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A bitter pill to swallow: obstacles facing refugee and overseas doctors in the UK

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Introduction

In a climate which is increasingly hostile towards migrants coming to the UK, there is one group which challenges the negative assumptions. Refugee doctors have the potential to contribute to the country's economy, but all the evidence suggests that this valuable resource is being wasted.

This paper summarises the main difficulties facing refugee doctors in the UK. Unlike previous investigations of this issue it reports the personal experiences of over 30 doctors, including those who are unemployed and those who are in employment. The paper finds that the main difficulties facing refugee doctors in the UK are professional registration, unemployment regulations, being shortlisted for a job and career progression. For many refugee doctors, the hurdles they face within the UK are indeed a bitter pill to swallow.

The paper calls for immediate action to ensure that refugee doctors make full use of their skills.¹ More needs to be done to guarantee that doctors' previous experience is fairly assessed, that doctors are helped to enter the National Health Service (NHS) more quickly, and that they are subsequently guided in how to progress with their careers.

Refugee doctors in the UK

Case study: Kab is a qualified African doctor practising as a consultant in a UK teaching hospital. He came to the UK initially for higher and specialist training. However, when he completed his studies he was unable to return to his own country due to political problems. Since being in the UK he has progressed from an SpR (specialist registrar) position to his present consultancy post. And in fact he has achieved this post in a shorter period of time than would be expected of even a local graduate. He also has many academic interests which he has been able to develop through various overseas visits. He feels grateful to this country for the career opportunities that he has been afforded by the UK. He is also very positive regarding the treatment he has received whilst in the country. And he wishes to remain in the UK where he can develop his current post and pursue his academic interests.

Kab's case demonstrates what overseas and refugee doctors can achieve within the NHS. It may therefore be questioned whether there really is a problem. Regrettably, however, Kab is an exceptional case and the reality for many refugee doctors is professional disappointment, frustration and humiliation. A more typical experience is shown by Mohammed's case:

¹ This research was funded by a University of Dundee scholarship. I would like to thank Allan Findlay for helpful comments on an earlier draft of this paper. However, most importantly, I would like to express my appreciation and thanks to all the doctors who were so willing to share their stories with me. Pseudonyms are used throughout the paper. A summarised version of this paper was published by BMJ Career Focus (16 November 2002).

Case study: Mohammed is a Middle Eastern qualified doctor with over 20 years specialist experience, including consultancies for international organisations. Mohammed fled his country of origin due to the persecution he experienced and fear for his life. After initial problems settling his immigration status in the UK, Mohammed spent considerable time in finding out how he could restart his career in the UK. Since Mohammed has been in the UK he has only been able to get a staff grade post. In his present position he feels extremely frustrated. Despite the fact that both his fellow colleagues and superiors are aware of his medical knowledge and abilities he is still trapped in his current post. There is no opportunity for him to progress beyond his staff grade post which makes him feel desperate. He is annoyed that he cannot utilise his specialist knowledge within the UK when it is needed by the NHS.

Overseas doctors in the NHS

The present lack of doctors combined with the future impact of population trends will result in a growing demand for overseas doctors to fill gaps within the NHS (Doherty, 2001). The present situation within the UK has been caused by various factors. The trend amongst UK graduates to work abroad and the shortfall in overseas medical staff (Jinks et al., 1998) has contributed to the current NHS shortage of doctors and nurses (Beecham, 1997). The gaps are clearly identifiable but there is an urgent problem of sourcing both present vacancies and planned increases.

The historical and present importance of overseas qualified doctors working within the UK is demonstrated by the constant proportion of new registrations by overseas graduates with the General Medical Council (General Medical Council, 2000). Within the field of General Practice there are many projected problems. For example, there are large numbers of Asian GP's due to retire by 2007 (Gavin and Esmail, 2002). Presently, 15% of the GP's in UK qualified in South Asian medical schools. And although the government is offering a £10,000 'golden goodbye' to tempt people to stay over their retirement age (Gavin et al., 2002), the health service will soon lose a generation of Asian doctors. This will result in an estimated shortfall of 1000 GP's. Combined with the decline in the attractiveness of general practice to newly qualified doctors, there have been warnings that by 2010 the NHS will face serious doctor shortages (Jones, 1998).

