REACHE NORTH WEST

Evaluation 2012

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## Contents

**EXECUTIVE SUMMARY** ................................................................................................................. 4

**SECTION A  INTRODUCTION TO REACHE NORTH WEST AND POLITICAL, ECONOMICAL, SOCIAL AND TECHNOLOGICAL ANALYSIS** ............................................................... 6

1. **AN INTRODUCTION TO THE REACHE NORTH WEST PROGRAMME** ............................. 7

2. **THE POLITICAL CONTEXT** .................................................................................................. 10

   2.1 **The number of refugees and asylum seekers in the UK** .............................................. 10
   2.2 **The number of doctors and nurses available to the NHS** ........................................ 13
   2.3 **Modernising Medical Careers (MMC) and Medical Education England (MEE)** .......... 15
   2.4 **Changes in UK Work Permit Requirements** .............................................................. 16
   2.5 **Treatment of Black and Minority Ethnic NHS Staff** ............................................... 17
   2.6 **Patient Safety** ............................................................................................................. 19
   2.7 **Integration** ................................................................................................................... 20

3. **THE ECONOMIC CONTEXT** .................................................................................................. 23

   3.1 **How much does a doctor cost?** ................................................................................ 23
   3.2 **How long does it take?** ............................................................................................. 24
   3.3 **Duration, location and speciality in practice** ............................................................ 25
   3.4 **Opportunity Costs** ..................................................................................................... 26

4. **THE SOCIAL CONTEXT** ........................................................................................................ 28

   4.1 **Diverse Local Populations** ........................................................................................ 28
   4.2 **Acculturation** ............................................................................................................ 29
   4.3 **Impacts on Refugee Doctors** ..................................................................................... 30
   4.4 **Language and Culture** .............................................................................................. 31

5. **THE TECHNOLOGICAL CONTEXT** ...................................................................................... 33

   5.1 **Post graduate Medical Training in the UK** ................................................................. 33
   5.2 **Language Testing** ...................................................................................................... 33
   5.3 **Professional Linguistic Assessment Board (PLAB)** .................................................. 35
   5.4 **Clinical Attachments, Clinical Apprenticeship Scheme (CAPS) and Experience** ....... 35
   5.5 **Comparison with Other Programmes** ....................................................................... 37
   5.6 **Refugee Doctors Liaison Group (RDLG)** .................................................................. 37
   5.7 **ROSE Website** .......................................................................................................... 37
SECTION B  THE REACHE NORTH WEST PROGRAMME ................................................................. 39

1. THE REACHE MEMBERSHIP ........................................................................................................ 40
   1.1 CURRENT MEMBERSHIP ........................................................................................................ 40
   1.2 RETURNED TO EMPLOYMENT .............................................................................................. 40
   1.3 ALTERNATIVE CAREERS ....................................................................................................... 40
   1.4 IELTS ...................................................................................................................................... 41
   1.5 PLAB1 ................................................................................................................................... 41
   1.6 PLAB2 ................................................................................................................................... 42
   1.7 GMC REGISTRATION ............................................................................................................. 42
   1.8 ACCOUNTING FOR ALL OUR MEMBERS ............................................................................. 42
   1.9 STATISTICS ............................................................................................................................ 44

2. RESPONDENTS AND COMMENTARY ......................................................................................... 46
   2.1 DEMOGRAPHICS OF THE RESPONDENTS ......................................................................... 46
   2.2 CAREERS IN THE UK ............................................................................................................. 46
   2.3 GAINING STATUS AND EMPLOYMENT .............................................................................. 46
   2.4 SOCIAL STIGMA ................................................................................................................... 49
   2.5 PREPARATION FOR EMPLOYMENT ................................................................................... 50
       2.5.1 ENGLISH TEACHING .................................................................................................... 50
       2.5.2 COMMUNICATION SKILLS .......................................................................................... 52
       2.5.3 PREPARING FOR WORK IN THE NHS ....................................................................... 52
       2.5.4 CLINICAL ATTACHMENTS ......................................................................................... 53
       2.5.6 SHORT COURSES ......................................................................................................... 55
   2.6 THE REALITY OF WORK ....................................................................................................... 56
   2.7 BEYOND SUPPORT INTO EMPLOYMENT .......................................................................... 59
   2.8 AREAS FOR DEVELOPMENT ............................................................................................... 61
   2.9 EXTERNAL FACTORS AFFECTING REACHE ..................................................................... 62
   2.10 FINAL COMMENTS ............................................................................................................... 63

3. OTHER REACHE ACTIVITY AND THE FUTURE ..................................................................... 67

REFERENCES ................................................................................................................................... 69
Executive Summary

1. As Reache North West approaches its first decade it was felt that it was time to re-evaluate the programme and its journey. An external report was produced in 2006 and much has changed in the intervening period. It was felt that it was appropriate to use similar models of evaluation as the 2006 report, as it allows a comparable evaluation with regards to the contextual placement of Reache. The evaluation in this report differs from the 2006 report as it does not engage with the current membership body, but instead engages with those who have gone through the programme and have successfully gained employment, therefore being able to give a more informed review of Reache North West and its programme of study.

2. The first section sets the present and past context for Reache Northwest from 2003 up until 2012. As Reache functions effectively through a multidisciplinary team, this mirrors the reality that there are multiple contexts for the programme. Using a PEST (Political, Economic, Social, Technical) analysis we explored the external influences on the programme and how they have manifested over the last ten years.

3. The second section of the report details the membership of Reache from 2003 until 2012, the responses and commentary of the interviews undertaken for the evaluation and a brief summation of other activities Reache is undertaking and plans for the future.

4. Twenty-five previous members of Reache were invited to take part in a semi structured interview to evaluate their experiences of the education, training and support offered to them in their return to their professional roles or alternative career options. Eight members replied to the email shot, with only five being able to make time in their work schedules to participate in the semi structured interview. The overwhelming majority of the Reache membership is comprised of doctors and all of those that responded came from this group of refugee healthcare professionals. As such this report focuses on the evaluation of the doctors’ experiences.

5. From the responses received in the interviews it is clear that Reache is providing a safe, supportive learning environment for asylum seeking and refugee healthcare professionals and is continuing to provide an excellent educational environment that has evolved since it was founded in 2003. Many of the issues raised by the respondents with regards to teaching content had been addressed before the interviews had taken place.
6. In particular the language and communications skills training has been significantly expanded with a multi-disciplinary approach that has moved beyond preparation for the International English Language Testing System (IELTS) examination and more fully prepared the members for the NHS working environment. This was complemented by the introduction of a workbook with a more structured approach to Preparing for Work, which included areas (e.g. ethics, confidentiality etc) that had to be signed off to be eligible for clinical placements. This has ensured that members are more prepared for the rigours and reality of daily work. The issue of being on-call is not an area that Reache can prepare the members for, the level of responsibility cannot currently be simulated through the resources available. Though this may be an area for development in the future and some exposure does happen while students are on the Clinical Apprenticeship Scheme (CAPS)

7. The clinical placements/attachments were seen as highly valuable experiences that returned confidence and gave the doctors a sense of what to expect when they eventually returned to work. It would appear from the interviews that asylum seekers should be strongly encouraged to undertake more clinical attachments while waiting for their status or General Medical Council (GMC) registration to ensure that they didn’t lose heart, confidence or their clinical skills.

8. A variety of social issues were addressed in the interviews and the importance of Reache in the doctors’ lives was evident. For some Reache had been a lifeline, where they knew that they would receive a sympathetic ear, a cup of tea and a gentle push in the right direction. For others, Reache provided a sense of purpose, a reason to get up and most importantly the drive to return back to their professions. Some felt that Reache should develop more social support in terms of social networks and support groups. This has been addressed with the introduction of the trainee social worker role at Reache as a variety of support groups have been made available for the members.
Section A
Introduction to Reache North West and Political, Economical, Social and Technological ANALYSIS
1. An Introduction to The Reache North West Programme

1.1 The Refugee and Asylum Seeking Centre for Healthcare Professionals Education (Reache North West) was formally opened in April 2003 at Salford Royal Foundation NHS Trust (SRFT [Previously known as Hope Hospital]).

1.2 Dr Maeve Keaney, a consultant microbiologist at SRFT and the Director of Reache, had extensive experience working as an Associate Postgraduate Dean with International Medical Graduates (IMGs) and had seen an increase in the number of asylum seeking and refugee doctors and allied healthcare professionals seeking support into work in the North West area. The opportunity to establish a unit, which could offer support from English language provision, Medical equivalency examinations, career advice and work placements, was offered and was officially opened on the 20th February 2004 by Sir Liam Donaldson, the then Chief Medical Officer for England.

1.3 Reache currently employs two full time members of staff who support (and are supported by) a variety of paid part-time staff including; the Director, a nurse tutor, a GP tutor, language tutors, administration and simulated patients. The team is also supported by a team of dedicated volunteers, which includes; consultants, GPs, nurses, external agencies, Human Resource professionals, medical students, members of staff at SRFT, the Strategic Health Authority, and the general public.

1.4 Reache currently offers rolling enrolment to potential members with a layered approach to membership depending on where they are on their return to work and qualification pathway. Most members come to us prior to attaining the GMC language requirements, a minimum of band 7 in each of the four skills; reading, writing, listening and speaking of the International English Language Testing System (IELTS) examination. All members are required to undertake a Reache language assessment to ensure that appropriate support is put in place during their membership period. Currently, there are five days of English language teaching which include; General English, Professional English, and IELTS examination techniques, some of this teaching is performed via video conferencing with an international expert. Communication skills training is also provided on a regular basis to ensure that members are using appropriate English in social and clinical situations.

1.5 The medical equivalency examination, Professional Linguistic Assessment Board (PLAB), previously included a language assessment alongside the medical theory (PLAB 1) and practice element (PLAB 2) of the test. Reache provides weekly PLAB lectures usually from a wide range of volunteer
consultants ensuring that the members are exposed to a variety of clinical practice for consideration not only in the examination but also for safe practice in the UK. This is currently also supported by essential clinical knowledge (ECK) teaching, which explores UK practice further and ensures that the membership are familiar with processes, ethics and professional behaviour in the UK. Further communication skills training is open to the membership on a weekly basis; Patients, Listen to and Negotiate with (PLAN), allows members to explore clinical scenarios with support from volunteers and medical students who guide them in identifying miscommunications and developing a British consultation style with a more patient centred focus then they may be used to.

1.6 Intensive courses are run on a regular basis addressing the issues of; Preparing for Work in the NHS (PFW), and Safe and Effective Clinical Communication skills (SECC). Usually these courses run over a 1 week period or over several consecutive weeks. Preparing for Work highlights the various issues that members may encounter when they are employed in the NHS. This includes but is not limited to; professionalism, fitness to practice, risk management, ethics, consent, safe prescribing, evidence based practice, reflective writing, interview skills, CVs and application forms.

1.7 SECC uses a multi-disciplinary approach to clinical communication skills. For each course, a clinical scenario (mock ward round) is deconstructed into skill areas for example note summarising, history taking, team working etc. These skill areas are then taught in a non clinical context by a linguist before being consolidated into the individual clinical skill areas. After each skill has been practised independently they are placed into the clinical context of a mock ward round to use the skills simultaneously.

1.8 Exposure to the working environment is very important to assist the development of refugee doctors and healthcare professionals. Reache encourages the entire membership to engage in paid employment or voluntary work and have established a relationship with the volunteer department at SRFT. Reache offers one week taster placements for students who have not yet met the required IELTS score, but who have sufficient language skills to benefit from the placement. These placements offer the opportunity to see the range of UK clinical practice including, GP surgeries, Hospital Wards, and Public Health. These placements can lead to career changing decisions as the differences from UK practice and practice abroad are highlighted.

1.9 When members have passed PLAB 1 they have the opportunity to undertake
a 1 month clinical attachment which offers the opportunity of shadowing a range of clinical staff in a department for a longer period of time to gain exposure to a range of clinical encounters which often highlights the practical application of some of the teaching at Reache.

1.10 Members who have passed PLAB 2 and who have attained full GMC registration are offered the opportunity of a Clinical Apprenticeship Scheme (CAPs) post. These posts are unpaid supervised “clinical training” positions which give the doctors the opportunity to train further by working at Foundation Year level for a three month period. This then gives them UK clinical experience and also gives them a UK reference from a clinician. All members who have undertaken a CAPs placement have obtained work shortly after completing the scheme. Unfortunately, this scheme is not available to doctors who only obtain provisional registration with the GMC.

