staffing Advisor, Fife)

Only when a post has not been filled does the local Trust have the responsibility to recruit. Around half of PRHO posts in Dumfries remain unfilled, with most graduates preferring Glasgow. Nevertheless, on average there are currently up to 300 applications for such posts. So there is great competition for these junior posts. In addition, these posts are often filled at the last minute so doctors need to be ready to apply for jobs in the few weeks before rotations begin (i.e. February/August). This is indicated by the following quotes:

> PRHO when we have a vacancy it's last minute, it goes on the SHOW website and ask them to email CVs and I email them to the relevant consultants and he doesn't necessarily interview them all he'll shortlist some he wants to interview. (Medical Staffing Advisor, Edinburgh)

> We will keep a list of people who have called in that last month and expressing an interest and we can contact them if something comes up. 3 of our last 7 that is how they have got the jobs. (HR Advisor, Ayr)

A high level of competition also exists for SHO posts. This ranges from around 100 applications for posts in Dumfries and Fife to 700 applications for SHO A&E posts in Stobhill. The number of applications per SHO post therefore depends on the Trust and the speciality. On average, if there is an intake of around 12 SHO posts, there are normally around 300 applicants competing. By applying for PRHO or SHO posts, refugee doctors are directly competing with fresh graduates from medical school. Refugee doctors therefore need to think about how to distinguish their application from these candidates e.g. by emphasising experience.

Medical CVs

Refugee doctors should know that CVs will be scrutinised by an individual consultant or several consultant recruitment managers. Some doctors may take the initiative and send CVs in advance to clinical directors. In some human resource departments, CVs may be reserved for the future (e.g. Argyll and Clyde). However doctors are advised by other Trusts (e.g. Fife) not to send in CVs blindly to departments or human resources departments. So, on balance, it seems better to make targeted efforts in response to job advertisements. Consider the comments below:

[5] Within UK hospitals there are two main types of post, career grade and training grade posts. Within career grade and training grade positions there are a variety of levels. For career grade posts, the range of medical posts in a hospital from the most senior to junior are: Consultant, Associate Specialist, Staff Grade. The levels of training posts from senior to junior are: Specialist Registrar (SpR), Senior House Officer (SHO), Pre-Registration House Officer (PRHO) (Parkinson, 1999).

> Don't be afraid to submit your CV for jobs that may come up in the future … people quite often send their CVs in advance before we advertise for the post, the consultants may have a bundle of CVs which have been sent in so in the next SHO intake, they have a possible chance …. rather than just send the CV too I'd always follow it up……a phone call to the consultant, the person with the training responsibilities, a personal contact. (Medical Staffing Advisor, Argyll and Clyde)

> I wouldn't recommend they send in a blind CV because it will not go anywhere, we do not have the resources to hang on to it, so if we've got a vacancy it will go on the pile, but if it comes to us outwith the recruitment process it will not go anywhere. (Medical Staffing Advisor, Fife)

A 'scatter gun' approach of sending the same CV for every application will not be likely to lead to success (see quotes below). Handcrafting a CV to show how the individual meets the criteria of the person and job specification saves time for the selector. It is also interpreted as showing 'professional commitment'.

> A lot of shortlisting is down to what is contained in the application form about the individual, so obviously shortlisting is to do with an application form so refugee doctors need to produce very good application forms, because we see scratchy application forms, and we see high quality ones. (HR Manager, Tayside)

> You get the feeling from some of them, that they are applying for so many they don't know who you are when you call, some of them have no recollection, some of them have standard letter and their CV all ready they go through the BMJ and just fill out the name at the top. (HR Advisor, Ayr)

> One of our problems is that people try to cover their backs by applying for hundreds of jobs using one generic application form, and don't tweak it, they don't try to make it particular to that speciality, and that causes the trust a bit of concern. In the same way, as pertains to non-medical posts, if I had one person applying for 10 jobs with the same application, with no real thought process, I would be disregarding their application. (Medical Staffing Officer, Grampian)