Overseas recruitment

To address the shortfall in doctor requirements within the NHS various measures have been tried. Recruiting overseas doctors to the UK has occurred with targeted packages to European countries (British Medical Association, 2001). This strategy has also been implemented for other health professionals such as in the International Recruitment of Nurses (Department of Health, 1999). However growing evidence suggests that the migration of skilled workers such as doctors and nurses may have negative impacts on development in poor countries (Glover et al., 2001). So although many overseas recruitment policies may be ethically driven, the concept of spending money to recruit personnel from overseas seems ludicrous when there are refugee doctors living in the UK, who are able and willing to work. Rather than recruiting

from abroad, the priority should be to use the qualified doctors already within the country. Indeed a recent policy recommendation made to DFID was to identify new policy tools to increase the efficient use of skills brought to the UK by refugees (Findlay, 2001).

Refugee doctors

The priority should be to utilise overseas qualified doctors who have settled in the UK rather than spending money to recruit from abroad. Historical examples clearly demonstrate the immense contribution that overseas graduates can make to the UK (Lyall, 2001). The British Medical Association estimate that there are between 500 and 2000 refugee doctors currently in the UK. A medical education is long and costly. The medical education of a student costs £200,000 per person (Berlin et al., 1997). Refugee doctors who are in this country are effectively 'ready-made' doctors who should be employed. It has been described as a 'win-win' situation (Berlin et al., 1997). Also, given the increasing refugee populations within the UK the skills of refugee doctors could be used to also benefit refugee communities, especially within the health field (Health Panel, 1999). The language, culture and professional skills of refugee doctors are needed to help with these communities (Wenzel, 1999). The employment of refugee doctors would therefore benefit both local and refugee communities.

The government initially provided £500,000 for the Refugee Doctors Project (Gavin et al., 2002; Mayor, 2000). Further the Refugee Doctor's Database has been set up by the Refugee Council and British Medical Association. A report was specially prepared to investigate the issues facing refugee doctors and dentists, providing recommendations and areas of improvement (Department of Health, 2000). The professional, financial and cultural obstacles facing refugee doctors have been well documented over the past 5 years by those within the medical system (Adams and Borman, 2000; Berlin et al., 1997; Cheeroth and Goraya, 2000). Although there is evidence that the careers of refugee doctors are thwarted by the system, it is less clear that the personal experiences and opinions are being considered. Therefore unlike previous studies, this research aimed to investigate the issues from the standpoint of the refugee doctors themselves.

Brain waste?

There has been little study of skilled refugees and the effect of brain wastes, namely the under-utilisation of an individual's skills (Koser and Salt, 1997). Bloch (2000) confirms that refugees are well-educated and under-employed in low-skilled jobs due to structural barriers. The result is that highly motivated professionals are forced to do menial jobs which can cause economic destitution (Hope, 1997). The personal experiences of health care workers and doctors demonstrate that they have difficulties in gaining employment within their host countries (Health Panel, 1999). Problems included recognition of degrees and the length of time required for re-qualification.

The personal experiences of refugee doctors informed this research. Unlike previous studies, this research uniquely interviewed refugee doctors at various stages of their careers, both those employed and unemployed. Most research (Adams et al., 2000;

Cheerorth et al., 2000) has logically focused on re-entering the profession but the fate of refugee doctors once they have passed their exams and gain registration has been paid less attention. This research will report directly from 42 doctors and will try to address the refugee doctor story as a whole.

Methodology

In order to contact refugee doctors personally a variety of avenues were pursued. The main tool used was a postal questionnaire which aimed to contact refugee doctors currently employed in the UK. A questionnaire of five pages was distributed to 1000 overseas qualified doctors. The names were chosen at random (using statistical random number tables) from the British Medical Register. The postal survey was conducted from Summer to Autumn 2001. During this time over 300 individuals responded. The results from this questionnaire have been statistically analysed.

Respondents to the questionnaire, who were employed refugee doctors, were interviewed. It was much more difficult to contact unemployed refugee doctors. An advert was placed in the 'Refugee Doctors News' distributed by the BMA requesting help with the project. Therefore, a sub sample of respondents to the postal questionnaire were interviewed in addition to unemployed refugee doctors who responded to the advert. In addition, there were some individuals who were contacted by means of snowballing techniques. As a result, all of the subjects interviewed were self-selected or recommended by other persons previously interviewed. The difficulty in obtaining interview subjects, particularly within the recently arrived refugee groups, meant that this technique was employed (Bloch, 1999). This follows the example of official studies (Carey-Wood et al., 1995). However there are disadvantages to using snowball techniques. These include not providing an accurate sampling frame and the danger of interviewing people with similar experiences (Bloch, 2000). This sampling approach technique does not claim to be representative however the results vitally uncover the personal experiences and in-depth narratives of refugee doctors.