1.11 Pastoral support and career advice is offered throughout the process. Reache focuses on the development of safe practitioners rather than examination success to ensure that members adapt safely to UK practice and enjoy their UK careers with minimal difficulties. This ethos is in line with national policies regarding the NHS managers’ code of conduct ensuring the care and safety of patients and protecting them from risk.
2. **The Political Context**

2.1 The political context refers to the broadest interpretation of ‘political’ encompassing public opinion, societal, conflict dynamics, party politics and policies – that may affect the members of Reache Northwest.

2.1 **The number of refugees and asylum seekers in the UK**

2.1.1 Migration into the UK over the last decade has increased with a reported 3 million immigrants entering the UK from 1997 up to 2010 (Migration watch, 2011), this includes asylum seekers and refugees alongside economic migrants. A large proportion of the media and politicians have profiled refugees and asylum seekers in an often, unflattering light providing negative frames of reference to influence beliefs (Hartmann and Husband, 1974, O’Rourke and Sinnott 2006, Fang and Zikic 2007, Constant et al 2009) and to further political agendas (Khosravinik, 2009, Weiss and Wodak, 2003:13, Greenslade, 2005). It should be noted that the broadsheets tend to report on asylum seekers and refugees in a more neutral fashion with some using more positive connotations (Gabrielatos and Baker, 2008), there are proponents for asylum seekers and refugees but they have been in the minority with a much smaller audience (Greenslade, 2005). The 1951 Refugee convention details in legal terms those who are considered refugees. Yet, forced and voluntary migration (which includes asylum seekers and refugees) can be seen on a spectrum from lack of opportunities to succeed (educationally or financially) and/or to specific events of torture and persecution, with the reality of the grey areas. The decisions being made regarding refugee status are becoming much more difficult, as definitions of asylum seekers often have great variation within government policy. This is becoming especially difficult as migration in the 21st century may be affected through wars, economic crises or climate change (Colville 2007, Crisp 2007). Chantler (2010) points out that economic issues are closely related to conflicts over scarce resources and that abject poverty is a form of persecution and is often politically motivated.

2.1.2 The numbers seeking refuge in the UK as reported by the Home Office in February 2011 indicate that there has been a decline in the numbers of asylum claims in the UK with 2010 seeing the lowest number of application since 1989 (UNHCR). A peak of 84,130 claims were made in 2002 and these did not include families and dependants. The numbers have steadily decreased with a twenty seven percent decrease in 2010 (17790) compared to 2009 (24,485). The UNHCR (28 March 2011) have stated that asylum seeker numbers have been almost halved in the last decade with the United Kingdom falling to the sixth largest recipient of new asylum claims in 2010.
The UNHCR also commented that the root causes of these reductions are worthy of further investigation and study, to determine whether there are firmer immigrations policies and restrictions in place or whether motivations for migration in countries of origin have changed. 'Countries of origin' have seen a further level of fluidity with Serbia becoming the number one country of origin in 2010 for asylum claim, this occurred also in 2005 due to the Balkan war. The number of asylum claims from Afghanistan have decreased since 2001 however; this number fluctuates and has not shown any sign of abating. A decrease in the number of Iraqi claimants being processed was also seen. However, claims from; China, Iran, Sri Lanka and the Russian Federation, have increased since 2009. At present further official figures are yet to be released, however refugee and asylum organisations expect to see an increase in the number of claims from countries currently undergoing political turmoil, such as Libya, Yemen and Syria.

2.1.3 Since, the introduction of the Commonwealth Immigrants Act 1962, immigration policy in the UK has followed a similar course of action, seeking to restrict an influx of migrant workers in economically difficult times, yet researchers and business analysts reported that a lack of formal immigration controls had formed a migration pattern that coincided with the natural ebb and flow of the business cycle (Flynn, 2005). A variety of restrictive acts were enacted as law, often with devastating effects, such as ending or impeding family re-unification (1972 Immigration Act) though this curtailment was later abolished in 1997. New Labour sought to modernise immigration and asylum with several positive approaches including admission of same-sex partners and an impressive expansion of the range of skilled migration. However, in their haste of asserting stronger border controls they abolished cash benefits and introduced a strict policy of dispersal (Asylum and Immigration Act 1999), which was only accepted as the public mood was so antipathetic towards this group. This period was followed by the 2002 white paper ‘Secure Borders, Safe Haven’ emphasising security measures and a potential risk of anti-social behaviour, crime and terrorism from immigrants from every group. In 2011 David Cameron declared that multiculturalism had failed at an international security conference in Munich, stating that he ‘blamed a doctrine of “state multiculturalism” which encourages different cultures to live separate lives’. While this may be a valid argument his proposal that English classes were of great importance was seen as hypocrisy as funding cuts were made to ESOL classes across the country denying many the opportunity to integrate as he would like them to. This has given elements of the media the opportunity to highlight asylum seekers and refugees as taking advantage of the system and has fortified these commonly held perceptions (Greenslade, 2005).

2.1.4 The economic benefits gained from migrants has been widely accepted through industrialised countries (Gott and Johnston 2002, Tait, 2003), this
includes asylum seekers and refugees. According to the Institute for Public Policy Research (2005) immigrants including asylum seekers and refugees contribute more to government revenue and less is spent on them than the native population. The economic benefits of migrants were exploited in the UK with programmes such as the Highly Skilled Migrants Programme (2002) filling workforce gaps that UK residents could not fill. This programme was later replaced in 2008 by the “Tier 1 General a new points based immigration system. Commentators feared that humanitarian concerns could be ignored in favour of admitting only skilled asylum seekers. Tait (2003) rightly highlighted “unlike economic migrants, people seeking asylum do not arrive in the UK ready to enter the labour market, but are in need of safe haven from persecution, and may have to overcome barriers such as trauma of flight and exile.’ This point is supported through Maslow’s (1943) hierarchy of needs, which emphasises physiological and safety needs as being the most important needs for asylum seekers upon entering the country.

2.1.5 Since the inception of the NHS in 1948 there has been major reliance on overseas healthcare professionals. The Willink committee (1957) on medical manpower reported that 12% of all doctors, in a randomised sample from 1953-1955, were mainly overseas-trained (Simpson et al, 2010). This was supplemented by expansive numbers of Irish and Caribbean nurses who were seen as essential to the expanding services that the NHS was providing. There was a repetition of international recruitment in the early 2000s though with nurses from Africa, India and the Philippines (Mackintosh et al, 2006). Johnson (2005) reported that in 2003 29.4% of NHS doctors and 43.5% of nurses recruited to the NHS after 1999 were born in a country other than the UK. The Information Centre for health and social care compiled data using the NHS workforce census and reported them in 2010; those figures show that
31.5% of doctors working in the NHS obtained a primary medical qualification outside the UK. The workforce census also reported that of all non-medical staff, only 14% were represented by ethnic minority groups. The census did not report on non medical staffs’ primary qualification. Of the professionally qualified workforce 16.8% were represented by ethnic minorities and this included nurses and allied health professionals. The General Medical Council (GMC) list of medical practitioners (2011) showed the number of registered doctors with an overseas primary qualification at 37.3%, though the NHS workforce census 2010 reported 31.5% of its doctors as holding an overseas primary qualification. This discrepancy in numbers could be explained by private practice, career breaks or retirement. The Nursing and Midwifery Council (NMC), 2004) reported a steady increase in the number of overseas nurses and midwives registering with the professional body each year, in May 2011 approximately 80,000 overseas nurses (including EEA and non EEA) were registered.

2.1.6 Winkelmann and Eversley (2004) evidenced vacillating opinions regarding refugees from the 15th Century onwards coming to the UK. The attitudes towards refugee doctors and nurses have also been rife with divided opinions on the benefits with some being welcomed, while others encounter barriers and hostility. Winkelmann-Gleed (2005) highlighted the perception of in-groups and out-groups with an ‘us and them’ mentality pervading the workplace, though this applies to all migrants with this divisive mentality also being prevalent in the immigrant workforce. Adapting training and experience to UK requirements also creates perceived insurmountable barriers (Eversley and Watts, 2001), when in fact they are actually requirements to ensure a level of patient safety and satisfy UK professional bodies that overseas qualifications are equivalent and appropriate to practice.

2.2 The number of doctors and nurses available to the NHS

2.2.1 The Labour government in the early 2000s laid great emphasis on its plans to increase NHS resources. The NHS Plan (2000) indicated that a shortage of human resources had become its biggest constraint not a lack of finances. In 2005, Lord Warner, the Health Minister published figures that illustrated an increase in the number of consultants (7,542) and GPs (3,331) compared to 1999. These figures bolstered the target set out in Priorities and Planning Framework (2002) for 15,000 more consultants and general practitioners by 2008. Overseas recruitment was high during this period and many doctors were sought for the Highly Skilled Migrant Programme, however, this changed in 2006 as the government restricted recruitment of non-European doctors in training posts in the NHS, this was overturned in 2008 by the House of Lords.
The contentious issues of the European Working Time Directive and new General Medical Services (nGMS) contract were also thought to impact on recruitment and retention (Butler and Everington, 2006).

2.2.2 The GMC (2011) reported 239,084 registered doctors. Of that figure, 59,727 are GPs with the remaining 179,357 being split across the other specialities. Of the total number of doctors 33% identify themselves as being from overseas, however around 60,000 doctors do not report on their ethnicity or country of origin. The British Medical Association (BMA) currently holds a list of refugee doctors and has around 1363 Refugees doctors registered as of March 2012. However, this number does not give a true picture of the number of refugee doctors working in the UK. Many, after returning to work disassociate themselves from the label ‘refugee’ in an effort to distance the memories and experiences during this time and seek to resume their ‘normal’ lives. Since 2007, the GMC has collected data on refugee doctors and at the time of writing they had 124 doctors who had identified as refugees.

2.2.3 The NHS workforce Census (2011) reported that in 2010 there were 352,104 qualified nursing, midwifery and health visiting staff working for the NHS. The Nursing and Midwifery Council (NMC) reported on 25 May 2011 that the registered number of overseas staff including EEA totalled 82,792. With 23.5% of the nursing workforce being from overseas it seemed short-sighted that the government in 2006 wished to halt the recruitment of overseas doctors. Dr Beverley Malone, the then general secretary of the Royal College of Nursing, believed it short-termism with the Shadow Health Minister of the time (Andrew Murrison) supporting this sentiment.

2.2.4 There have been numerous criticisms of workforce planning of the NHS with individuals and organisations publicly stating their views to various strands of the media. Dr Terry John, the then chairman of the BMA, was quoted in 2006 as saying “we need long-term solutions not knee-jerk reactions” in relation to UK and overseas doctors and how poor workforce planning had affected them. Isolationist regional recruitment has caused rather large problems nationally as the actual workforce requirements were not always matched appropriately with training organisations. In 2011 a new national NHS workforce organisation (Heath Education England) was formed and it was announced that it would be fully operational from 2012.
2.3 Modernising Medical Careers (MMC) and Medical Education England (MEE)

2.3.1 Launched in 2003 Modernising Medical Careers sought to implement programmes in response to, *Unfinished Business*, the Chief Medical Officers report. Widespread consultation was undertaken before the four UK health departments embarked upon the initiative, though in hindsight this may not have been as wide as originally thought. 2005 saw the introduction of a new two year foundation training programme “that forms the bridge between medical school and specialty or general medical practice training” (MMC website 2011). The programme sought to provide a transparent and efficient career path, which had previously been not been apparent with the Senior House Officer (SHO) posts as they lacked; educational definition, structured career pathways, time limits, and vague dissemblance between training and service. Foundation Year 1 (F1) and foundation Year 2 (F2) training posts replaced the House Officer (HO) and SHO positions. The replacement speciality training was introduced in 2007 and split into two strands; Core Training (CT), offered two to three years of core training in competitive fields of clinical medicine before applying for advanced training in specialities through an open competition system. Speciality Training (ST), offered automatic progression through the training dependant on satisfactory completion of competency requirements.

2.3.2 Concerns were raised regarding MMC, sufficient enough that senior doctors around the UK boycotted its implementation. Firstly, existing trainees felt that they did not fit into the new system and were unsure of their progression routes with some worrying that they would be regressing into initial training post to continue their careers with the government reporting 23,000 posts for the 32,00 applicants (House of commons debate 2007). Secondly the online application system was inherently flawed as it was incapable of dealing with the large numbers applying for posts; more criticism was placed on this system as the process had flaws concerning the weighting and marking of candidates (Puttick, 2007). The concerns culminated in doctors marching in mass protest to the changes in medical education on 17th March 2007, this had been organised by Remedy UK and took place in both London and Glasgow. An independent enquiry and judicial review were undertaken with the royal colleges and deaneries resuming control of the recruitment process. Butler and Eversley (2006) felt that the concerns regarding the number of posts were valid but could not analyse the long term impact on employment prospects of Refugee doctors.

