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Experiences and expectations of refugee doctors

Qualitative study

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Background Refugee doctors constitute a potentially valuable resource for reducing the recruitment crisis in psychiatry. However, various hurdles make their route into the National Health Service (NHS) difficult.

Aims To explore the perceptions and experiences of refugee doctors trying to practise psychiatry in the UK.

Method Thirty-one refugee doctors participated in qualitative interviews designed to elicit their experiences in trying to practise as doctors in the UK. Twenty were re-interviewed about 6 months later.

Results Doctors identified a range of practical problems that made it difficult for them to take the required steps towards practising in the UK. These included lack of appropriate information, lack of a clear route through the system and feelings of isolation. The English language examination was seen as a particular bottleneck, as were finding clinical attachments. The psychological impact of the experience was profound.

Conclusions These findings have important implications for how refugee doctors are introduced to the practice of psychiatry in the NHS.

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Psychiatric services in the UK have difficulties with recruitment and retention of their workforce. About 20% of consultant-level posts in England remain unfilled, especially those in general adult psychiatry (Royal College of Psychiatrists, 2005). The UK government has recognised that refugee doctors constitute a potentially valuable resource in making up these deficits (Department of Health, 2000). It has been estimated that there are about 2000 refugee doctors in the UK keen to work (Adams & Borman, 2000). Very little is known about these doctors' own perspective on the process of getting to practise medicine in the UK and their views on the usefulness of the supports and training initiatives available to them. The aim of our study was to explore the needs and experiences of refugee doctors interested in practising psychiatry, through qualitative interviews.

METHOD

Participants

Participants were refugee doctors who took part in one of three introductory courses to psychiatry conducted at the Institute of Psychiatry between 2002 and 2004. Course participants were recruited through advertisements in the *BMJ*, through the British Medical Association refugee doctor database and through all postgraduate deaneries in the UK. Refugee doctors at all stages of their training, irrespective of their legal status (i.e. including asylum seekers) and their progression through the steps towards registration in the UK, were invited to participate. A total of 136 doctors enquired about participation, 123 of these registered and 82 of those registered attended one of the courses.

A subgroup of doctors was selected for the qualitative study, using purposive sampling (Silverman, 2001) to ensure that the sample was as representative of the participant group as possible, with attention paid to age, gender, country of origin and progress towards becoming a National Health Service (NHS) doctor. Two doctors did not wish to participate. Thirty-one doctors took part in the initial face-to-face interview at the start of the course and 20 of these were available for a telephone follow-up interview about 6 months later. Table 1 summarises the demographic characteristics of all course participants and those selected for the qualitative interviews.

Settings and procedure

Participants were interviewed individually for 20–40 min by two researchers (J.A. and K.M.). The content of the semi-structured interview guide was prepared by consulting with experts in the field of cultural psychiatry and anthropology and in discussion with refugee doctors themselves (further information available from the authors upon request). The interview guide consisted of open-ended questions designed to encourage free expression and generate responses related to refugee doctors' personal experiences, in particular the challenges and difficulties they faced in getting to work in medicine in the UK, as well as how they were accepted by British society and their hopes and goals for the future. All interviews were conducted in English in an unhurried fashion to ensure that interviewees who were less fluent in English were able to express their views. The follow-up interviews focused on continuities and discontinuities in their situation. Ethical approval was obtained from the Institute of Psychiatry ethics committee.

Data analysis

The interviews were transcribed verbatim from tape-recordings by the two interviewers. The interviewees were ascribed numbers, which were used in the transcriptions and the report. We pursued a method of grounded theory, in which the general emerging themes were identified from samples of the raw data by the full research team, and the transcriptions used to generate and question hypotheses in an ongoing fashion (Brown & Lloyd, 2001: p. 353). The emerging themes were then applied to the full set of individual transcripts through the use of a coding glossary and adjusted to ensure relevance and reliability across the entire data-set. The full research team reviewed this coding strategy throughout the period of analysis to ensure both

Table 1 Characteristics of participants

	Course attenders (*n*=82) *n* (%)	Study participants (*n*=31) *n* (%)
Gender		
Female	19 (23)	12 (39)
Male	63 (77)	19 (61)
Age, years		
25–35	34 (42)	7 (22)
36–45	32 (39)	13 (42)
>45	11 (13)	8 (26)
Not given	5 (6)	3 (10)
Region of origin		
Middle East	41 (50)	14 (45)
Africa	13 (16)	8 (26)
Asia	9 (11)	3 (10)
Eastern Europe	8 (10)	3 (10)
Central and South America	2 (2)	1 (3)
Other	9 (11)	2 (6)
Legal status		
Asylum seeker	20 (24)	7 (23)
Refugee status	17 (21)	4 (13)
Indefinite leave to remain	14 (17)	17 (55)
Exceptional leave to remain	16 (20)	0 (0)
British national	2 (2)	1 (3)
Other	2 (2)	2 (6)
Not known	11 (14)	0 (0)
Examination level		
IELTS taken	49 (100)	22 (100)
Score <7	10 (20)	2 (9)
Score 7 or above	36 (74)	18 (82)
Score not given	3 (6)	2 (9)
Those with IELTS score of 7 or above	36 (100)	18 (100)
PLAB 1 taken	21 (58)	8 (44)
PLAB 2 taken	11 (30)	5 (28)