Forty-two in-depth interviews were conducted with overseas qualified doctors and typically lasted one to two hours. Not all of these individuals had official refugee status. Some were asylum seekers and others had left countries where they faced persecution or warfare, but did not consider this the main motivation for their mobility. Interviews were carried out in various parts of the UK to minimise regional biases. The interview schedule was adapted from one interview to another, for example those individuals still living as refugees or asylum seekers differed to those presently employed in the UK. The interviews were semi-structured and basic areas that were explored included: Basic Information, Arrival to the UK, Asylum Application, Professional Experiences as Refugee Doctor, Personal Experiences in UK, Migration event, Experiences in Homeland, Your Future Plans.

The demographic characteristics of the sample are summarised in the tables below. Two thirds of people interviewed were male (Table 1) and almost half of the sample were between 40 and 49 years of age (Table 2). Around two thirds of people were married at the time of the interview (Table 3). Refugee doctors from 16 different countries were interviewed but the largest proportion were from Iraq (Table 4). According to the BMA this is the top nationality of refugee doctors in the UK. All

levels of medical doctor were interviewed including those employed and unemployed (Table 5). Interviews were carried out all over the UK but the two main clusters were in Glasgow and London (Table 6). Over half of the sample were asylum seekers or had been granted refugee status (Table 7). However in addition, others had left countries where they faced persecution or warfare and these have been classified as forced migrants.

Table 1: Gender division of interviewees

<i>Gender (total = 42)</i>	
<i>Gender</i>	<i>Number (percentage of total)</i>
Male	29 (69%)
Female	13 (31%)

Table 2: Age of interviewees

<i>Age (total = 39)</i>	
<i>Age</i>	<i>Number (percentage of total)</i>
20-29 years	6 (15%)
30-39 years	7 (18%)
40-49 years	17 (44%)
50+ years	9 (23%)
Non-response	3

Table 3: Marital status of interviewees

<i>Marital status (total = 42)</i>	
<i>Marital status</i>	<i>Number (percentage of total)</i>
Single	13 (31%)
Married	26 (62%)
Divorced/widowed/ Other	3 (7%)

Table 4: Country of origin of interviewees

<i>Country of origin (total = 42)</i>	
<i>Country of origin</i>	<i>Number (percentage of total)</i>
Iraq	15 (36%)
Sudan	5 (12%)
FRY	3 (7%)
Iran	3 (7%)
Nigeria	3 (7%)
Kosovo	2 (5%)
Sri Lanka	2 (5%)
Bangladesh	1 (4%)
Burundi	1 (2%)
Congo	1 (2%)
Eritrea	1 (2%)
Georgia	1 (2%)
India	1 (2%)
Romania	1 (2%)
Russia	1 (2%)
Turkey	1 (2%)

Table 5: Medical employment of interviewees

<i>Medical Employment (Total = 42)</i>	
<i>Job Title</i>	<i>Number (Percentage of Total)</i>
Unemployed	15 (36%)
Consultant	12 (29%)
Staff Grade	6 (14%)
Retired	2 (5%)
SHO	2 (5%)
Surgeon	2 (5%)
Specialists	2 (5%)
General Practitioner (GP)	1 (2%)

Table 6: Scottish/English Dimension of Interviews

<i>Location In UK (Total = 45)</i>	
<i>Location in UK</i>	<i>Number (Percentage of Total)</i>
Scotland	24 (53%)
England	21 (47%)

Table 7: Migration motivation/category of interviewees

<i>Migrant Category (Total = 42)</i>	
<i>Migrant Category</i>	<i>Number (Percentage of Total)</i>
Forced Migrant*	16 (38%)
Refugee Status	13 (31%)
Asylum Seeker	10 (24%)
Career Progression	2 (5%)
Students Initially	1 (2%)
* see explanation of term in text.	

The part of the interview which will be reported in this paper is the Professional Experiences as a Refugee Doctor. However the interview aimed to uncover the personal narratives, ‘life-history’ or biography (Halfacree and Boyle, 1993; Miles and Crush, 1993) of the person. Therefore the results presented were not the only findings and were enquired about in the context of the person’s life history. The results aimed to tell the migrant’s story, their subjective history, their feelings and thoughts, how they see life and what their opinions are. This qualitative research strategy does not represent the opinions of all overseas qualified doctors in the UK. However it importantly gives a taste of the experiences and obstacles facing refugee doctors.