2.3.3 Tooke (2008) in his report Aspiring to Excellence suggested several measures as part of his independent report on modernising medical careers.
One such measure was the formation of Medical Education England, a body, which would provide independent expert advice on training and workforce planning. This organisation met for the first time in 2009. In 2010 the formation of a coalition government which aggressively sought to change the NHS and medical education left many wondering if the MMC debacle would be repeated with MEE; as it appeared to be placed in position to undertake more than an advisory role. January 2011 saw the formation of ‘Health Education England” which would not only be responsible for workforce planning but would also be replacing Medical Education England in its advisory role in education and training. This new body will also act to redesign the education and training of the healthcare workforce not just doctors (Health Workforce Bulletin, 2011). Widespread criticism from the public and professional bodies in 2011, regarding rapid, sweeping changes, led to the government pausing for a ‘listening exercise’. At the time of writing, no further information regarding the changes to medical education is available.

2.4 Changes in UK Work Permit Requirements

2.4.1 With increased output from UK medical schools in the 2000s, came a growing concern that the international recruitment of doctors would deprive UK graduates of employment and training posts. The government in 2006, through the Department of Health, announced a restrictive policy on International Medical Graduates including EEA and non EEA countries. Only those IMGs who had graduated at a UK institution were allowed to continue. The previous exemption for post graduate doctors and dentists requiring a work permit was abolished and instead they had to apply for a tier 2 work visa, which would bring them into line with other sectors of the UK economy (HRD policy release, 2006). The policy release also gave assurance that doctors and dentists already in the training system would be able to continue in their posts and that there were still places for international doctors to train, however they now needed to adhere to the usual immigration controls.

2.4.2 Whilst the policy gave assurance of continued training for those already in post, the Department of Health retrospectively debarred International Medical Graduates from posts, and hospitals were instructed to recruit UK graduates first before advertising posts to IMGs if they could not find a suitable home grown candidate. This decision was challenged by the British Association of Physicians of Indian Origin in the High Court, which ruled that guideline was illegal and this decision was later upheld in 2008 by the House of Lords. Whilst this was seen as a major success, it did nothing to compensate the trail of IMGs who had their careers disrupted at great personal and financial cost.
2.4.3 The long-term implications of the action were not fully taken into account especially as the NHS has a long history of being reliant on immigrants to provide the services required (Simpson et al., 2010). The coalition government planned to apply more rigorous measures of control for highly skilled migrants, which ignored the actual NHS service requirements (Jones and Snow, 2010) especially as there is still a need for International Medical Graduates to fill positions both in training grades and standard posts in particular specialities which continue to be areas less popular with UK graduates e.g. psychiatry (Simpson et al., 2010).

2.4.4 The UK Border Agency (UKBA, March 2011) is currently restricting visa applications for non-consultant, non training posts, and medical staff grades to the following specialities: Anaesthetics, Paediatrics and general medical specialities delivering acute care services. Consultant posts are restricted to audiological medicine, genito-urinary medicine, haematology, medical microbiology and virology, neurology, nuclear medicine, obstetrics and gynaecology, occupational medicine, paediatric surgery, forensic psychiatry, general psychiatry, learning disabilities psychiatry and old age psychiatry. There is an implication from the restrictions that while we currently have larger shortages in the consultant grades, we would appear to have medical graduates both UK and international in training posts to fill those consultant positions in the future.

2.5 Treatment of Black and Minority Ethnic NHS Staff

‘One of the nurses went into a family one night and there was a very obstreperous man and he said ‘we’ll have none of the Irish and none of them blacks in here’ so she said ‘Fine, no problems. I shall leave now but there won’t be anybody back because we are all them Irish or them blacks.”
Clodagh Health Visitor (Ryan, 2007)

2.5.1 Institutional racism in the NHS has been reported widely on in the media, especially after the death of Stephen Lawrence (BBC, 1999). Anecdotal reports of racism were common though this wasn’t addressed until the late 1990s after the MacPherson report, on the racist murder of young black man Stephen Lawrence, highlighted institutional racism in the police force. Bracken and Thomas (1999), demonstrated this racism in terms of psychiatry and healthcare with regards to the ‘Defeat depression’ campaign which imposed the biomedical model onto a condition which may or may not be defining the
illness correctly and it also ignored cultural beliefs of non-western patients. This was reinforced by Mckenzie (1999) who discussed poorer access to care and service use by ethnic minorities patients. The British government is making efforts to combat racism with the consolidation of various acts into the Equality Act 2010, which has given the NHS the opportunity to significantly move forward in the elimination of discrimination and inequality in care.

2.5.2 Though racism had been discussed It was not until the King’s Fund published ‘Racism in Medicine: an agenda for change” in 2001, that there became a much wider view of racism in the NHS. The report transformed anecdotal reports into sufficient evidence alongside studies, that racism was rife within the medical profession and the NHS. The British Medical Association (BMA) followed this in 2003 with a report detailing the experiences of racism to UK graduates from ethnic minorities as well as overseas trained doctors. The following quotations illustrate common experiences and perceptions in the NHS:

I have attended many interviews as the only Caucasian (with less qualifications) and got the jobs. - British female, White (Cooke, Halford and Leonard, 2003)

The NHS is a very racist place and mirrors society. Also the referral system favours the status quo. People keep quiet because they want a good reference – British male, Black African (Cooke, Halford and Leonard, 2003)

2.5.3 The institutional racism can still be seen in many sources regarding the NHS. Omissions of details regarding migrants supporting the NHS are startling missing from the ‘historical timeline’ on the NHS website (NHS Choices). Gerard Noiriel (1988) describes this omission as collective amnesia, a process which marginalises and denies the impact and contributions made by immigrants.

2.5.4 It is important to note that racism experienced by Black and Minority Ethnic staff is not always the sole representation of white British racism. Winkelmann-Gleed (2006) discussed layered levels of social exclusion which Ryan (2007) exemplified with Irish nurses disassociating themselves from racist remarks by distinguishing that they were talking about a lower Irish class, not the nurses. Winkelmann-Gleed and Seeley (2005) discussed this further noting how prejudice had multiple facets and that migrant nurses held perceptions of subgroups of other migrant nurses. They also gave an example of Eastern European nurses perceiving their African colleagues as lazy with strong accents that they could not understand.

2.5.5 Refugees and asylum seekers often face additional barriers which impede
their ability to truly integrate into not only the NHS but also British society. Employment issues may include a lack of documents or access to those documents to prove qualifications and experience. The inability to acquire references from previous employers is also an issue, especially for those coming from war torn countries (Winkelmann-Gleed and Seeley, 2005). This inability to give required information is often not comprehended by British staff who have no concept of what being an asylum seeker or refugee really is.

2.5.6 Alexis and Vydelingum (2007) reported that overseas nurses felt that a lack of trust and monitoring of their work led to low self-esteem and reduced confidence. What many of the nurses did not realise was that it is usual for the NHS and most employers to monitor performance during probationary periods. This feeling was mirrored by a group of refugee doctors to Reache Northwest in 2009 during a national training programme. Many of the doctors did not realise that it was not a racist trait, but that everybody was subjected to a probationary period and monitored closely. The lack of knowledge of not only NHS culture but also British working culture led to their perceptions of themselves and the workplace being altered, often in a negative manner.

2.6 Patient Safety

2.6.1 Safety in the medical profession has always been a central facet of importance. The General Medical Council (GMC) and the Medical colleges ensure rigorous training, validation and revalidation requirements are in place to facilitate an accepted standard for national safety. Butler and Eversley (2006) discussed how the media had affected government policy with regards to occupational health checks specific to overseas doctors. With the introduction of equality acts it was no longer possible to treat overseas doctors in a discriminatory fashion and occupational health checks were standardised for new entrants to the NHS. 2010 saw a further change in the law with organisations no longer being able to ask health screening question in the application process, which had been previously used to disqualify candidates from roles.

2.6.2 Recent media attention has been placed firmly back on the training requirements required to practice in the UK. 2009 saw the case of Dr Daniel Ubani, a German GP on his first locum shift in the UK. The unfortunate death of a patient due to Dr Ubani’s care led to national uproar regarding the GMC language requirements for overseas doctors, especially EU doctors who did not have to satisfy them. The Health Select committee reported in 2010 called for a language test of all EU doctors to satisfy GMC requirements. The GMC responded welcoming the recommendation and stating ‘that patient safety
must take priority over the free movement of labour. As the regulator we must be able to test the language and clinical competence of doctors who qualified within the EEA”. Whilst they currently cannot do this until the changes have been secured they have advised all employers to check language and clinical competency to ensure that doctors are fit to practice.

2.6.3 While this would appear to be a solution there are a substantial number of EEA doctors already working in the UK who have not had to fulfil a minimum language ability requirement. One response to this is by the London Deanery who has support available to doctors with language and communication difficulties through the Language and Communications Resource Unit (LaCRU). LaCRU was set up in 2010 and operates assessment days alongside training courses and is available to all doctors covered by the London Deanery.

2.7 Integration

If the road to hell is paved with good intentions, then the highway to community harmonisation is littered with the debris of intergovernmental agreements (Blake, 2001:95)

2.7.1 Integration is a particularly difficult concept to define as its meaning is movable depending on location, and the interests, values and perspectives of the population (Castles et al, 2002). Robinson (1998), believed the process of integration to be “individualised, contested and contextual”. From these perspectives we can see that integration cannot be confined to a definitive process that every refugee or asylum seeker will traverse. Kuhlman (1991) notes that refugees have added elements of difficulty as they have usually fled without planning and resources and their flight comes from experiences which are often traumatic.

2.7.2 Historically the UK has always been a home to multitude of ethnic groups, though integration of immigrants and diversity management became to the forefront post World War II (Cheung et al, 2007). The arrival of the Empire Windrush in 1948 with 492 skilled Jamaican workers created a panic with requests being sent to the Foreign Office asking them not to provide special assistance as it might create an influx (Winder, 2004). Winder, pointed out that had their been appropriate political leadership for this ethnic group that attitudes of the white majority over the next five decades could have been significantly different. The early 1960s saw a strong belief that immigrants could be assimilated into British Life. Though this ‘British way of life’ was undefined and ignored the complex and stratified cultural pathways that the native population struggled to navigate (Tomlinson, 2008). By the late 1960s
recognition was given to the realities surrounding the differences, with integration and pluralism superseding assimilation in official documents (Tomlinson, 2008). Roy Jenkins (1966), the then Home Secretary, believed that integration was not a flattening process of assimilation, but an equal opportunity to be accompanied by cultural diversity, and mutual tolerance. This perhaps laid the foundations for the idea of multiculturalism.

2.7.3 Multiculturalism rose to prominence during the 1980s and has dominated public policy until recently. Modood (2006) observed that multiculturalism required members of the host community as well as immigrants and ethnic minorities to engage in a two-way process of socialisation to ensure that no one party could be accused of failing or not trying to integrate. A particularly difficulty with this concept is that there is an assumption that there are perhaps only two groups seeking to integrate through the idea of culture not race (Brighton, 2007). Modood highlighted this by recognising that true multiculturalism emerges only when that process is identified as being distinct for each group, which results in ‘pluralistic integration’.

2.7.4 Recent government policy has seen a shift back towards the assimilation policies seen in the 1960s. This was partly a response to the 2007 attacks in London with Tony Blair (2007), the then Prime Minister, stating one of the Labour government’s objectives was to achieve ‘better integration of those parts of the community inadequately integrated’. Though the race riots in the north of England in 2001 also contributed to the regression towards assimilation (Joppke, 2004). With the recognition, both academically (Brighton, 2007) and politically, that strong meta-communities are needed to bind and integrate immigrants, David Cameron in 2010 sought to create the idea of ‘Big Society’, an initiative to help people come together to improve their own lives and transfer power from the government to communities. Unfortunately, at the time of writing, public opinion towards the ‘Big Society’ has not been positive. This is partly due to the communication strategy offending a large portion of the population with many feeling that the government is trying to absolve itself of the responsibility to provide a safety net for its citizens. The impact of ‘Big Society’ on refugees and asylum seekers is currently unclear, with many organisations struggling with severe financial cuts during austerity measures.