> Doctors are notoriously bad for having awful CVs, they have a standard front sheet and put the reference number, so there is nothing that makes it stand out when you are short listing, so my message is make your CV look different, make it look presentable, that you've taken time to put it together, a lot come in with a picture at least that is an identity. Sell yourself on that bit of paper, doctors are bad at that they think they can get by on their experience, if you are up against 999 CVs, consultants have seen enough, so you need to be a bit smarter when you send a CV to us …. no exaggeration there is a front sheet photocopied 20 times, they will not end up in the post. (Medical Staffing Officer, Fife)

Shortlisting

The next step is to be short-listed for a job. Application forms and CVs are first received by the human resource department. These are then passed on to the relevant consultants in the department. It is the department employing the doctors that does the shortlisting and not the human resources department. The candidates' CVs are compared to the employee specification. Below is a series of quotes indicating the process of shortlisting for PRHO and SHO posts:

> They don't actually go through interview for an HO I go through the CVs and go to the consultant and say what do you think and then I will phone them up and offer them the job based on their references, there's nothing, even the Units know we do that, when you're employing a HO experience doesn't matter for anything because they are going to be in there with people who are just out of Unit and have never had their hands on a real patient in a ward so we don't usually put them through an interview, we select from info on the CV the criteria might be have they had some experience, have they had any in this country have they had CAs, what have they done in their own country, shown an interest in, medicine, surgery, what have they put on their CV actually sold them as HOs to us. (Medical Staffing Advisor, Fife)

> The SHO … it's basically up to the college tutor, who is a consultant in the Trust, to take away the CVs and basically go through them to determine who is being shortlisted and who isn't, it's as basic as that really. (HR Advisor, Glasgow)

> In junior level again the consultants would take that forward on a panel process, normally the lead consultants, the business manager, the general manager whoever that might be, for that speciality along with lead consultants who will be involved in due process they shortlist against the criteria for an SHO or SpR – that's selecting down from the 300 to 10 or 20 that they actually interview. (HR Advisor 2, Glasgow)

> It might be the clinical director or the lead consultant who would take responsibility for recruitment for that speciality within the department and they have that as part of their job description that they recruit for the junior staff each round of intake. (HR Advisor 2, Glasgow)

> The shortlist then goes off to the managers and the consultants with all the names of those who have applied and then that will come back with the list of names ticked against the yesses and nos and we do ask them for details of why they have or have not shortlisted someone and this will be entered on to the system. (Recruitment Manager, Glasgow)

> Applications are received within the HR dept then we put that into a pack and pass it normally to the consultant who has responsibility in that area and then that consultant would call either a panel together in order to take decisions or circulate copies to them in order to decide who are the most favoured candidates. (HR Manager, Tayside)

There are steps which can be taken to improve chances at this stage. To get shortlisted, participating in research or audit and presentations is increasingly important. Below are some further insights from HR departments regarding how to increase the chance of being shortlisted:

> Try and find out more about the organisation they're applying to and maybe ask if it's possible to go a visit in respect of the particular job they're applying to, that might help their knowledge and that would help them and give them a focus in terms of filling in their application form and as a consequence they then could present themselves more effectively and certainly if they are called for an interview it would be helpful if they made contact with the dept and asked to be shown around, so I think that would make a difference. (HR Manager, Tayside)

> I always recommend visiting the hospital, asking questions, being seen to show that interest actually going up and seeing that hospital … the visit is probably the best in their interest because when it comes to the shortlisting it will be remembered that doctors xy and z came up and visited whereas bd and c didn't and that's obviously when you are shortlisting and people have equal experience and knowledge that might be something that is advantageous to actually show that level of interest. (Medical Staffing Advisor, Argyll and Clyde)

> I will say though a lot of the consultants will say they will not meet with anyone until they have been shortlisted, but if you imagine you have a 1000 CVs and 1000 people wanting to look around your department then we don't have the resource to do it, but A&E if they don't make contact before this does not stand them well when they come for interview as they have not shown interest, been keen to make themselves known, not before but after they've been shortlisted … it's a telephone request sometimes with little time before interview so it can be difficult. (Medical Staffing Officer, Fife)

This qualitative material illustrates that although it is important for the refugee doctor to requalify, it is equally vital to be aware of the hospitals' expectations in terms of the medical CV and criteria for shortlisting. Insight has been gained into how the process of shortlisting operates, how to apply for jobs and most interestingly what refugee doctors can do to improve their chances of being shortlisted. Gaining information about the hospital, targeting their CV and visiting the hospital before the interview were all suggestions identified by HR departments in Scotland.