Results

Doctors made it evident that the road to re-starting their career in the UK is fraught with many obstacles and hurdles. The route to GMC registration is long and complex. Before gaining GMC registration a number of requirements must be met, including passing the International English Testing System (IELTS) and the Professional and Linguistic Assessment Board (PLAB) parts I and II. The PLAB has been criticised for various reasons. For example when it was sat by a sample of 50 UK Medical Graduates only two passed (quoted in (Gavin et al., 2002)). It is also considered unsuitable in its preparation of overseas graduates planning to stay in the UK (Eastwood et al., 1998) because many who sit the PLAB return to their country of origin.

However at present this is the requirement set out by the General Medical Council for all refugee doctors who will obviously remain in the UK. Many individuals highlighted the PLAB as problematic. The refugee doctor below explained how the PLAB exam is a very basic exam, equivalent to finals in medical school. This is extremely difficult for a specialist doctor who has practised in one speciality for many years to pass. He also noted the time spent waiting to sit an exam as frustrating.

We were asked to wait for 6 months for decision with the GMC 6 months later they said you have to take PLAB exam, the next exam was 6 months later because you can’t take it just tomorrow and because we were both at the time specialised ...it was very difficult to go back and get a primary exam such PLAB exam”. (European refugee doctor, male)

The IELTS was also described for its' difficulty and unreasonableness. The two quotes below demonstrate that refugee doctors from very different continents experience similar problems. The first doctor related that he knows many individuals who are unable to pass the exam. The second asylum seeker doctor explains the cause of this situation. She stated that IELTS does not evaluate the English needed to practise as a doctor. They both consider IELTS as an unsuitable exam for refugee doctors.

It was really hard because, that IELTS is not a question of knowing English, it is a question of passing it as a specific exam you know .. I have seen many doctors in London who are here already 5 years or 4 years they cannot work because they have tried to pass that exam, they cannot pass it, although their English is perfect. They can write correctly English, but it is impossible for them to pass that test. (African refugee doctor, male)

IELTS is very difficult for me to pass eh because it, it really doesn't evaluate your knowledge of English or how you can communicate to your patients or how you can go on in your career, it's something, a very general thing. (Middle East asylum seeker doctor, female)

The preparation for exams such as the PLAB was also hindered by a lack of direction and specific textbooks. In some instances a refugee doctor can be registered with the GMC through the specialist doctor route if they have more than seven years experience, yet there may difficulties in proving this. Alternatively if a doctor passes the exams of a specialist college they may gain GMC registration. However difficulties are faced when a subject area bridges two specialities and one Royal College refuses to issue the registration.

Although there are local courses for exam preparation, many efforts are co-ordinated locally which results in uneven services. A good example is the Refugee project in Waltham Forest (Cliff and Letts, 2002). But many refugees are now dispersed across the UK which results in the need for specific services being available UK wide. Fortunately, implementations are being made by local medical postgraduate deaneries but as with most projects it will take time for these developments to benefit the refugee doctors in various localities.

Unemployment regulations

Another major problem identified in the interviews was the difficulties faced after doctors have passed their exams. Once a doctor has refugee status they receive social security benefits and must be ready for work. But job centre regulations often do not recognise the unique situation of refugee doctors who are seeking medical employment. The result is that they may be forced to take an unskilled post, causing the deskilling of some doctors. The refugee doctor below from the Middle East explained the immense pressure placed upon refugee doctors by local job centres to find employment. They are often forced to take unskilled positions such as in the service sector. This will inevitably result in deskilling over time and prevent re-qualification. Studies have shown that for recently arrived individuals there were no significant differences in employment outcomes for those with or without

qualifications (Waxman, 2001). It is therefore vital to recognise qualifications and not allow time to pass when people could become de-skilled because once in an unskilled position or on welfare it will become increasingly difficult to re-enter the medical profession.

The DSS provides support for refugees but it's not easy for a refugee doctor to work as a waiter the job centre won't accept that you are looking for a medical post. They say that you need to find a job, any job, and that they don't care about the qualifications that you may have from your country of origin. They don't know about the situation facing refugee doctors and what the government is doing to help them. (Middle East refugee doctor, male)

To date a sum of £500,000 has been allocated to help refugee doctors (Gavin et al., 2002). If the BMA estimates that there are between 500 and 2000 refugee doctors in the UK that only works out at £250 per person. That is hardly enough to invest in this resource. It is estimated that it would cost £3500 for courses and exams to have a qualified GP to work in the community (Elliot, 1998). Therefore a minimum of £7 million would need to be invested. The small sum of money has been provided to enable refugee doctors to take up unpaid clinical attachments (Gavin et al., 2002). The doctors interviewed in my research highlighted a major problem with this. The posts are unpaid so if a doctor was to accept such a post they would conceivably have no financial resources on which to survive. They also highlighted the small sum allocated in comparison to the money spent on overseas recruitment.