2.7.5 Further rhetoric has incensed communities with David Cameron (2011) claiming that multiculturalism has failed at a security conference in Munich. Whilst many might agree that the state has not provided a society in which immigrants wish to belong, Muslims targeted in the speech have seen an increase in the amount of racism directed towards them since the terrorist attacks in London. This was highlighted by Winkellman-Gleed and Seeley (2005), who reported that a male refugee nurse was taken by surprise when a
patient said ‘I don’t want to be treated by a terrorist’. Further comments made to other nurses included ‘All Arabs treat women like slaves’, though it was not only comment made to nurses that caused offence. One female nurse told a male patient to 'stop being a big baby' reinforcing her cultural gender stereotypes and marginalising the patients concerns regarding surgery.

2.7.6 From this brief summary we can see that integration is not a concrete concept that has clearly defined boundaries or targets as a result of which a person could say that they have integrated. The sensitive process would appear to be a lifelong mission that has challenges when accessing different communities throughout society as one must navigate the often vast cultural and regional differences that affect our communities.
3. The Economic Context

3.1 How much does a doctor cost?

3.1.1 An evaluation of the cost of providing training for health professionals in the UK has been a core issue for funding bodies for some time. In the current economic climate, this is perhaps the most important facet of providing services for refugee health professionals. The coalition government’s NHS restructuring plans alongside NHS cost improvement programmes may place a huge strain on education departments who are seeking to provide the same level of service with less financial and physical resources. For many organisations, funded from NHS and Non NHS sources, a time of great uncertainty has resulted through the coalition government’s cuts in this time of economic recession. The services to refugee and asylum seeking healthcare professionals are not seen as essential or core elements of business funding, with many organisations unable to acquire further funding to continue, such as St Bartholomew’s who ceased providing training opportunities in December 2010 and RAGU (Refugee and Advice Guidance Unit), who at the time of writing, were struggling to gain funding to maintain their services beyond 2012.

3.1.2 The costs of training for doctors has been widely discussed in the media over the past decade, especially with the changes of modernising medical careers and the concern regarding the potential lack of employment opportunities. The estimated costs of training a doctor are variable as much will depend on the specialty chosen and the training pathway. The following are the estimated costs initially reported in 2006 by Butler and Eversley;

- **Medical school** £250,000
- **International recruitment** £Can cost up to £37k in relocation costs plus £8k tax relief on relocation costs
- **European doctors** £ recruitment and relocation
- **St Georges Hospital Medical School** £10,000
- **Queen Mary, University of London** * £5,200 to £7,750
- **Redbridge and Waltham Forest** * £3,000
- **Stepping Stones** * £10,800
- **Reache North West** * £12,800

*Refugee Doctor Programmes – Some of these programmes provide only ‘selected’ training elements for refugee doctors.
3.1.3 Current costings as a comparative to the 2006 figures are difficult to obtain as many of the refugee doctor programmes have ceased to function with staff moving to different roles. However, costings in 2012 were only available to show a comparison from the Personal Social Service Research Unit (PSSRU) report “Unit costs of Health and Social Care 2010” in the following area;

- Medical school and completion of Foundation programme £274,354

3.1.4 The actual costs to train/re-train a refugee health care professional are not easy to calculate. However, the figure is generally a small fraction of the total cost to train a medical student in the UK.

3.1.5 Directly comparing the associated costs between projects is spurious as each project provides often vastly different services. For example, Reache North West is a hospital based holistic service providing; English language support and IELTS training, PLAB support, Safe and Effective Clinical communication skills and preparing for work in the NHS programmes alongside staged work placements (e.g. Taster placements and the Clinical Apprenticeship Scheme - CAPS) and pastoral support. This cannot be compared to some of the London projects who manage (d) particular stages of the process e.g. the London Deanery and their management of the Clinical Apprenticeship Scheme (CAPS).

3.2 How long does it take?

3.2.1 As mentioned earlier, the NHS has relied heavily on overseas workers to meet short term demand in filling essential posts. Butler and Eversley (2006) believed that the creation of the new medical schools would satisfy the key gaps in the long-term as the numbers studying medicine increased. However, recent written and verbal reports from the UKBA (2011) and the Royal College of Psychiatrists (2011) suggest that there are still specialties which are undersubscribed.

3.2.2 The undergraduate programme usually takes 5 years (though some postgraduate routes are shorter) before newly qualified doctors enter the postgraduate training route. This then consists of 2 years in foundation training and is followed by core and specialty training. This is undertaken for a minimum of 6 years before coming a consultant or three years of training to become a General Practitioner. As Butler and Eversley (2006) pointed out, ‘the prospect of retraining refugee doctors in fours years or less remains a useful medium term solution’ in relation to training medical students.
3.2.3 Butler and Eversley (2006) reported evidence from several sources that the journey to secure employment upon passing the IELTS takes approximately 2 years. Evidence from Reache NorthWest suggests that this timeframe to return to employment is still valid though there are exceptions for both shorter and longer timeframes.

3.3 Duration, location and speciality in practice

3.3.1 Support and Employment of refugee doctors is clearly beneficial to the NHS and there are several arguments for the investment of money, time and resources into their development as NHS staff. The issue of permanent residency is not an issue for Refugee doctors but can be for international medical graduates. Refugee doctors wish to contribute to the health sector and the community and the NHS can benefit from their accumulated experience prior to coming to the UK.

3.3.2 Whilst refugee doctors would like to practice in the areas in which they have settled there is an increasing understanding, not only for refugee doctors and international recruits but also for home students, that relocation for employment may be a necessary option. The current jobs market is extremely volatile, though there are areas of the country where there are clear shortages of medical staff.

3.3.3 Of the 186 refugee doctors registered with the British Medical Association in the North West, it is expected that a large proportion of them will wish to remain in the area they know, but also because of family educational commitments. The most frequently reported specialities were General Practice, General Medicine, Obstetrics and Gynaecology, and Paediatrics. There is often huge difficulty in securing any clinical attachment generally and the added difficulty of finding appropriate attachments in certain sought after clinical areas may make it difficult for some doctors to return to their original speciality if no UK clinical experience can be gained. Most Reache refugee doctors are willing to switch specialities and/or retrain in order to work in the NHS.

3.3.4 The wide clinical, cultural and linguistic experiences and expertise of refugee healthcare professionals should not be ignored as they may be able to contribute extensively to healthcare provision and integration of multi-cultural communities, asylum seekers medical centres in the main dispersal areas in the UK and other regions.
3.4 Opportunity Costs

3.4.1 There are many costs associated with the journey undertaken by refugee healthcare professionals. The individuals themselves shoulder the burden as do the NHS and other agencies and public services. Financial constraint is often the major barrier to entering the workforce; with a lack of funding or a lack of programmes and projects to offer the necessary support, alongside registration and examination fees, the journey becomes much more difficult.

3.4.2 The financial difficulties faced by refugee doctors have been recognised by the GMC. Two free attempts of the PLAB1 test are available to those doctors with refugee status, exceptional leave to remain, humanitarian protection, or discretionary leave to remain (with no restrictions on working). If the examination is failed more than twice a reduced fee of £145 for is available for two further tests. If the examination is failed four times there are no further concessions. PLAB 2 is offered at £215 for the first two attempts and then at £430. It should be noted that PLAB2 can only be attempted four times. There is currently no discount for refugees for the registration fee though the GMC offers either a quarterly or ten-monthly payment plan. The GMC do offer a 50% reduction of annual retainment fees if income is below a set amount.

3.4.3 Refugee doctors face additional challenges on their journey to re-qualification for example, if they are in receipt of public funds e.g. Job Seekers Allowance. Job Centre Plus often has strict policies and programmes which job-seekers must follow. If a refugee doctor is enrolled on one of these programmes, finding relevant work experience through the Job Centres is extremely difficult and clinical attachments organised outside of the Job Centre may not be accepted by individual Job Centre advisors as acceptable. Loss of benefits can be an extreme sanction against refugee doctors who do not comply with Job Centre policies. Individual negotiation with job centre advisors can help ameliorate this situation.

3.4.4 Funding agencies and programmes must also examine short term opportunity costs. For funding agencies target based results often give an ideal success rate, when in actuality the success of a programme may not be evident through examination results or employment gained. However, a patient safety career based focussed programme may be more beneficial than a programme that solely relies on qualifying examination success. The investment of time and money given to ensure the displaced healthcare professionals are acclimatised to the NHS working culture and UK working expectations may in the long run save valuable resources ensuring that candidates do not undergo
disciplinary proceedings or fail GMC revalidation procedures in the future. Other benefits may include engaging wider communities in outreach programmes because of more input to refugee doctors.
4. The Social Context

4.1 Diverse Local Populations

4.1.1 The North West of England is home to a diverse population, which has associated health needs of a complex nature. Recent figures are unavailable to show the distribution of Greater Manchester’s refugee community, however in 2006 it was reported that the refugee community stood at around 10,000 with Manchester, Salford, Oldham and Bolton housing the largest proportions of this population (Butler and Eversley, 2006).

4.1.2 With this increased population comes a greater demand for employment. Recent reports in the media have focussed on rising unemployment, generally among the indigenous population, yet there are also pressures from the Job Centre to find employment in an increasingly aggressive and competitive market. The Guardian (March 6 2012) published findings of an Experian study ranking 326 local authorities in England on several factors including; risk of poverty, risk of financial exclusion, households whose income is less than 60% of the median for England and households at risk of chronic obstructive pulmonary disease (COPD). The North West as a region ranked fairly highly on the list with Manchester being placed at 7 for those currently in poverty and also for those at risk of poverty, and Salford being ranked at 29 and 26 respectively. Manchester was also ranked 17 for a risk of long term employment with Salford ranking at 40.

4.1.3 The British Medical Association maintains a refugee doctor’s database which gives us some information about those doctors who voluntarily register as refugees. The current total number of doctors on the database as of 8 March 2012 is 1363, though this does not necessarily truly reflect the number of refugee doctors in the country. The North West has seen an increase in the number of refugee doctors since 2006 from one hundred and twenty two to one hundred and eighty-six. The largest proportion of refugee doctors in the north west are from Iraq with Afghanistan being the second most likely country of origin, this mirrors the national profile regarding the refugee doctor population. These figures represent untapped potential from a section of society who wish to contribute to the workforce. With the most reported speciality experience being; General Practice, General Medicine, Obstetrics and Gynaecology, and Paediatrics. Many refugee doctors change their future speciality career choice to gain employment in the NHS.
4.2 **Acculturation**

4.2.1 Acculturation can be defined as a process in which members of one cultural group adopts the beliefs and behaviours of another. This often is seen as a minority group adopting habits, attitudes, values and the language of a dominant group (Kovacev and Shute, 2004). Sam and Berry (1995, 2010) believed that acculturation could be defined as behavioural and psychological challenges and changes that occur as a result of the two cultures coming into contact. Kwon (1995) stated that the contact and changes often have significant impacts on ethnic identity, values, attitudes and behaviour patterns. Berry, Kim, and Bosky (1988) suggested that acculturation was a process which resulted in a better outcome when undertaken in a habituated context, achieved through changes in psychological characteristics, environment or social contact.

4.2.2 Berry (1984) identified four strands of acculturation in relation to a). - retention or rejection of native culture and b). - adoption or rejection of the host culture. This results in the following:

- **Assimilation** occurs when there is a rejection of the native culture and the host culture is adopted.
- **Integration** (or Biculturalism) occurs when there is successful adoption of the host culture and there is maintenance of native culture.
- **Separation** occurs when there is rejection of the host culture with minimal interaction.
- **Marginalisation** occurs when there is a rejection of both cultures and is often associated with identity crises, confusion, anxiety and alienation.

4.2.3 There are multiple factors that affect the resettlement of refugees and asylum seekers. Kovacev and Shute (2004) highlighted *cultural changes, the loss of social relationships and the need to form new social relationships* as some of the more prominent aspects. These factors and the arrival into “multiple worlds” (Cooper, Jackson, Azmita & Lopez, 1988; Kovacev and Shute, 2004) impact on their ability to successfully navigate through a new and alien culture. Some concerns have been raised regarding disengagement from society as there are long-term risks when there is a failure to interact with society (LaFromboise et al., 1993; Phinney, Lochner, & Murphy, 1990).