IELTS, International English Language Testing System; PLAB, Professional and Linguistic Assessments Board.

that the categories remained robust and that the identification of themes was consistent. The final stage involved analysis of the full set of transcripts using Qualitative Solutions and Research NVivo computer software (QSR International Pty Ltd, Doncaster, Victoria, Australia), a relational database specifically designed for qualitative data analysis. This allowed not only for individual statements to be analysed according to the common topics but also for the overall set of themes to be collated and grouped into related hierarchies from across the entire set of transcripts. Thus, the overall reliability of the analysis was established through the relationship between individual transcripts and the general themes identified from all the interviews.

RESULTS

Only the major themes emerging from the interviews are reported here. These were:

(a) practical problems;

(b) accessing information and progressing through the system;

(c) social networks and acceptance into society;

(d) psychological impact of their experience;

(e) support through organisations.

Practical problems

For the majority of respondents the practical aspects of daily life, such as dealing with immigration issues, establishing semi-permanent accommodation, the arrangement of finances and the ongoing responsibilities of supporting family members, were some of the difficulties that prevented them from fully engaging with the routes towards professional recognition. Especially, the women doctors talked about the difficulties of balancing retraining with family commitments.

A central theme was the lack of certainty and stability in these practical areas; this described not simply the common experiences of (for example) having to move from one part of the country to another, but also a more psychological sense of uncertainty arising from the various bureaucracies and agencies that constantly required redefinitions and reapplications. This is illustrated by the quotations below and in the data supplement to the online version of this paper.

> 'The most difficult thing for us now, it's we need decision from Home Office. I don't know if we can stay here. If you know you are staying, it's more easy for us. It's our psychological problems . . .all the time we have to think about it because we can't go to our country, it's dangerous for our family. For one year and a half we not got an answer, we are still waiting and we don't know how long we will be waiting.' (Doctor 26)

Accessing information and progressing through the system

Many doctors expressed feelings of exasperation over the lack of a clear, centralised source of information:

> 'The most difficult thing I faced on this journey is I don't have any information, lack of information. I got most of information after 2 or 3 years and so I started preparing for the PLAB [Professional and Linguistic Assessments Board] in April. By this time I should have got into the medical profession but the problem as I said there was a lack of information, who to contact, who to speak about, where to get. I was blind and had to discover it my own.' (Doctor 4)

Not knowing whom to contact as a first step generated the common feeling among these doctors not only that they were having to assemble knowledge piecemeal, but also that there was some secret mechanism or 'system' that only 'insiders' were privileged to know about and have access to and from which they were effectively excluded. As one doctor expressed it, 'We need to know these tricks'.

A second issue arising from the general sense that all the relevant information was hard to obtain was amazement about the apparent lack of any clear, linear arrangement to the overall process. Although virtually everyone we interviewed was aware of the different professional qualifications necessary and in what order they had to be obtained, this structure was not integrated in a more detailed path from an initial contact, through the examinations and placements to finally gaining employment.

Almost all the respondents also talked about language acting as a key barrier. Many were frustrated about the requirements of the International English Language Testing System (IELTS) test – questioning both why it was such an early method of gatekeeping, rather than having language assessed further along the route towards professional recognition, and the way in which medical language itself was a specialised skill which often fell outside the usual scope of English learning provision. The sentiments of the latter point were expanded by some as a more general problem of not only linguistic but also cultural translation. This group talked at length about how there are 'hidden' rules and codes, that the assessment mechanisms and individual assessors might not be aware of themselves. More than one respondent encapsulated this by confessing that they could, in the end, never be a 'full Englishman'.

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Although participants were less concerned with the Professional and Linguistic Assessments Board (PLAB) test as a hurdle, those who had progressed through the system beyond PLAB mentioned difficulties in obtaining clinical attachments and getting a first job. Some doctors expressed a sense that even though they had successfully taken the hurdles of the IELTS and PLAB examinations they somehow remained second-class citizens, for whom it was difficult to penetrate the system successfully.