Interviews

During the interview process the interviewers complete an interview sheet which tries to capture all basic requirements and skills that are being sought. The interview panel specify a ranking of how well each person meets the specification. The aim of this section is to explore more fully how decisions are made during the interviewing process and what qualities departments are seeking in candidates. As well as gathering substantive information, this section also probes beneath the logic of how final decisions are made. The series of quotations below illustrate the equal importance of tangible and intangible factors in the interview process:

It's that value judgement you think about people when you meet them for the first time …. you are looking for someone who is articulate, who can explain well what they want and why they want it, you are most impressed by candidates that are able to come and say to you "this is a job I want and this is why I want it, and I hope it will take my career" .. someone who has a clear idea of what they want and they are able to say that in the interview process. (HR Manager, Glasgow)

In the interview situation someone showing attributes to be willing to be a team member, working with other members of staff, commitment, an effective way of communicating, a demonstrable interest in the job they are applying for, it would be helpful if they had an understanding of career progression, what are they trying to achieve where are they trying to get to, because that would make them look like an individual with much more focus. (HR Manager, Tayside)

Obviously someone who is qualified, has a local interest, has found out about the hospital, bed numbers, operation numbers, if they are going into surgery, acute medical assessments if they are going into medicine, has maybe come up the hospital for a visit to familiarise themselves with the geography of the place, someone who done a bit of research, someone who has pretty much excelled through the course of their study, and other than that it is more personality than anything else. Someone can have the academic ability, and educational qualifications coming out of their ear, but they might not be a people person. If that comes across at the interview, they will tend to be ranked lower down the list, so someone with a bit of sparkle and a bit [of] patient ability. (Medical Staffing Officer, Grampian)

A good command of the language … open and forthcoming and not speak in monosyllables and they're interested and enthusiastic and talk about any experience they might have …. Someone who sells themselves, you do get some particularly doctors from overseas they are perhaps nervous, a lot is hanging on it, they haven't had a job before and it's crucial, so important to them in terms of getting registration they are nervous and they don't show the confidence that others would show. What I'm aware of is the culture differences in psychiatry, it depends so much on communication the job, in surgery a leg is a leg, but in psychiatry you have to have a command of the language and appreciation of the culture that doesn't come overnight and not everyone has it and if you haven't got it then you have to have something else, something outgoing, as they do not have a lot of life experience in this country, but you can tell from the way they are wherever they are they will make a good job of it. (HR Advisor, Ayr)

Generic for all specialities … a patient focus, an interest in service development, good communication skills with patients, relatives, colleagues, a willingness to learn about their speciality. (Medical Staffing Advisor, Argyll and Clyde)

As illustrated by the various quotes above, the final decision to appoint an individual can be regarded as based upon a combination of tangible and intangible factors. The

interviewees identified qualities such as professional ability, team working, a good command of English and educational qualifications. A refugee doctor could potentially improve his/her position relative to these tangible factors by increasing training and ensuring that s/he met requirements for requalification. The research, however, also identifies a number of intangible factors which influence employment decisions. Human resource managers are seeking candidates with 'sparkle', 'commitment' and base employment decisions on a 'value judgement'. These requirements are clearly not measurable or quantifiable. As such it may be more difficult for refugee doctors to meet these intangible determinants or to improve in these areas. This insight into employment procedures illustrates that integration is a two-way process, involving both the refugee doctor and the medical employment environment. These findings may therefore point to the need for employers to continually scrutinise recruitment procedures to ensure fairness and equal opportunities for all.