4.2.4 Support networks are especially important for asylum seekers and refugees, yet they can be extremely difficult to obtain with various barriers preventing the establishment of meaningful social support. Simich et al (2005) noted that ‘navigating the system’ and learning how and where to access support was one of the largest barriers for new arrivals, Jasinskaja-Lahti et al (2006), reported that whilst ethnic networks (which included family and friends), may be available, there was a lack of people from the host society within the support network. This was highlighted as being especially difficult in societies...
that were not receptive to immigrants.

4.2.5 Montgomery and Foldspang (2007) identified that experiencing discrimination is an important resettlement stressor that often affects mental health, with increased ethnic identification negatively impeding well-being. With asylum seekers and refugees often experiencing situations which would impact on their stress levels and mental health, it becomes more difficult for them when they experience discrimination in the host country. Kovavec (1994) reported that the most commonly experienced incidents which led to flight from home countries included; confiscation of all property, bombing and shelling, being expelled from home, death of a family member, witnessing killing or torture, and being verbally threatened. Similar accounts were obtained by Momartin, Silove, Manikavasaagar, & Steel (2002). Doctors are more likely to be targeted because of their position in society but also because they help and treat all who need medical attention and the Ruling Party will object to this and see it as support of the opposition in a conflict situation. With the negative media profiling of asylum seekers and refugees reported in 2.1.1, the establishment of support networks for this group was especially difficult.

4.3 Impacts on Refugee Doctors

4.3.1 Refugee healthcare professionals are faced with a variety of issues, which may adversely affect their journey of re-qualifying and gaining the necessary experience before returning to work in the UK. These may include:

- Current events country of origin, e.g. Civil war in Libya, Syria
- Legal challenges and deportation
- Threat of dispersal
- Divided families or legal issues of family reunification
- Pressures from Job Centre Plus to gain paid employment to remove the need for benefits
- Childcare issues, particularly impacting on women
- Community hierarchy e.g. Doctors are often seen to be leaders of their communities and the impact of not returning to work or gaining alternative employment can demotivate the entire refugee community from their country of origin. Alongside this element of social responsibility they often act as advocates, interpreters and give advice.


4.4 Language and Culture

4.4.1 As mentioned in 2.6.2 the linguistic competence of international doctors has been brought once again to the fore, in less than fortunate terms. This is not the first time there have been queries regarding the linguistic range that international doctors require to perform their duties and ensure patient safety. The media also often ignores the positive linguistic attributes that Refugee and International doctors bring to the communities they are serving, as they often have a greater understanding of the cultural, linguistic and socio-economic background of patients from ethnic minority and international backgrounds.

4.4.2 There has been a greater shift towards language and communication skills an example is in postgraduate medical education with the formation of the Language and Communications Resource Unit (LaCRU), within the London Deanery. There is a need for medical educators to engage with this area as more public debates about doctors’ language skills are seen in the media. One of the areas which has been highlighted as an area for development is how to use a multi-disciplinary approach to incorporate language teaching within clinical teaching (Cross and Smallridge, 2011).

4.4.3 With the consolidation of various acts into the Equality Act 2010 the NHS has been working towards equal care across communities that reflect the needs of those communities. Language and culture plays an important part in many health care scenarios from the type of care received to how health and treatment plans are communicated.

4.4.4 Greater use of interpreters and translators has been seen, however in 2011 and 2012 there was a call to reduce the cost of this service as many local newspapers were reporting bills of over two hundred and fifty thousand pounds; This is Leicestershire (ThisisLeceistershire.co.uk) reported a bill of approximately £500,00 pounds on the 28th February 2012. While many may believe that family members could be used to help ailing patients translate their symptoms and concerns, there are ethical considerations to take into account (Wright, 2010) and patients may be embarrassed by their relatives knowing the details of their medical history.

4.4.5 As mentioned in the previous paragraph the demand for translation and interpretation is high. With an ageing population requiring more specialised care in all communities where the reported prevalence of long term illnesses and chronic conditions are elevated, this demand may increase further. Black, Minority Ethnic, Refugee and poorer communities have felt the impact of some conditions much more disproportionately (NHS Choices 2012). With the
introduction of the Equality Act 2010 the NHS hopes to address the disparity of care across communities
5. **The Technological Context**

5.1 The technological context in the context of Reache North West and Refugee Healthcare Professionals refers to the organisations who offer support and routes to gaining professional registration in the United Kingdom.

5.1 **Post graduate Medical Training in the UK**

5.1.1 In the 2006 Evaluation, Butler and Eversley reported on the creation of the Postgraduate Medical Education and Training Board (PMETB) in 2003. As the public body responsible for postgraduate medical education they were tasked with ensuring that the training was of the highest standard for those doctors working in the NHS or privately in England. In 2010 the PMETB merged with the GMC and all functions and operations were transferred to the GMC.

5.1.2 The GMC has rigorous requirements with regards to the postgraduate education of doctors, and their approval of curricula, assessment methods, training programmes, trainers, and training posts is needed before training can take place.

5.1.3 As mentioned in 2.3.3 Medical Education England (MEE) is an independent expert organisation which offers advice and guidance on the training and workforce planning of healthcare professionals in England. MEE is advertised as the greatest opportunity since the establishment of the NHS in 1948 to align professional training, education and workforce needs with the needs of the service and patients. However, each of the professional bodies (GMC, Nursing and Midwifery Council [NMC], General Dental Council [GDC]) currently regulates the education and training of their professions and MEE will have a challenging role.

5.2 **Language Testing**

5.2.1 At present language testing is a contentious issue in the UK with regards to internationally trained healthcare professionals. Due to European agreements European nationals are currently considered to be exempt from formal language testing, even if they have never studied English. All other overseas healthcare professionals must take an approved examination, even if they trained and qualified in a European institution.

5.2.2 The International English Language Testing System (IELTS) tests the
proficiency of English language across four skill areas (reading, writing, listening, and speaking) against a ten point banding system rating candidates from zero to nine in proficiency.

5.2.3 There are two routes for the IELTS; general and academic. All of the professional regulators and training providers require the academic route to be taken. Candidates receive a band for each of the four skills and an overall banding. All of the professional bodies have minimum language requirements for overseas professionals seeking to take examinations and register.

<table>
<thead>
<tr>
<th>Professional Body</th>
<th>Overall Band (minimum)</th>
<th>Individual Skill area – minimum band</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical Council</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Nursing and Midwifery Council</td>
<td>7</td>
<td>7</td>
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<tr>
<td>General Dental Council</td>
<td>7</td>
<td>6.5</td>
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<tr>
<td>General Pharmaceutical Council</td>
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5.2.4 The score must be obtained in a single sitting and the results are only valid for 2 years from the examination date.

5.2.5 Butler and Eversley (2006) highlighted the debatable relevance of IELTS as an appropriate language examination for working with patients especially as the examination has a more academic focus which generally does not enhance patient communication. This is still a widely debated area, however at the moment there is no viable alternative.

5.2.6 Another issue surrounding the IELTS examination is the rising cost and the frequency with which refugees are taking the examination to obtain the required score. Many of the Reache doctors take the examination on a regular basis despite the tutors advising them against this, as not only is this expensive and damaging to morale but it is also for some a waste of time, as they are not going to achieve the required level as they are not yet at the required standard. IELTS provision for refugee healthcare professionals has been on the decline with the reduction of funding for refugee projects. Some colleges provide IELTS courses, however the costs for these courses are
often prohibitive.

5.3 Professional Linguistic Assessment Board (PLAB)

5.3.1 The Professional Linguistic Assessment Board examination is the GMC’s professional equivalency examination which must be undertaken by overseas doctors outside of the European Union if they wish to gain registration with the GMC and practice medicine in the United Kingdom. The examination is a 2 staged process with; part 1 testing theoretical clinical knowledge through extended matching questions and single best answer questions, while part 2 is an observed structured clinical examination (OSCE), which consists of 14 clinical stations, a pilot station and a rest station. Part 2 of the test assesses; clinical examination, practical skills, communication skills, and history taking.

5.3.2 The PLAB was initiated in 1975 as the Temporary Registration Assessment board (TRAB) examination which included proficiency in English and professional knowledge this was then altered in line with legislation in 1979 to become PLAB. Concerns were raised in the early 90s regarding the lack of a clinical component which led to the introduction of OSCEs in 1993. IELTS was offered as an alternative to the English portion of the examination in 1996 which became compulsory in 1997 for all new entrants to PLAB and then in 1998 IELTS became compulsory for all candidates. The accepted speaking score element of the IELTS was raised to band 7 with nothing lower than a 6 in 2000. With, all the elements (listening, writing and reading) being raised to band 7 in 2010. November 2005 saw the introduction of Alternative Evidence of English being accepted however the GMC is currently reviewing this. The GMC is currently undertaking its third review of PLAB (Review of the PLAB exam – Call for Evidence 2012) with previous reviews being undertaken in 1999 and 2003. The above information was provided by the GMC in 2012.

5.4 Clinical Attachments, Clinical Apprenticeship Scheme (CAPS) and Experience

5.4.1 The British Medical Association (BMA) defines clinical attachments as a period of time when a doctor is attached to a clinical unit, with a named supervisor, with the broad aims of gaining an appreciation of the nature of clinical practice in the UK and of observing the role of doctors and other healthcare professionals in the NHS.

5.4.2 Recognised as an opportunity for refugee doctors to experience the NHS
directly, clinical attachments give many doctors who are studying for the PLAB 2 examination a contextual basis to work towards, often alleviating concerns about the examination and allowing them insight into the real world of the NHS. Butler and Eversley (2006) highlighted evidence from the GMC which reported almost all overseas doctors undertaking their first post had already undertaken a clinical attachment and that the clinical attachments had been a significant means of discovering employment opportunities. The availability of clinical attachments varies greatly with location and the willingness and availability of supervising clinicians, in some cases there is a charge to undertake them. This is mainly in the South of England.

5.4.3 The Clinical Apprenticeship Scheme (CAPS) set up by Reache and the London Deanery provides a supernumerary honorary post which gives refugee doctors the opportunity to undertake supervised clinical training positions working at foundation level for between three and six months. UK clinical experience is gained and a UK reference from a clinician is then available for them when seeking further employment. The London Deanery offers six month paid posts, however Reache does not have the same funding and can only offer 3 month unpaid positions, which are supported by clinicians who work voluntarily with Reache. If after three months the supervising clinician has any concerns the placement can be extended or another position may be organised in an alternative setting to gain wider clinical supervision. These posts have often been debated as Butler and Eversley (2006) reported in relation to the appropriateness of the post for the refugee doctors and the patients they may come into contact with. The BMA and the London Deanery strongly objected to unpaid posts due to a variety of reasons. However, the success of doctors finding employment after being on the CAPS through the Reache programme has lessened some of the hostility to the unpaid posts. Reache NorthWest reimburses CAPS students for travel during the placement.

5.4.4 National media coverage of unpaid internships in the last 12 months has highlighted various problems with these types of post. However, the Chartered institute of Personnel and Development have made several recommendations in their report “Internships that Work”;

- Interns should be recruited openly, in the same way as other employees.
- Interns should be given as much responsibility and diversity in their work as possible
- Interns should be allowed time off to attend job interviews
- Interns should have a proper induction
- Organisations should allocate a specific individual to supervise interns, mentor them, and conduct a formal performance review to evaluate the success of their time with the organisation
- On completion of the internship, organisations should provide interns with
5.4.5 Of these points, only the first is not adhered to as Reache is funded for refugee doctors and the placements are tailored to the individual members to give them the best experience and also members may gain GMC registration at different points and a placement cannot be arranged until they have received their registration. However, Reache students are formally interviewed for the scheme and only taken on if they are, in the consultant’s opinion, suitable to work at Foundation Year 1 level.

5.5 Comparison with Other Programmes

5.5.1 In 2006 Butler and Eversley reported on the mapping of pathways for refugee doctors with the vision of robust comparisons between programmes to gain evidence for further projects. Unfortunately due to the economic crisis there has been a reduction in the number of refugee programmes nationally, with attendance at the refugee doctors liaison group diminishing. Currently Reache cannot be compared with any of the other existing programmes in England at present as they do not provide the same comprehensive services and support in a similar environment.

5.6 Refugee Doctors Liaison Group (RDLG)

5.6.1 The RDLG is currently hosted by the BMA and has been since it inception in the 1990s. With the drastically reduced number of programmes available the previous chair (Dr Ed Borman) introduced the idea of liaising with other health profession organisations. As of 2012 the group is now the Refugee Doctors and Dentists Liaison Group and they hope to bring other healthcare professions on board to give wider support to asylum seeking and refugee healthcare professionals in the future.