Short-listing

The next hurdle is to be short-listed for a job. The GMC only provides limited registration when a doctor has a job offer. Refugee doctors noted considerable difficulties in competing with other candidates when they do not have GMC registration. They were also aware that they lacked the UK references needed which are almost impossible for an overseas qualified doctor to have. As a result most doctors felt they were disadvantaged at the shortlisting stage and that preference was always given for local candidates. As this doctor told me, he was not even short-listed for a position, despite the fact he was previously a consultant in his home country. This caused him extreme disappointment and frustration.

I applied for registration and GMC registered me through the senior doctor route and I've been applying for specialist registrar jobs to be re-trained from zero (what I have been as a consultant).. and I've not been even short-listed and taking into account that those who are competing with me are the fresh graduates and SHO's who have just done some basic training or practice and have no ... experience, I find this very disappointing and frustrating I'm trapped here to be on the dole. (Middle East refugee doctor, male)

Doctors explained that the time spent leaving a country and re-qualifying has an immense impact on their career prospects. Indeed, it has been highlighted that the time taken to re-enter the profession is the greatest problem facing refugees (Carlisle, 2001). Of those spoken to it was mentioned that the passage of time means that they

were considerably older than the new graduates with whom they were competing. The doctors also have a gap in their professional CV's which was a disadvantage in the short-listing process.

The time period elapsed also results in an initial professional disadvantage of not practising medicine for a period or time which may cause some, in specialities like surgery, to 'lose the touch'. It is understandable that the profession must ensure high standards by setting exams but the time taken for re-qualification is undoubtedly a problem. And despite government measures to speed up the process the reality for those spoken to was that it took on average two years for most refugee doctors to make the transition to a full time working post within the NHS.

Career progression

Once within the health service, the problems do not stop for many refugee doctors. Typically there may be stagnation in the middle grades as people are unlikely to get training posts but are forced into staff grade or associate specialist posts. These were referred to by one interviewee as 'jail sentence jobs'. There is a feeling amongst many doctors that they are treated as second class citizens or slaves within the NHS. This is highlighted by Mohammed's quote. He was employed in a staff grade post but unable to progress further despite his vast experience.

There is no way to progress, that's a frustration you know ... as a staff grade in this hospital, I've been working in the capacity of the registrar completely this is a non-training post but I'm doing it exactly, exactly the same duties, so here is the frustration yeah, it is a big, big frustration because you know you feel like you know that the system is not fair you've done everything what other people do, you have the same experience as what they are doing ... and the people working with you they are very convinced that you are an experienced person but then when you apply for, to be given the licence to work at the higher level they say no, simply no, that's it. (Middle East refugee doctor, male).

Further, the jobs which are open to refugee doctors are normally within the less popular specialisms (e.g. psychiatry) which are difficult recruitment areas. Due to the fact that their overseas experience appears to count for nothing they have to begin in an SHO post. Indeed, the following doctor had vast experience but this did not count when she applied for a position in the UK. She was forced to begin in an SHO post despite having over 10 years specialist experience.

I think that the thing is that nobody considered what experience I've had overseas at all in, in whatever way I worked as a doctor for 14 years, they consider only the past 6 years as my medical career .. I think nobody had ever wanted to looked at what I had done in the past and how would that be beneficial ... I use that myself but it wasn't made to feel that it was appreciated at all ... it's really useful if you look at somebody who had done 10 or 15 years at something so I mean at least just looking at the CV and see what somebody has done because I mean I felt wherever I'm starting eh I could prove that yes I know a lot and the people around they can feel, feel it but in a way it wasn't taken into consideration ...I

have 16 years experience as a doctor .. and I find myself working with people who have only just graduated ... and eh in a way we are, we are equal. But what I'm trying to say, I mean I have this background and knowledge and I'm older ... so yeah I don't think I'm happy about my, my professional life at all. (Middle East forced migrant, female)

There is a feeling that it is very difficult to proceed to consultant level despite being over-qualified for the post. And if consultantcies are achieved these most likely to be in District General Hospitals rather than the preferred teaching hospitals.

Within the system, refugee doctors perceive that preference is given to local candidates. There were varied opinions regarding whether this was right or wrong. Some were resigned to the fact that local candidates would get preference but the consensus view was that a doctor should be evaluated on their ability rather than their nationality or place of training. However some also reported preferential treatment of European doctors which caused considerably more resentment. Despite the fact that many refugee doctors' education was in English, they must still take the IELTS. Meanwhile, European candidates are exempt from this exam which annoys refugee doctors who personally witness the poor English performance of European doctors within hospitals.