Discussion and Conclusion

The main results from this research project included exposing myths about medical personnel requirements in Scotland. In reality there is an oversupply of junior doctors with shortages existing in the middle grades or consultant positions. Further, shortages are mainly experienced in certain specialities. The in-depth interviews also uncovered requirements for CV's, candidate specifications, interview and employment procedures as well as the taken-for-granted assumptions of the workplace. The importance of handcrafting the medical CV and the danger of the 'scatter gun' approach were highlighted. In terms of shortlisting, candidates are advised to gain information about the hospital and to visit the institution before interview. Finally the tangible and intangible factors which influence employment decisions were also uncovered by the in-depth interviews.

At this point it should be acknowledged that widespread, structural problems are also likely impacting upon the employment outcomes of refugee doctors in the UK. The situation facing refugee doctors may be symptomatic of the wider problems facing immigrants in the UK labour market (Dustmann *et al.*, 2003). It may therefore be part of the discrimination experienced by all immigrants in the UK. Research specifically within the NHS has also reported underachievement, lack of career progression and discrimination against overseas doctors (Esmail and Everington, 1997; Esmail *et al.*, 1998; Grant *et al.*, 2004). It might be expected that refugee doctors are doubly disadvantaged, being qualified overseas and having refugee status. Although the aim of this project was not to specifically address these larger issues, it is hoped that by increasing individuals' familiarity with the UK medical system this may be the first step in breaking down the barriers currently facing refugee doctors.

To conclude, standing back from the detail of the research project, important lessons can be drawn from this innovative project. First, it is reiterated that integration should be regarded as a 'process' which is bound up with individual and institutional factors. To increase the recruitment of refugee doctors, therefore, the focus of programmes should not be solely upon the individual or the medical system. Both factors need to be considered alongside each other. Second, any future research projects should seek to draw upon the expertise of academics and practitioners. As such there should be continued funding of local initiatives to encourage cross-fertilisation of ideas and sharing of research skills between academics and practitioners.