5.7 ROSE Website

5.7.1 The Rose website was managed by NHS employers until 2011 when the Refugee Healthcare Professionals (RHPs) programme came to an end. Reache Northwest has taken over the management of this resource and the site is due to be re-launched in 2012 once all technical challenges have been
addressed with the hosting organisations. During a research activity to update the site further evidence was found of the decline of refugee healthcare professional programmes (RHPS) as the number of organisations who responded to the call for contact details had declined since the close of the RHPs programme from fourteen to four (March 2011).
Section B
The Reache North West Programme
1. The Reache Membership

1.1 Current Membership

1.1.1 Reache currently has sixty-one active members, with forty-nine of those being doctors, five dentists, four pharmacists and three nurses. The members come from a wide range of countries currently experiencing difficulty, though the following countries are major contributors to Reache’s membership; Afghanistan, Iran, Democratic Republic of Congo, Syria, and Iraq. Currently 55 members have leave to remain while 6 are still going through the asylum process. This is a major change as previously more than 50% of students were asylum seekers and therefore did not have permission to work and could only undertake limited voluntary work.

1.2 Returned to employment

1.2.1 At the time of writing Reache had successfully helped a total of 135 refugee healthcare professionals back to their original roles this includes; 124 doctors, 5 dentists 4 Pharmacists, 2 Allied Health Professionals and 1 Nurse.

1.3 Alternative Careers

1.3.1 In addition, Reache has often helped refugee healthcare professionals into viable alternative employment when it was difficult for the refugees to return to their original career or they decided on this as a future career choice. Unfortunately individual statistics for this are not available from 2003 –2011 but a guesstimate would be around six.

1.3.2 In 2011 Reache had the opportunity to use some funding for alternative careers for those members who believed that they would not be able to complete the difficult journey back to their professional role. Initially two one -year fixed term contracts were available as pharmacy assistants at Salford Royal Foundation NHS Trust. Both of the members who undertook these one year placements secured employment either before or at the end of the contract. Both members have also completed modules for an NVQ level 2 in pharmacy.
1.3.3 A further post as a medical support worker on hospital wards was later funded and at the time of writing, the member had made such a positive impression that the department reported to Reache that they felt overall working standards had improved due to the Reache member’s professionalism and influence. Two part time posts as night-time medical support workers have been funded with a start date of May 2012 and a new pharmacy placement is due to start in early summer 2012.

1.4 IELTS

1.4.1 The majority of the current membership is currently studying for the International English Language Testing System (IELTS) examination. With the GMC increasing the minimum standard the number of members passing the examination has decreased. Whilst the doctors were dismayed by this increase, it also brought them in line with all the other health professions. Of our current membership approximately fifteen are within one band of the required score with a further thirty attending English classes at Reache and at a local college. Whilst the doctors would prefer the Reache English team to focus solely on examination technique, this is unlikely to result in the required marks and is extremely unlikely to produce safe and effective practitioners.

1.4.2 The team of English teachers ensure that the basic foundations of language are solid with a wide ranging knowledge of language and culture. Difficult and culturally sensitive topics are broached early on in these classes often challenging the members’ views, opinions and perceptions of what is culturally and legally acceptable in the UK. The early introduction of these topics helps prepare the students to better understand the culture in which they will operate as healthcare professionals.

1.5 PLAB1

1.5.1 Nine members have passed the IELTS stage of GMC registration and are undertaking PLAB1 study. Weekly lectures, alongside clinical seminars give members the appropriate medical teaching and refreshment of their clinical knowledge. Reache Tutors are insistent that members should not concentrate solely on examination techniques or questions as this often results in failure of the examination. By studying medicine generally with some examination technique in addition, the members should be sufficiently prepared for the examination.
1.6  PLAB2

1.6.1 Seven members have currently passed PLAB 1 and are preparing to undertake the PLAB 2 examination. Part of this preparation involves intensive practice on short courses as well as utilising Reache resources and the clinical skills facilities at Salford Royal Foundation NHS Trust.

1.6.2 Once members have passed PLAB 1, a one month clinical attachment is arranged to ensure that members have some knowledge and observational experience of the clinical practice in the NHS. They also interact with clinical teams and learn the ways of the NHS.

1.7  GMC Registration

1.7.1 Three members recently passed PLAB 2 and achieved GMC registration. Two of these members are currently undertaking a Clinical Apprentice Scheme (CAPS) and the third is awaiting clearance to start a CAPS. We would expect that all three will gain employment quickly after completing the CAPS scheme. All previous members who took part in the CAPS scheme have gained work as doctors in the NHS.

1.8  Accounting for all our members

1.8.1 Since 2003 there have a total of 391 members of Reache North West. Some of these members left Reache for a variety of reasons, however most of them were asylum seekers and were forcibly moved away from the Reache catchment area by the UK Border Agency under NASS housing arrangements and policy at the time. This movement could be very frequent and often across the country.

1.8.2 One of our current members reported being moved four times in a month! This was often very stressful as they would arrange not only their domestic situation but also for children to attend a local school and then would be moved a week later. Due to this, contact with these members was often lost and many of the members may have been deported or voluntarily returned to their country of origin, whilst others wish to forget their experience as an asylum seeker/refugee and do not keep in touch.
1.8.3 Over the years there have been a small minority whose membership has been closed due to unprofessional behaviour, poor attendance or non-compliance with Reache policies and procedures. An even smaller minority were removed from Reache membership as they did not appear to understand the need to adapt to ensure they would practice safely in the NHS.

1.8.4 Of the total number, Reache closed the membership of 186 asylum seeking or refugee healthcare professionals, due to the above mentioned reasons. Of this group 41 are currently registered with professional bodies (37 - General Medical Council, 3 Nursing Midwifery Council, 1 General Dental Council), 1 member’s registration had lapsed due to administrative reasons and 1 other had relinquished their GMC registration voluntarily. We do not have any other data regarding the employment history for these members.
1.9 Statistics

The above pie chart shows successful registration as a Reache member. Since 2003, only 18 applications to join Reache North West have been rejected as they did not fit the criteria as an overseas trained asylum seeker or refugee healthcare professional.

Of the closed membership 23% managed to obtain professional registration, however there is no evidence that they are currently working. There is no data available on the remaining 77% of members whose membership was closed. As mentioned in section 1.8 there are a variety of reasons for membership to be closed. What can be noted from the statistics is that if members complete the Reache programme they are three times more likely to return to their professional role.

Taking into account the total membership the following pie chart shows the current known employment status of all accepted applicants onto the Reache programme.
Reache Member Destinations 2003-2012

- 46% Working in Professional Role
- 39% Currently training with Reache
- 15% Unknown, Alternative Career, Unemployed or Training alone
2. **Respondents and Commentary**

2.1 As reported earlier eight out of twenty-five working members of Reache responded to the call for interviews. Of those that responded, five arranged a time and date for the interview whilst the other three could not take part due to clinical and personal commitments.

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2.1 **Demographics of the Respondents**

2.1.1 Two females and three males constituted the cohort with a range of five nationalities; Iran, Iraq, Sudan, Zimbabwe and Chechnya.

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2.2 **Careers in the UK**

2.2.1 Of the five respondents one was in a two year foundation training post, one was in the GP training programme, another had been accepted into Core Medical Training and the remaining two had secured service posts and were continuing to look for appropriate training posts. All of the doctors had relocated for job opportunities. For all of the doctors there was a substantial career gap, this was due to a variety of reasons, which were often personal and profound.

2.2.2 ‘I came to England but, for many reasons and some personal reasons I was unable to look at my professional life at all. I had to survive and I had to live day by day’.

2.2.3 For some, they felt that being in asylum was a temporary measure before returning home

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2.3 **Gaining Status and Employment**

2.3.1 The year of entry of these doctors into the United Kingdom was from two thousand and two up to two thousand and seven. The time to achieving refugee status varied for the respondents with the shortest period being one year and the longest eight years. This period was often a very stressful experience for the doctors as the wait to determine their futures was arduous and often left them destitute. One of the doctors reported frequent relocations across the country via the National Asylum Support Service (NASS), with only
the intervention of Reache preventing further movement. This doctor believed that without Reache’s intervention and support, the return to employment would have taken much longer than nine years.

2.3.2 Life as an asylum seeker was restrictive to all of the doctors with approximately only £30 per week being available for food and bills, this impacted on their ability to integrate as a feeling of inequality became apparent to them from simple statements and questions like “what did you do this weekend?”. This feeling also occurred after gaining status but before employment was found. One doctor spoke of their experience;

2.3.3 “You know, initially you don’t think about it but, then you’ll be asked; what did you do this weekend? you know, I’ve been on holiday and, you know, and think oh, you can’t participate in that sort of thing and not that you have to always participate in every conversation but, somehow you start feeling less worthy, less equal. “

2.3.4 This feeling of inequality often took some time to dissipate;

“There’s always a stage where people are getting used to you and initially I got the feeling that my work was always being checked. You know, is it okay? The registrar checked my stuff over again and stuff like that. And then, I decided okay. I mean, I have to be safe, we are here for the patients’ safety and as long as I learn something along the way and then when they got used to me they’ll say; oh, normally, you know, usually in case like this, this is what we do or I would ask them how do you normally do things, you know, and then we got more comfortable with each other and I grew in confidence and now I, I feel I fit in.”

2.3.5 Many of the doctors felt that their ‘work was always being checked’ but after a period of time, they felt that everybody’s work was checked when they started working in a new department. This lack of knowledge regarding UK working culture and probationary periods was often a barrier to integration. A feeling of racism being present until they visibly saw a native British person being treated in exactly the same way. However, what is also notable is the assimilation of NHS and UK values into changing their perception of the situation as the above quotation remarked on patient safety.

2.3.6 Once refugee status was attained there were often remarkable changes to the doctors’ lives. Accessing housing and job centre support were initial steps, with General Medical Council (GMC) registration and employment being the final pieces to their new lives. However, for some the status change was not quite so straightforward. With a large number of unprocessed asylum claims, which were named ‘legacy cases’, the government took action to clear this backlog within five years. Of the 450,000 cases identified in 2006, 361,000 had been concluded by January 2011. Many of these cases were granted
leave to remain, however there was no mention of the asylum/refugee process. Indefinite leave to remain, may seem like a dream to most people but without the label of refugee attached to their new legal documents more difficulties were often faced. Asylum and Refugee organisations and charities could often no longer help as officially they were not eligible; housing and benefits issues were also complicated.

2.3.7 One “Legacy Case” doctor spoke about the difficulties they faced with registering with the GMC without refugee status. Various documents were required by the GMC to verify information; however this information was either extremely difficult or impossible to obtain due to war or political situations. In some cases universities are no longer functioning due to them no longer being physically present. Continued requests for further information left the doctor feeling stressed and believing that they were unlikely to return to work as the difficulty in obtaining the documentation from the country of origin was so great. And with no official status as a refugee, exemptions or alternative arrangements could not be taken into account. The time gaining registration could not be accurately guessed with one doctor receiving registration within a month of applying and another taking almost three years.

2.3.8 One doctor stated

“There was no battle and nothing was in my control I had done what I could have done whatever I could have done and then it was up to other people to decide for my future. That was very difficult I found it the most difficult bit actually. I found it extremely difficult I mean I could manage working full time, part-time studying, studying under boss, like struggling, all these things wasn’t as difficult as waiting for the GMC”

2.3.9 Following on from this was the timescale for gaining the first paid clinical post, this varied in two ways; Firstly time from status change and secondly time from receiving GMC registration and license to practise.

2.3.10 In the first case the time varied from four months to four years with the average being around the two year point. The shortest case in this regard was quite unusual as GMC registration had been held for two years before immigration status to work had been obtained.

2.3.11 From receiving GMC registration the fastest to engage in paid clinical work was twenty days and the longest three years. The shortest time, of twenty days, was due to a foundation doctor becoming suddenly ill and a locum position became available. As the Reache doctor had recently been on an attachment in the hospital and had current Criminal Records Bureau (CRB) checks and occupational health clearance the trust involved believed that
offering the locum position to the Reache doctor was the most viable option as far as interview times and gaining the appropriate clearance was concerned. The longest time frame was due to GMC registration being given two years prior to refugee status and the doctor concerned was unable to undertake paid employment due to immigration restrictions.