Social networks and acceptance into UK society

A number of respondents spoke about how personal support from family and friends had sustained them and helped them to press on with their career aspirations (quotations available in the data supplement to the online version of this paper). Many also expressed their appreciation of informal networks of support in their local community. However, there was a concern that by relying on these they were effectively denying their own individual opportunities by defining themselves as marginal. One (Doctor 8) explicitly said that working with the local community 'prevents me from going through'. Some acknowledged that social ties could be a hindrance as much as a support for the respondents. The need to provide a sense of personal safety and encouragement for their family members and dependants was clearly put into profile by their past experiences and reasons for leaving their country of origin. The demands of these dependants tended to be channelled almost exclusively through the respondents, many of whom had been the head of the household when employed as a doctor. With reticence, therefore, family members were sometimes identified by respondents as a burden at this stage of their career development, when ideally they should be striving wholeheartedly to be recognised in the UK.

A few doctors described experiences of racism or discrimination and tried to deal with this by using their own professional training in psychiatry to explain and cope with these attitudes and behaviours they had encountered:

> 'When my neighbour knew that I am a doctor he began to respect me and he invited me for a cup of tea, but before that when he saw me walking on the corridor he slap his door, he went, . . . but I take this things very simple because I'm psychiatrist and work in mental health and I know there is a lack of education.' (Doctor 23)

Psychological impact of their experiences

The psychological impact of their experiences was framed by many in terms of the importance of their career to them and their dedication to being a doctor. They also saw their present experiences in terms of what they had left behind. Beyond the loss of their homeland and the loss of material goods, this meant the loss of a profession they loved and which was highly important to them, and the loss of at least part of their identity and of the status, respect and dignity associated with it:

> 'I lost the most important part of my life, I was younger, better, more creative . . . I lost that part, so . . . I couldn't get the things that I expected or I tried, but it was not my fault, because of the revolution in my country and lots of things and . . . I have to cope and just use the best of that.' (Doctor 2)

Many provided stark descriptions of the negative emotional impact that trying to work as a doctor in the UK had had on them. Some described their present predicament as being between their past and a future they felt was unlikely to unfold. This overall feeling of being static, of having been halted by circumstances and having to 'start again', was seen to be a major threat to their own psychological well-being. Some had become clinically depressed; others described major personality changes:

> 'I have no interest for life, I have no concentration, I can't read, I can't watch TV, I try! (Doctor 27)

> 'Yes, I know I have changed personally, I have changed my personality in a way like I was always very sociable, now I feel like going to a shell.' (Doctor 10)

Only a small proportion described the experience as a challenge that had allowed them to grow and to gain in confidence.

Although some described clear personal hopes for the future, often emphasising that their love for their profession, identity as a doctor and belief that they had something to offer kept them going in their view that finally they would reach their chosen career aspirations, several others described having to adjust and manage their hopes and aspirations for the future and to alter their career path. Others expressed a sense of loss of their own personal future in medicine. Instead, the sense of having a future was frequently projected solely onto their children. It was the children who might have new opportunities, who might become more integrated into UK society and the world of work, and who might lose the sense of being a permanent refugee. These sentiments were frequently relayed with some regret – as though such over-investment in the next generation betrayed their own hopes and ambitions that had either been lost in the past, or could not be articulated in the present.

Support through organisations

Many doctors acknowledged the importance of both emotional and practical support through various refugee organisations. Often there was a sense that contact with one organisation opened doors to help from other sources and facilitated smoother progression through the system. However, there were also more sceptical voices emphasising the limited nature of some of the supports available, the fact that information was out of date, leading to false hopes being raised, and that support might have been well-meaning but was not individually tailored:

> 'Lots of money go into those projects for helping refugee . . . last year, the year before . . . I don't know about this year . . . but is not effective . . . a lot of courses . . . a lot of lectures . . .all like painkillers and nobody knows what the problem is.' (Doctor 12)

The doctors also emphasised that although the sharing of experiences and the need to 'speak with one voice' were crucial to improve their situation, they were reluctant to do so, on the grounds that by so defining themselves as a 'refugee doctor' they might be permanently labelling themselves to the detriment of ever being fully accepted. Several people emphasised the need for a centralised source of information and support, which could deliver individually tailored support in a step-by-step fashion, both offering practical assistance and helping keep up morale.

Themes from the follow-up interviews

At follow-up, many doctors' general outlook was unchanged. Many expressed their frustration at the lack of progression, in terms of 'becoming stuck', 'feeling extremely disappointed' and even 'feeling depressed'. As one doctor said:

> 'I thought, "What's the point?" . . . [it] is very sad and traumatic and frustrating and gives me a lot of trouble psychologically and emotionally speaking, and obviously economically speaking

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> . . . everything seems to be going around in circles.' (Doctor 7)

Interviewees who did not express such generally negative feelings had managed to alter some of their circumstances; significantly, this more positive attitude did not seem to be based on the nature of the change. Changes ranged from passing one of the examinations, such as the IELTS, to gaining a job as a medical assistant, to simply volunteering in a health-related capacity.