Discussion

Many problems described by refugee doctors are practical and there may be solutions if there is a will to do so. However the underlying discriminating treatment which the refugee doctors reported at all levels within the NHS is something which may be harder to address. Unfortunately, this negative treatment of refugee doctors is not surprising.

Firstly, this situation may be symptomatic of the wider problems facing immigrants in the UK labour market (Dustmann et al., 2003a). Research has concluded that minority immigrants have on average lower employment probabilities. The situation facing refugee doctors may therefore be part of the discrimination experienced by all immigrants in the UK.

Secondly, two surveys conducted specifically within the health service demonstrated that there is discrimination against ethnic minority candidates. The first survey in 1992 and the subsequent one in 1997 found that British trained doctors with Asian names were less likely to be shortlisted for posts as senior house officers (Esmail and Everington, 1997b). The candidates although British born and qualified had Asian names and as a consequence faced considerable discrimination. In the shortlisting stage one would expect that refugee doctors would be doubly challenged as they have both overseas qualification and foreign names. The difficulties reported by the respondents above seem to confirm this.

And the discrimination found in the health service is not specific to the lower levels within the profession. In subsequent surveys researchers have found that not only is discrimination experienced in the attainment of lower level posts such as senior house officers (Esmail et al., 1997b) but also in the allocation of distinction awards made to consultants (Esmail et al., 1998). Therefore the negativity experienced does not

appear to depend on the level of the doctor. No-one is excluded or exempted from this negative and frustrating treatment. So it is not surprising that discrimination is found at every level within the NHS for refugee doctors.

Previous research has concluded that racial discrimination is still endemic in the NHS (Esmail et al., 1997b) but one could ask if this problem is purely racial or directed towards all overseas qualified doctors. This is a very difficult question to answer. Undoubtedly many refugees in my research reported problems and this could have been caused by the colour of their skin. However, as demonstrated by the examples above, there are accounts from many different continents including Europe.

Indeed, European refugee doctors have faced similar experiences and difficulties (Ezsias, 1998) within the NHS. Whatever is really happening, it demonstrates that many overseas doctors in the UK are still experiencing difficulties. The call for things to be changed such as the standardised form for shortlisting for equal opportunities (Esmail and Carnall, 1997a) need to be listened to and acted upon. And the issue of institutional discrimination in the NHS should be investigated further.

Personal Issues

In addition to practical problems, personal, emotional and psychological issues play a critical role in doctor integration and career prospects. All individuals in my interviews mentioned that the lack of family support can make life problematic. Further the lack of both professional and personal networks makes initial integration and adaptation to the NHS very difficult. Few studies of skilled migrants have focused on the socio-cultural dimension of professional integration, however it has been shown that cultural barriers can significantly affect successful work performance (Remennick, 2002). So for many refugee doctors, the difficulties in adapting to a different culture and living in a foreign country may affect their initial employment performance. It is therefore a real consideration when deciding upon various ways and methods of successfully helping and assisting refugee doctors to integrate within the health service.

The initial emotional impact is felt by refugee doctors as they wait for an immigration decision, prepare and sit the professional exams and apply for a job. The psychological impact of being forced to leave your country of birth is very traumatic. Like all asylum seekers, doctors undergo a trying and stressful time when they are waiting for an immigration decision. This can cause extreme depression and anxiety as told by one asylum seeker doctor:

I feel I can't do anything else and eh until a decision, I hope a good, will be taken, I'm like in prison, I can't do anything, it's a form of prison and eh it's, it makes you stressed, it gives you stress ... it's not easy, it's not easy ...” (African asylum seeker doctor, male)

But added to this, the sudden departure from their country of origin means that they are also detached from their professional lives. Refugee doctors leave a life in which they were full-time medical professionals and become unemployed suddenly. This was described by one asylum seeker:

We think everybody looks to us as asylum seekers, that means we are ... the lowest level in the community, the lowest in society when I was in my country I, I had my job, I had my cars, I had my own home, I had everything, I had my family, I had my friends, I lost everything so I have to start from the beginning but of course after the decision of the Home Office. (Middle East asylum seeker doctor, male)

Refugee doctors go from an extremely powerful and influential position in their country of origin to nothing when they enter the UK (Weaver, 2001). There is also intellectual deprivation of the person's identity as they cannot practise their profession. This was explained by two asylum seeker doctors from Africa and the Middle East. As the quotations show, in this country the refugee doctors' professional identity is forcibly removed by the migration event. It is not just the experience of real poverty but also the mental and emotional effects of migration which impact negatively on the person.