Table 1: Consultant Vacancy Rates by Trust and Speciality - 2003																
	Scotland	NHS Ayrshire and Arran	NHS Borders	NHS Argyll and Clyde	NHS Fife	NHS Greater Glasgow	NHS Highland	NHS Lanarkshire	NHS Grampian	NHS Orkney	NHS Lothian	NHS Tayside	NHS Forth Valley	NHS Western Isles	NHS Dumfries and Galloway	NHS Shetland
All Specialties	**6.7%**	**6.1%**	**9.9%**	**6.5%**	**12.6%**	**6.4%**	**10.4%**	**13.7%**	**2.4%**	**20.0%**	**4.5%**	**2.9%**	**5.1%**	**25.0%**	**10.9%**	**21.0%**
All Medical Specialties	**6.8%**	**6.3%**	**10.0%**	**6.6%**	**12.9%**	**6.7%**	**10.7%**	**13.9%**	**2.2%**	**20.0%**	**4.1%**	**2.7%**	**5.2%**	**25.0%**	**11.2%**	**21.0%**
Hospital Medical Specialties	**6.7%**	**6.5%**	**10.4%**	**6.5%**	**13.0%**	**6.7%**	**11.2%**	**14.0%**	**2.3%**	**0.0%**	**4.2%**	**2.4%**	**4.7%**	**25.0%**	**10.3%**	**23.6%**
Accident & Emergency Medicine	8.1%	0.0%	0.0%	0.0%	0.0%	13.3%	50.0%	14.3%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%
Anaesthetics	3.3%	0.0%	22.2%	17.4%	0.0%	3.5%	5.6%	0.0%	0.0%	0.0%	1.1%	0.0%	0.0%	0.0%	6.8%	33.3%
Clinical Laboratory Specialties	4.6%	0.0%	25.0%	4.8%	14.9%	1.3%	9.1%	13.1%	0.0%	0.0%	5.7%	3.8%	10.7%	0.0%	0.0%	0.0%
Chemical pathology	3.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Haematology	5.7%	0.0%	33.3%	16.7%	15.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%
Histopathology	6.4%	0.0%	0.0%	0.0%	0.0%	3.5%	20.0%	20.4%	0.0%	0.0%	12.1%	7.4%	0.0%	0.0%	0.0%	0.0%
Medical microbiology & Virology	1.9%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medical Specialties	**7.1%**	**13.5%**	**19.4%**	**0.0%**	**15.6%**	**6.4%**	**14.7%**	**15.9%**	**6.0%**	**0.0%**	**1.9%**	**2.4%**	**3.0%**	**25.0%**	**17.4%**	**31.3%**
Dermatology	8.2%	0.0%	0.0%	0.0%	37.9%	0.0%	33.3%	0.0%	25.0%	0.0%	0.0%	0.0%	50.0%	0.0%	0.0%	0.0%
General medicine (group)	**5.9%**	**16.8%**	**32.2%**	**0.0%**	**10.6%**	**6.3%**	**10.6%**	**12.9%**	**2.3%**	**0.0%**	**1.4%**	**0.0%**	**0.0%**	**0.0%**	**14.5%**	**0.0%**
Cardiology	10.7%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	42.9%	0.0%	0.0%	7.0%	0.0%	0.0%	0.0%	50.0%	0.0%
Endocrinology & diabetes	11.0%	0.0%	0.0%	0.0%	0.0%	13.3%	100.0%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Gastroenterology	11.7%	0.0%	0.0%	0.0%	50.0%	29.6%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
General medicine	3.9%	17.7%	20.0%	0.0%	0.0%	5.6%	7.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Renal medicine	3.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	27.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Respiratory medicine	8.3%	0.0%	61.1%	0.0%	50.0%	0.0%	0.0%	37.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Genito - urinary medicine	12.8%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Geriatrics	11.2%	25.0%	0.0%	0.0%	19.0%	3.9%	0.0%	24.1%	9.4%	0.0%	5.3%	20.8%	0.0%	50.0%	33.3%	0.0%
Medical oncology	25.9%	0.0%	0.0%	0.0%	0.0%	32.8%	100.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Neurology	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Paediatrics	4.0%	0.0%	0.0%	0.0%	20.0%	3.8%	0.0%	11.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	100.0%
Clinical oncology	11.9%	0.0%	0.0%	0.0%	0.0%	15.6%	0.0%	0.0%	33.3%	0.0%	8.9%	0.0%	0.0%	0.0%	0.0%	0.0%
Rehabilitation medicine	5.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	33.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Clinical Neuro-Physiology	25.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