2.4 Social Stigma

2.4.1 As mentioned in the political context, the media has often given very unflattering and at times vitriolic portrayals of asylum seekers and refugees. The respondents were often hyper aware of these stereotypes and opinions and this often affected them during their journey.

2.4.1 “Interviewee: So you find at times you were there but, you were not really mixing with other people as well as you could have done because you always had this, you know, and not wanting to say a lot about yourself because it’s not all the clinical attachments where I went to clinical attachments and where the people..., probably the consultant would be aware of my status. But not the other people they would just think, I would let them assume, I was just an overseas doctor.

2.4.2 Interviewer: Did you feel uncomfortable talking about being an asylum seeker or refugee?

2.4.3 Interviewee: It’s just sometimes you don’t know how people would take it or they would have said some comment you know, that makes you think okay let’s maybe I’ll leave it there yeah.”

2.4.4 “Interviewer: Do you think that (difficulty in gaining acceptance in social circles) happens with native speakers though as well?

2.4.5 Interviewee: Probably but, it would be more difficult for us wouldn’t it you have a background that really is a bit like awkward you’re a refugee you haven’t worked for like I talk with my colleagues at work and they say what have you been doing I’m saying I haven’t worked for six years is this a big thing to say but, I don’t have to hide it so it is just really difficult.

2.4.6 Interviewer: When people ask you “what have you been doing?” Do you tell them or do you hide it?
Interviewee: I generally tell them. If it is someone that is really, I don’t tell lies I may not tell everything. If someone is like totally a stranger I may not but, generally yes I say I have been with an organisation like coming here I told my friends that I’m going there because there was an organisation who helped me and I’m going to have an interview with them they’ve asked me to speak about my experience so, no. No it is not as if I’m ashamed of being, no. I always like to change that image in people if they have prejudice about asylum seeker I like to break that prejudice so I always say yes I am a refugee doctor.

Interviewer: So, do you think it’s a good thing for your colleagues or the refugee doctors to tell people about them being refugees.

Interviewee: Yes because everybody thinks refugees are a bunch of people who are coming and doing nothing no I like to do that even being Iranian oh, you’re Iranian they don’t expect Iranians to be, I don’t know”

2.5 Preparation for Employment

2.5.1 English Teaching

Reache currently provides five days a week of English language teaching, which prepares members for the IELTS examination and to work safely in the NHS. The language teaching offered at Reache has evolved over the last nine years and this has been in response to feedback from external stakeholders such as supervising consultants who felt that language skills of refugee doctors were weak on clinical attachments compared with UK and other doctors’ general language skills. Whilst the primary focus is to pass IELTS, Reache also hopes to give members the tools to function in a wider context than the IELTS though one doctor commented on the language teaching;

“Actually the teaching classes in English was really good to help us passing the IELTS, it was the IELTS oriented completely so that was helpful”
One doctor in particular felt very strongly that a greater emphasis on English was needed before the PLAB examination. The sentiment is shared by the Reache staff.

“Interviewer: On reflection what could you have done to make your journey back to work easier?

Interviewee: I think, probably taking English more seriously, putting more time and effort and of course studying medicine something personal, I think we leave it here.

Interviewer: Why do you think taking English more seriously?

Interviewee: Because sometimes you have time and you just passed the IELTS you don’t really commit yourself to keep studying English after that you study medicine, it is a lifelong learning there is no point that you can say I’m just confident as a doctor and as a doctor you really need to be very good, almost perfect.

Interviewer: In English?

Interviewee: Yes of course with communicating with different people, I mean people real, elderly, hard of hearing. Adding to that accent, grammatical mistakes that would make communication much easier, it is already difficult, there are hindrances in-between like the age, being elderly, hard of hearing, being very ill, having a weak voice, so it all adds up.

Interviewer: So, do you think it’s easier to study more English before you start into the medicine.

Interviewee: Yes, yes I think we all need to work on that even communication, even talking and speaking. I have patients that sometimes I have to repeat my questions few times and I know the only problem is accent but, patients are very forgiving they just ask and then they understand and they answer back”

As the language classes have evolved at Reache so has the structure and focus with a much wider focus of providing a solid language base that encompasses colloquial language and a wide subject knowledge in English to ensure that Reache members have more versatility in functioning at work, socially and in society.

The IELTS requirements have also made an impact upon the teaching of English at Reache. The previously required score of an overall 7 with nothing lower than a 6, was increased to an overall 7 with nothing lower than a 7, by the GMC in October 2010. This has caused great anguish and despair for many doctors as the length of
their journey has increased as they study to a higher level. This change was welcomed by Reache staff and our working doctors understood the need for higher levels of English.

2.5.1.14 “I know that IELTS is getting more difficult, which is good because in real life even you need more skills writing a letter to GP liaising with community hospital they are just not that easy communications. I mean still, I think the bit that I really am struggling with is communication with clinical and medical bit, you know, you learn and then you have medical staff around you the registrar, the higher grade people. We can always get advice. The one bit you really can’t ask people is; can you read my letter to the GP, please to make sure if it’s just fine and if it’s much less.”

2.5.2 Communication Skills

2.5.2.1 Reache runs regular patient communication scenarios with volunteers and simulated patients/actors (SPs). This provides the Reache members the opportunity to practice their language and communication skills and obtain feedback from tutors and the patient perspective. These skills were also often consolidated in simulated ward rounds, where volunteer consultants and SPs would give feedback to the members.

2.5.2.2 “I think the most important thing is your communication skills, because that’s as a doctor I think could be the most important thing.”

2.5.2.3 “Reache has covered most of the things that we could, from history taking, from writing discharge summaries, from managing in-patients, from presenting patients, then how to present patients under watch of the doctors and I still didn’t do that well because I would get anxious, no I think perhaps because the Reache team were a clinical team they basically almost covered everything.”

2.5.3 Preparing for Work in the NHS

2.5.3.1 Preparing for Work (PFW) initially ran every Friday, however due to varying numbers of doctors at the various stages of returning to work, Reache has recently turned this into intensive one week courses which are run every 12 weeks. Alongside this programme is a workbook which covers some of the essential aspects of working in the NHS, e.g. Consent, Ethics, Confidentiality etc. This revised programme hopes to ensure that areas are not missed by members as they progress on their journey to work unlike some of previous
members who unfortunately did not receive all of, what Reache considers, essential teaching.

2.5.3.2  
“Well obviously there’s many things to when you will face difficulty we’ve got by the time there is many ethical issues actually, many ethical issues you will learn during your practice it would be better to know them before you start practicing like you know like there’s medico-legal and ethical this is many things they are altogether in one group you can’t classify them like, like when you decide someone not for escalation of care so it would be like for not for ICU, not for high dependency just for ward, not for resuscitation those kind of decision before I start working I didn’t know how this decision is based on. I didn’t know how it should be is it just a consultant decision or do you involve the family or do you involve the patient first or the family and things like this and some of these communication difficulty as well the I feel difficulty with the patient and the relative you need to know who you’re speaking to first, which is this need to be very, very important to be highlighted to all those who want to practice in UK.”

2.5.3.3  
“You need to know who you’re speaking to no matter who it is. What’s the relationship because some people will say I am this is my relative but, it’s his niece or whatever or his far off, his neighbour might say I’m his relative so to find out what’s the relationship and even if his brother or mother you have to clarify if the patient wants you to speak to them, so these kinds of things need to be all the time highlighted because you keep forgetting them sometimes even medical trainee from UK who graduated from UK some people they miss these sometimes. It’s really happening in front of me some people they just start saying some medical condition of the patient over the phone with the relative, which is not appropriate by medical staff or by the nursing staff sometimes they do this mistake but, you need to be all the time reminder there. “

2.5.4  Clinical Attachments

2.5.4.1  Reache provides one month observational posts (Clinical attachments) for doctors who have passed PLAB 1 and in some cases the doctors may have passed PLAB 2 depending on how long it took to arrange the placement. Reache believe the Clinical Attachments are a necessary part of the journey to return to work as they give members the opportunity to observe clinical staff and wards in action. For many the extensive gap in the career can lead to a loss of confidence and a 1 month commitment to observe clinical interaction can do a lot to counteract the negative effects of unemployment. For some
the clinical attachment can re-instil confidence and allay fears of returning to work. The experience of seeing live clinical encounters before the PLAB 2 examination is invaluable and allows the doctors to deviate from formulaic communications and engage naturally with colleagues and patients. All of the respondents had undertaken at least one attachment before finding employment with the average undertaking 2 and one doctor had undertaken five.

2.5.4.2 All of the doctors felt that the clinical attachments were useful experiences

2.5.4.3 “Basically you are just there, you know, what you’re expected to do, you know, how nurses start work, how the whole hospital is certainly different. I sometimes think if I hadn’t been doing the clinical attachment and I didn’t being have this training have I ever feel confident enough to apply for jobs even if I was allowed.”

2.5.4.4 “Actually it (clinical attachment) improves your communication skills with patients and with the staff and prepares you to start working straight away afterwards you won’t find difficulty starting working with NHS if you have a face to face interaction with staff and patients.”

2.5.4.5 “For me it (1 month) was enough, maybe for others might be…. or I think more it depends actually, for me it was enough.”

2.5.4.6 “I learnt how system in the UK work and how NHS it works. And how to communicate with people around medical field. With the nurses, doctors,, occupational health and others you can meet, many of these similar other teams in addition to working there.”

2.5.4.7 “One of the the most useful aspects was getting a reference”

2.5.4.8 One of the doctors felt that the introduction to the clinical attachment was very short and believed that a longer introduction like the two week induction to the postgraduate training programme would be better. While this may be a valid concern that a longer induction period for a clinical attachment would be beneficial anything longer than 1 or 2 days would be excessive for a one month observer-ship. There was an often overlooked aspect of asylum seekers undertaking clinical attachment, which impacted on their mental health, confidence and self-esteem.

2.5.4.9 “Interviewee: ….. The other side of the clinical attachment, they used to make me feel rotten sometimes.”
Interviewer: Why?

Interviewee: What you wear to work! It’s something conscious of that and then when you’re living on a very tight budget, you know, even people saying let’s go and have a coffee together could mess up my whole plan.”

2.5.6 Short Courses

Reache runs short courses on a regular basis for its regular membership. However, in 2008 funding from the European commission was given for a 2 year project called ARRIVE (Assisting Refugees Return Into Viable Employment). This allowed Reache to open short course nationally with many of the Reache members being eligible to attend these courses as well. The courses mainly focused on communication and employability skills. Reache currently runs Preparing For Work in the NHS courses on a regular basis alongside Safe and Effective Clinical Communication skills and Ward Round training days.

The doctors interviewed believed that the courses provided by Reache were extremely useful in preparing them to work in the NHS;

“Communication skills, interview skills, there was application and interviewing, one was about starting working in NHS. I thought very useful to do this.”

“Really useful at that time and I still appreciate the usefulness of it.”

“I enjoyed actually those simulation sessions with professional you know actors they’re really useful sessions, they’re really useful “

“You realise that when you start working, you know how useful these courses are, it’s very useful.”

“Communication skills personal development again another advanced communication skills, note summarising, acute illness management course, medical course, communication course, and basically different courses actually to make you familiar with the system here like about consents taking consent from patient we have had many trainings, which is very good I mean without that, however we could never have worked. I mean yes later on at work you may learn but this is different to be really equipped with all this knowledge.”
“Communication, effective clinical communication. It was really good.”

“I mean like personal development planning was something a new concept you make use of it in your daily life as a personal thing just not knowing but, something organised something that we rely on that as like mapping your career mapping your personal life that was a whole new concept so communication skills or foundation program without that how would I have known about foundation program. What are the requirements, how can I prepare myself it’s like Reache actually train you for like swimming they teach you all the skills you need for the time that you need to swim you are able to swim.”

2.6 The Reality of Work

The doctors were asked to reflect on the courses they attended and how they felt Reache prepared them for the workplace once they were in work and how this impacted on their medical practice and interactions with colleagues and patients. The doctors’ highlighted experiences that they believed enhanced their skills; in some cases they felt a sense of pride and relief that they were not starting work with no skills or lack of familiarity with the workplace.

“We met many NHS employees who have twenty or twenty-five years experience like nurses like palliative care teams something and they really touch some point during the sessions. Which is really important! Which have a great impact on future, you know my future work or work environment. How to deal with a patient and how to be empathy and sympathy and those kind of things, which really is very important in practice. If you’re not looking for the concern of the patient all the time he’s in-patient or as an out-patient these are a key to practice in UK while it’s different maybe in other countries, in other country just do the right thing and you don’t care but, here the big priority is the patient and what’s his concern and then the second is the guidelines. You look at the guidelines and you try to you know and put them together to get in to, to arrive to a decision”.