You are getting contact but for work really I miss too much, I miss to practise, to see patients, to be treating, it is very nice to be dealing with people, to see people, whenever I went to a hospital here, really I have this, this feeling that I should have done something, to be, to work but ... (African asylum seeker doctor, male)

Yes it's quite hard of course for me, eh I was working in the, you can say in the best hospital in my country and ... you get the respect of the people ... and when I came here, because it is not easy, because you have nothing, you have no money, you have no society support, no family ... this is not easy to cope with especially that, the loss of respect and the loss of family. (Middle East asylum seeker doctor, male)

Many doctors explained the severe mental effect of being devalued, under-utilised and de-skilled. One main contributing factor to this was the time taken to re-enter the profession. Negative feelings increased the longer it took to begin employment. There is a real feeling of frustration, demoralisation and hopelessness. One article written in the British Medical Journal expressed similar feelings:

The mental anguish and physical deprivation, the sense of annihilation and loss of reference points, and the vulnerability and desperation of refugees the language difficulties, the lack of relatives and friends and knowledge of the 'system', the uncertainty and the daily struggle for survival and to keep one's sanity and integrity; all these reduced life to a miserable existence. (Ezsias, 1998).

Unfortunately however, the negative feelings of being under-valued are not removed when the individual gains employment. A doctor may face difficulties in career progression or attaining a job in his or her preferred speciality. The inability to fulfil their professional expectations can cause extreme frustration and disappointment. Many agree that their experience within the UK is a bitter pill to swallow. One refugee doctor summarises:

They know you are capable of doing it yet they will not give you the job discrimination I mean ... the greatest humiliation that's what I would

call it, in fact many of my colleagues would call it .. a 'jail sentence' what we call 'jail sentence jobs' like trust grade, staff grade and I'm telling you it affects people's psychology, you know you are being used as slaves. (African forced migrant doctor, male)

Proposals

In mapping the professional route taken by a refugee doctor from entering the UK until gaining a paid position, there are various stages. These are outlined in Figure 1 (Annex 1). The four main stages are GMC registration, being shortlisted for a job, gaining an occupation and career progression. Based upon the interviews, the main obstacles facing refugee doctors taking this route can be classified as either 'structural' (related to the existing system) or 'agency' (related to the individual doctor). In order to construct meaningful proposals to address these problems, both structural and agency influences must be addressed. Firstly the refugee doctor can personally address issues such as increasing social/professional contacts and adapting to the system. However as demonstrated in Table 8 (Annex 2), the main problems experienced by refugee doctors are intricately linked to the official constraints, or structural influences. Therefore to ensure improvements and to tackle the problems faced by refugee doctors, the structural constraints must be considered as priorities.

Of the four structural areas that have been highlighted, the following proposals should be addressed:

- GMC registration: review the suitability of the PLAB and IELTS for refugee doctors;
- unemployment regulations: make provisions so that unemployed refugee doctors can search for jobs and not be forced to take unskilled work, help refugee doctors to find medical employment;
- short-listing: standardize the short-listing procedure; and,
- career progression: ensure there are fair assessments of doctors' experience, skills and abilities.

Finally, to additionally help refugee doctors in the area of personal issues, there is a need for greater awareness of the emotional impact on the individual and to accordingly provide cultural/psychological support for refugee doctors.