DISCUSSION

This is the first systematic qualitative inquiry into refugee doctors' views and experiences of trying to work as doctors in the UK. By conducting a set of follow-up interviews we ensured that we did not simply generate a 'snapshot' of their views, but a picture of their more enduring difficulties and challenges. It appears that we attracted a broad range of doctors at very different stages in their progress towards working as doctors in the UK and that we facilitated genuine and revealing responses. Thus the picture that emerges from the interviews is likely to be a fair representation of the diverse experiences of refugee doctors currently in the UK.

Our study has a number of limitations. First, we cannot be sure that our study participants were fully representative of all refugee doctors in the UK, as we recruited from participants on our course rather than from a refugee doctor database. Second, although our purposive sampling strategy was successful in that those selected for the interviews were very similar to the total sample (see Table 1), a small number of interviewees participated because they particularly wanted to tell their story. This might have led to the selection of some unduly pessimistic or optimistic views. Third, all interviews were conducted in English, which might have prevented some participants from being able to express the nuances of their experiences.

Overall, our findings demonstrate just how entangled the practical elements of these doctors' employment predicament are with more social and culturally based expectations and impediments. Some of the participants conveyed an overall, single, experience of frustration, alienation and isolation from peers and especially from the medical profession. In contrast, others who did report progress, whether towards recognition as a doctor or in other aspects of their life, clearly adopted a more modest, step-by-step approach; the simple experience of change appears to have been the most valuable way to dismantle the monolithic sense of dissatisfaction. It is likely that some of the difficulties described here are not dissimilar to those experienced by other international medical graduates in the UK, but one would expect psychological problems related to trauma and alienation to be more prominent in the refugee group.

Given the current level of General Medical Council interest in professional practice it is not an easy task to progress doctors trained elsewhere to working in the UK. A number of initiatives to address refugee doctors' difficulties exist, following the report of the Working Group on Refugee Doctors and Dentists (Department of Health, 2000). Databases of refugee doctors, held by the British Medical Association and the Refugee Council, facilitate dissemination of information. Several of the doctors acknowledged that in terms of the availability of information, matters have improved in recent years. None the less, lack of specific targeted information and support both early on and as people were progressing through the various stages of becoming a doctor was one of the most commonly mentioned themes in our study. This suggests that there needs to be a central resource that organises the various components of gaining eventual employment along a clear temporal schema. Since our study was conducted, a new website for refugees and internationally qualified health professionals (http://www.rose.nhs.uk) has been set up, which goes some way in addressing this point.

Of the 300 doctors registered with the Refugee Council's database for refugee doctors, only 174 had stated their particular specialty. Ten of the 174 (6%) said that it was psychiatry. Extrapolating to the total estimated number of refugee doctors currently in the UK, we can estimate that about 120 will be specialists in psychiatry. Our data suggest that there may be a possibility of attracting doctors originally qualified in other areas into psychiatry, as several of our interviewees mentioned the wish to alter their career path.

Our findings have a number of implications for key stakeholders such as the Royal College of Psychiatrists, mental health trusts and individual psychiatrists working with this group.

(a) Many doctors reported difficulties in navigating their path through the medical system in the UK and in obtaining clinical attachments. The Royal College of Psychiatrists already has a method of offering attachments to post-PLAB trainees. In addition, it would be helpful if a database of consultants willing to mentor or offer clinical attachments to refugee doctors wanting to train in psychiatry was established.

(b) At the level of mental health trusts, it would be important to ensure that clinical attachments to refugee doctors are offered free of charge. This could be done in return for refugee doctors' offering their services as translators for trusts in a particular region. This recommendation may seem unrealistic as, in a climate where resources are limited and clinicians' time is scarce, trusts are becoming increasingly reluctant to offer clinical attachments at all, let alone free of charge. We believe that this is short-sighted. The NHS as a whole and mental health trusts in particular need to recognise the unique value of many of these refugees, not only in terms of their medical expertise, but also because of their life experiences. Further, they should recognise that these qualities in combination are increasingly required in the UK to improve the overall health of the nation, not only with respect to people who have endured similar trauma abroad, but more generally for all those who suffer from the experiences of loss of social identity and the future.

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(c) Individual psychiatrists can do much to help and support refugee doctors. Although consultants have an important role in providing training, assessing skills, giving feedback about strengths and weaknesses and providing references, junior doctors are often in an excellent position to give informal support. However, individual clinicians can only take on this commitment if they have the full support of their trust.

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