	Scotland	NHS Ayrshire and Arran	NHS Borders	NHS Argyll and Clyde	NHS Fife	NHS Greater Glasgow	NHS Highland	NHS Lanarkshire	NHS Grampian	NHS Orkney	NHS Lothian	NHS Tayside	NHS Forth Valley	NHS Western Isles	NHS Dumfries and Galloway	NHS Shetland
Obstetrics & Gynaecology	6.4%	0.0%	0.0%	7.1%	11.1%	11.5%	12.5%	0.0%	0.0%	0.0%	8.5%	9.7%	0.0%	0.0%	0.0%	0.0%
Occupational Medicine	4.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	17.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Psychiatric Specialties	9.0%	0.0%	0.0%	2.7%	13.7%	11.0%	19.3%	22.4%	4.6%	0.0%	7.4%	2.4%	5.4%	0.0%	12.4%	0.0%
Child & adolescent psychiatry	8.1%	0.0%	0.0%	0.0%	33.3%	17.2%	0.0%	0.0%	8.8%	0.0%	0.0%	0.0%	0.0%	0.0%	13.9%	0.0%
Forensic psychiatry	2.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
General psychiatry	9.8%	0.0%	0.0%	4.2%	9.5%	7.3%	19.0%	28.2%	5.9%	0.0%	10.4%	2.4%	9.7%	0.0%	13.4%	0.0%
Psychiatry of learning disability	7.7%	0.0%	0.0%	0.0%	0.0%	31.9%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Old age psychiatry	11.3%	0.0%	0.0%	0.0%	15.3%	17.7%	55.0%	42.2%	0.0%	0.0%	12.6%	0.0%	0.0%	0.0%	0.0%	0.0%
Psychotherapy	3.4%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	31.3%	0.0%	0.0%	0.0%	0.0%
Radiology	13.4%	26.7%	0.0%	18.4%	56.1%	10.0%	18.5%	19.8%	0.0%	0.0%	5.0%	4.2%	12.5%	100.0%	40.0%	0.0%
Clinical radiology	13.7%	26.7%	0.0%	18.4%	56.1%	10.0%	20.4%	19.8%	0.0%	0.0%	5.3%	4.4%	12.5%	100.0%	40.0%	0.0%
Surgical Specialties	**6.2%**	**5.0%**	**0.0%**	**5.1%**	**10.5%**	**6.7%**	**3.0%**	**16.3%**	**0.0%**	**0.0%**	**7.1%**	**1.7%**	**3.4%**	**50.0%**	**5.6%**	**0.0%**
ENT surgery	4.4%	0.0%	0.0%	0.0%	0.0%	5.7%	20.0%	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
General surgery	6.5%	0.0%	0.0%	5.9%	19.1%	7.0%	0.0%	15.0%	0.0%	0.0%	10.1%	5.8%	0.0%	0.0%	16.7%	0.0%
Ophthalmology	2.6%	16.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%
Trauma & Orthopaedic surgery	8.6%	8.3%	0.0%	9.1%	12.5%	11.5%	0.0%	26.7%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Plastic surgery	11.5%	0.0%	0.0%	0.0%	0.0%	8.3%	0.0%	0.0%	0.0%	0.0%	29.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Urology	9.5%	0.0%	0.0%	0.0%	0.0%	16.7%	0.0%	16.7%	0.0%	0.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Public Health Medicine	7.8%	0.0%	0.0%	14.2%	15.8%	8.8%	0.0%	14.3%	0.0%	100.0%	0.0%	14.5%	0.0%	0.0%	0.0%	0.0%
Community Medical Specialties	**5.8%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**6.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**100.0%**	**0.0%**	**100.0%**	**0.0%**
Community child health	9.3%	0.0%	0.0%	0.0%	0.0%	11.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%	0.0%
All Dental Specialties	**5.1%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**20.0%**	**0.0%**	**17.8%**	**6.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
Hospital Dental Specialties	4.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	20.0%	0.0%	12.6%	7.0%	0.0%	0.0%	0.0%	0.0%
Oral medicine	13.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Oral & Maxillofacial Surgery	30.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	50.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Community Dental Specialties	10.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Dental Public Health	10.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: ISD Statistics

REFERENCES

Adams K, Borman E. 2000. Helping refugee doctors. *British Medical Journal* **7239**: 887

Al-Rasheed M. 1992. Political migration and downward socio-economic mobility: The Iraqi community in London. *New Community* **18**(4): 537-549

Bauder H. 2005. Habitus, rules of the labour market and employment strategies of immigrants in Vancouver, Canada. *Social and Cultural Geography* **6**(1): 81-97

Berlin A, Gill P, Eversley J. 1997. Refugee doctors in Britain: A wasted resource. *British Medical Journal* **315**: 264-265

Bloch A. 2000. Refugee settlement in Britain: The impact of policy on participation. *Journal of Ethnic and Migration Studies* **26**(1): 75-88

Bloch A. 2002 *'Refugees' Opportunities and Barriers in Employment and Training*, Department for Work and Pensions: Leeds

Bloch A, Schuster L. 2005. At the extremes of exclusion: Deportation, detention and dispersal. *Ethnic and Racial Studies* **28**(3): 491-512