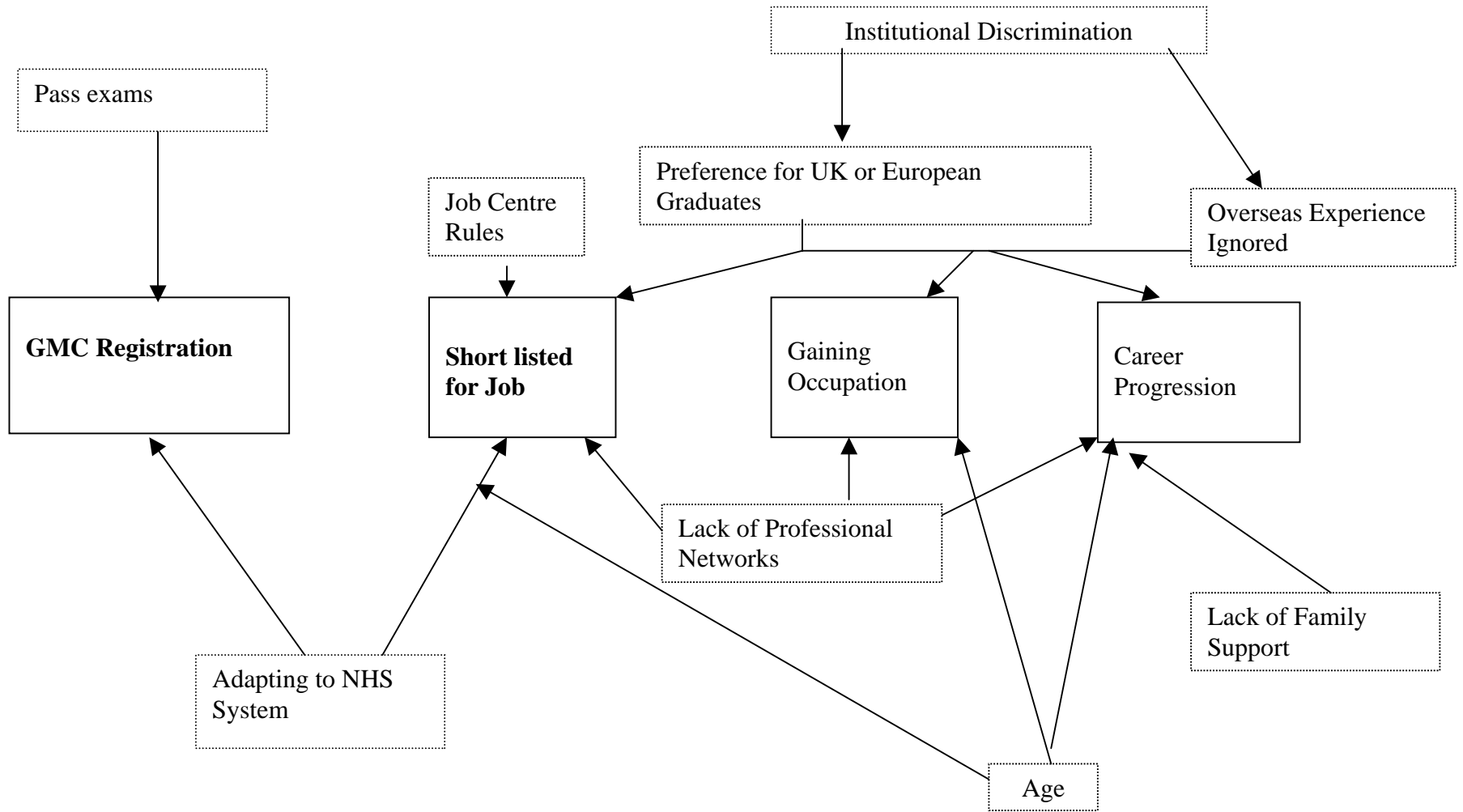
Conclusion

The refugee doctors in my research spoke clearly of the discrimination experienced at every level within the NHS. Some have been successful and are content. However this was not the case for the majority. The problematic issues associated with re-entering the profession are specific to refugee doctors but the difficulties within the NHS may be more widely experienced by other overseas qualified doctors. Although steps have been taken to assist refugee doctors within the UK, the full potential of this group is not being realised. First and foremost, the structural constraints must be

addressed to ensure that refugee doctors can overcome the hurdles. This will enable the NHS to benefit from this 'treasure' at a time when doctors are so desperately needed.

Figure 1: Obstacles facing refugee doctors

**‘Structural’
Influences**



**‘Agency’
Influences**

Table 8: Life as a Refugee Doctor in the UK

Periods of refugee doctors' lives	Official constraints	Problems faced by refugee doctors
GMC registration	Overseas Qualification not recognised by GMC IELTS, PLAB	Time and cost of exams (demoralisation of failing exams) Period of deskilling
Clinical attachment	Availability of posts	Un-paid post
Period of unemployment	Job Centre Rules	Doctor may be forced to take an unskilled job by unemployment benefit system
Shortlisted for job	Institutional Discrimination (preference for UK or European graduates)	Age of Refugee Doctor Gap in CV De-skilled due to long period spent out of employment Lack of UK references
Employed in the NHS	Institutional Discrimination Overseas Experience not recognised by GMC	Medically Adapting to the NHS System Stagnation in the middle grades e.g. no training posts but forced to accept staff grade or associate specialist posts Specialisms that are less popular e.g. psychiatry Working with foreign colleagues Dealing with local patients Personally Lack of family support, lack of networks (professional and personal)
Career advancement	Overseas Experience not recognised by GMC Training Route to Consultancy posts	Very rarely proceed to consultant level despite being over-qualified If consultant post is achieved it will very unlikely be in a teaching hospital Preference for local candidates or European qualified doctors

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