Charlaff L, Ibrani K, Lowe M, Marsden R, Turney L. 2004 *Refugees and Asylum Seekers in Scotland: A Skills and Aspirations Audit*, Scottish Executive Social Research: Edinburgh

Cheeroth S, Goraya A. 2000. 'Refugee doctors', *British Medical Journal*, <http://www.bmj.com/cgi/content/full/321/7267/S2-7267>, accessed: 29 January 2000

Constable J. 2004. An updated quick guide to working in the United Kingdom. *British Medical Journal Career Focus* **328**(19 June): 245

Crisp J. 2004. The local integration and local settlement of refugees: A conceptual and historical analysis. *New Issues in Refugee Research* **102,** UNHCR Evaluation and Policy Unit: Geneva

Department of Health. 2003 *Integrating Refugee Health Professionals into the NHS: A Report of the Department of Health Steering Group from 2001 & 2002*, Department of Health: London

Dustmann C, Fabbri F, Preston I, Wadsworth J. (2003) *Labour Market Performance of Immigrants in the UK Labour Market*, Home Office Online Report **05/03**: London

Easton G. 2003. Nearly 1000 doctors out of work. *British Medical Journal* **327** (Careers Focus): s28, 26 July

Esmail A, Everington S. 1997. Asian doctors are still being discriminated against. *British Medical Journal* **314**: 1619

Esmail A, Everington S, Doyle H. 1998. Racial discrimination in the allocation of distinction awards? Analysis of list of award holders by type of award, speciality and region. *British Medical Journal* **316**: 193-915

Gavin M, Esmail A. 2002. Solving the recruitment crisis in UK general practice: Time to consider physician assistants? *Social Policy and Administration* **36**(1): 76-89

Grant J, Jones H, Kilminster S, MacDonald M, Maxted M, Nathanson B, Owen H. (2004) *Overseas Doctors' Expectations and Experiences of Training and Practice in the UK*, Open University: Milton Keynes

Higgitt N. 2000. A model of refugee resettlement. In *Race and racism: Canada's challenge*, Driedger, L. and Halli, S.S. (eds.); McGill-Queen's University Press: Winnipeg, Canada; 98-115

Home Office. 2000 *Full and Equal Citizens. A Strategy for the Integration of Refugees into the United Kingdom*, Home Office: Croydon

Home Office. 2005 *Integration Matters*, Home Office: Croydon

Hope B. 1997. Refugee doctors forced to do menial jobs. *British Medical Journal* **315**: 269-274

Hurstfield J, Pearson R, Hooker H, Ritchie H, Sinclair A. (2004) *Employing Refugees: Some Organisations' Experiences*, Institute for Employment Studies: Brighton

Parkinson J. 1999. *Manual of English for the Overseas Doctor*. Churchill Livingstone: Edinburgh

Refugee Council. 2004 *Consultation Draft: Agenda for Integration*, Refugee Council: London

Scottish Executive. 2004 *Scottish Health Workforce Plan, 2004 baseline*, Scottish Executive: Edinburgh

Social Exclusion Unit. 2004 *Tackling Social Exclusion: Taking Stock of Progress and Priorities for the Future*, Office of the Deputy Prime Minister, London

Stewart E. 2002. Refugee doctors in the United Kingdom. *British Medical Journal* **325**(Careers Focus): s166-167, 16 November

Stewart E. 2003. A bitter pill to swallow: Obstacles facing refugee doctors in the UK. *New Issues in Refugee Research* **96**: UNHCR Evaluation and Policy Analysis Unit: Geneva

Tayal U. 2003. No place to call home. *British Medical Journal* **327** (Careers Focus): s93, 20 September

Valtonen K. 2004. From the margin to the mainstream: Conceptualizing refugee settlement processes. *Journal of Refugee Studies* **17**(1): 70-96

Zetter R, Griffiths DJ, Sigona N, Hauser M. 2002 *Survey on Policy and Practice Related to Refugee Integration*, Department of Planning, Oxford Brookes University, Commissioned by European Refugee Fund Community Actions 2001/2