“I could say those kind of end of life care we have a good session about the end of life care pathway and I’ve looked at everything during a Reache session and in my renal job I did many, I mean many people because I work in renal many people they reach that stage because it’s a chronic illness and no much cure in that field but, it was really helpful to know when to put and to why we put
and what’s the process of putting someone on the kill a kill time pathway and how to involve the family in that decision and obviously there’ll be a consultant or senior involved in it in the first place but, I will be a part of this team who take this decision so having an idea before hand is good enough to make it easier for me to run it in the wards”

2.6.4 “It (Communication Skills course) gives you an insight into what are the points that you have to cover you wouldn’t get that in English classes. Because we have our tutors here are doctors GP’s nursing staff so they just teach you something from they have their hands on the job. You can’t get this training anywhere no matter how much you are ready to pay in general English classes you don’t get that, communication skills for doctors how you should be sensitive, how you should approach this question or how you shouldn’t be embarrassed asking this and contrabits. Many of us don’t integrate or not integrate I mean we are not socialising for different reasons so it’s like having tips from what we need to do when we are out there. Some of us really are isolated.”

2.6.5 “I have to say majority of the doctors who I started with they were foreigners. And to compare with them I felt much better because, I’m talking about confidentiality, you know, aseptic technique. So, sometimes I learnt from other foreign doctors, they didn’t know some, you know, specific things about working here in Britain.”

2.6.6 Starting or returning to employment is seen as difficult task by the vast majority of people. The Reache doctors had a variety of difficulties which they faced including personal, social and professional issues.

2.6.7 “Interviewer: What’s been the most difficult challenge that you faced in the last year?

2.6.8 Interviewee: Being on call.

2.6.9 Interviewer: And why has that been so difficult?

2.6.10 Interviewee: Because you feel, because the environment you’re not used to. It’s new to you and you feel on your own you have to take some time not a decision I mean you need just a decision to stabilise I think. You need a decision to stabilise things you don’t need a decision to cure things. And there’s something you know how the hospital work, being on call is different from being in the ward because some other raised in while on call is different from
being in the ward, because you have to be more liaising with the other team in the hospital because, hospital like at night or in the evening time there's no seniority in the wards so you'll be the senior in the ward when you get called and then you will escalate things throughout. So you need to learn this thing the difficulty in learning these is by practicing and being safe enough to ask and ask and ask that’s the key to learn these but, it is difficult I would say that’s difficult.

2.6.11 Interviewer: Did you feel supported when you were on call, did you feel that you had the opportunities to ask other staff members for help and support?

2.6.12 Interviewee: The first time I started I thought I need it because back home or anywhere I practice I felt like you are the leader when you are on call, you are the leader you have to take decisions you don’t need to ask the nurses don't need because you’re asking nurses something stupid but, here it’s different completely you have to ask have to be safe. Always ask to be safe so with this kind of thing is really need to be always, always mentioned and keep saying those to the members and teach them the way they need to practice because some people they’re are just embarrassed or don’t want to ask they might sound silly when they ask this question or that by the time I felt whatever the, even if they start laughing at me I wouldn’t mind as long as I get the information and I have been doing a safe practice”

2.6.13 “It was this fear if I do a humongous mistake you know, and if I appear not to know too many things you know, you can want to ask questions but, you don’t want to appear to always be asking questions so yeah.”

2.6.14 “To be honest it is being lonely and sometimes I feel I wish I had Reache still available to me. I am still applying for jobs, what really hinders me is I’m not sure if the application I’m sending off is correct or not. I wish I had someone to ask what is this job, where is this place, like how this town looks. Because you can ask your tutors where is this place up-north, how it looks is it a good place because they know like most of the time they know about the hospitals and the counties and the towns and I still think we could benefit from Reache even after starting work. Advice for what jobs do you apply how you can develop if you need for example at job your given an audit to do but, you really don’t have much of a help or support everyone assume that, you know, how to do that other FY-2 doctors have done audits many when they were medical students; third year, fourth year. They have got feedback they know how to do
it I really feel embarrassed let’s say to a consultant this is my first audit can you give me advice so I think it could have been good that if I had Reache so when I was feeling embarrassed when I was feeling being docked you could go and ask for help guidance am I doing it right.”

2.7 Beyond support into employment

2.7.1 A recurring theme when speaking to the respondents was support networks and often the unavailability of emotional support from friends and family if they had arrived into the country alone or were waiting for reunions with family members. Some felt that Reache provided appropriate support, whilst others would have liked more support as they were quite isolated.

2.7.2 “Interviewer: We spoke before about you didn’t really have a support network, when you were going through the process. You were kind of on your own and you felt that Reache was your family?

2.7.3 Interviewee: Yes I was thinking for example if I lose my job and if I am penniless. I can go knock, knock Reache; Can I stay here? Can you provide me? You know it’s just when you have nobody then Reache is there, you know. Somehow, they are there for you. They are not just like God. They can’t do everything but, you know, they will show you perhaps how you can get support from other places if they can’t provide it.

2.7.4 Interviewer: Okay. And do you think the support network would have helped you?

2.7.5 Interviewee: Oh tremendously, tremendously I had lots of I think bouts of depression I mean I couldn’t have got through.

2.7.6 Interviewer: Do you think Reache could do more to create a support network?

2.7.7 Interviewee: Probably. I think I’ve never had difficulty getting one-to-one time with our tutors perhaps if they had had more staff.”

2.7.8 “I feel I was well supported. Especially, you know, where when I had to do, you know, it’s like I waited so long to have my status and it was
quite a process to get my registration and then there was a point where I was applying for jobs and not getting any positive response or any response at all and my confidence had suffered and then I’ll go back to Reache for pep-talks really yeah.”

2.7.9 “Interviewer: What could Reache have done to make your journey easier?

2.7.10 Interviewee: Reache did a lot for me truth be told, you know, I got a lot of support.

2.7.11 Interviewer: But, is there anything that we could have done more?

2.7.12 Interviewee: There are things that you couldn’t take away like, you know, how my world could be turned upside down overnight no one could stop that really.

2.7.13 Interviewer: So, it was external things that no one really, and we didn’t have any control over that.

2.7.14 Interviewee: No, no, no because then each time I had those problems I could come to Reache. You know have a cup of tea and moan and use the phone. And then when my purse money was cut off it’s just because you have like forty-two pounds and sixteen pence. You know and you never really had a lot left over you know.

2.7.15 Interviewer: To be able to pay for a phone call to them?

2.7.16 Interviewee: Yeah, yeah it just became so you understand and then on the weekend they cut you off, so they’ll say oh, cut off failing to pay and, you know, when we’ve got like maybe ten pounds to your name by the time I get organised, you know, get money from wherever so, stressful and I’m lucky in the sense that I didn’t have a good support network outside Reache as well. You know but, some people have absolutely nobody else.”

2.7.17 “I am from Russia and for example I learnt there are huge communities of doctors from Pakistan from India from some African countries, their medical training is similar to English training and, you know, first of all they knew about English health service. They had a support from, you know, their compatriots. But me, I had no idea really, and Reache was out there, with the help of Reache and without their guidance I wouldn’t be able to really qualify the doctor here in Britain. I really needed to take guidance because again I didn’t speak English, wasn’t efficient
expressing myself again I didn’t have a community of Russian doctors to support me, so Reache was the only centre which really helped me.”

“Sometimes I felt jealous, for example doctors from Pakistan, India especially when I started there were lot of doctors from Pakistan, India, and they were helping each other and they even spoke in their own language”

2.8 Areas for development

2.8.1 Whilst the respondents believed that Reache had helped them enormously there were mixed opinions about further preparation or support needed. Sometimes these opinions, whilst valid, were not entirely realistic with the feasibility of providing training or experience in some areas before they had entered work, being questioned. Room availability and actual staffing levels may have affected Reache’s decision on training, whilst information available to Reache also impacted on the advice given to members with regards to career routes and development.

2.8.2 “We had only one opportunity during that course or whatever to be on a ward round. I think if they had a course like for example five days running. Five days running not course, just ward round five days running it would have been more useful I think”

2.8.3 “Interviewer: What kind of things do you think we could have done to help you then?

2.8.4 Interviewee: I suppose it maybe more varied because I think I intended to go for certain types of logical bits of clinical attachments because of my preference I should have maybe, you know, widened my horizons and maybe yeah that I should not have been let to do what I wanted to do because at the time I tended to….

2.8.5 Interviewer: You needed more guidance and pushing?

2.8.6 Interviewee: Not in a bad way.

2.8.7 Interviewer: Okay. And do you think there’s anything more that we could do?

2.8.8 Interviewee: What you could do? It’s no it’s not like you can do it’s I’m asking myself what I should for Reache you know.
Interviewer: But there’s no particular courses or training that we haven’t done that you think actually that would have been really useful in work or do you think once you started work at the end of trainings to support you or it..?

Interviewee: If you have enough, I’ve got that enough training to support me and I feel at times there were other certain things, which I could have done more of that were being offered do you understand.”

“Well just one point if because people they are different if you have one rule you can’t apply this rule on all people it should be some flexibility, the flexibility sometimes brings people who are really good enough to start and push them forward to start working early and while some other people they need some more time to start so the flexibility”

“Arranging like occasions so social, social gathering for people mixing people up with other. Still I really don’t have the skills to mix up with people still I don’t I’m considered to be sociable, I think comparing to many of my colleagues. I am more confident than many and I still find it really difficult myself to get into circles, to see close to feel confident how to say what can I say.”

Some of the areas for development have been addressed through Reache’s programming of teaching, with the introduction of trainee teachers and trainee social workers focussing on the more social concerns.

2.9 External factors affecting Reache

As mentioned earlier Reache is housed by Salford Royal Foundation NHS Trust and with the building of the new private finance initiative hospital many departments, including Reache, have been re-housed several times. One of the doctors believed that the moving and our current location had affected the service provided.

Interviewee: For me, the way Reache is set up now doesn’t have that intimate feel to it anymore.

Interviewer: Okay. Do you think we’ve lost something from that?

Interviewee: We have.

Interviewer: What do you think we’ve lost?
2.9.6 Interviewee: The people now are, they would hardly know each other, do, you know, the way, the way, you know, I have contact with previous members you know.

2.9.7 Interviewer: You don’t think that they have got that?

2.9.8 Interviewee: I don’t think they have that. So, it’s a place they come and they do lessons I think and they leave, you know, we might hang around a bit if they’re, you know, in-between things but, I used to come from when, where I didn’t have anything on a particular day like I will stay and hang around and use the computer, yeah whereas you had to go to the library and use the computer there it was also the routine with other’s and because then that’s how, when I joined Reache I was preparing for PLAB-1 ‘N’ and what’s his name ‘M’ and ‘F’ were preparing for PLAB-2. I used to join them on their, when they were practicing yeah, yeah.

2.9.9 Interviewer: So, you had other people that you could associate with and you could go through the process together and you think they’ve kind of lost a bit of that?

2.9.10 Interviewee: I think they have.”

2.9.11 Whilst this is an extremely valid view, our current location has seen greater integration into the mainstream educational facility of the hospital. Our current membership are able to mix more freely with and talk to the medical students and staff of the hospital, the previous locations while supportive, were in a way isolated from the rest of the hospital.

2.10 Final Comments

2.10.1 Each of the respondents was given the opportunity to freely express their thoughts and feelings about the return to work and the support given by Reache.

2.10.2 “Interviewer: Is there anything else that you like to say about Reache or your journey back to work?

2.10.3 Interviewee: I think I’ve been just very fortunate and I’m grateful to life and I don’t know how long it could have taken me without it or would have been possible at some point to get back to my work. I mean forgetting my GMC
registration, Reache helped me tremendously, because in two or three years I was with Reache, of course I could get correct references. So I spent time here so people would know me, so they could recommend me. Without that how could I have got through because for my case my GMC registration wise was a difficult situation.

2.10.4 Interviewer: A difficult situation.

2.10.5 Interviewee: Specifically in my case I couldn’t have thought that I could have been without Reache I could have got refused if I was on my own.

2.10.6 Interviewer: Why do you think that is…?

2.10.7 Interviewee: Just like studying imagine if I could ever study IELTS, PLAB on my own.

2.10.8 Interviewer: And to you, that it’s just navigating the system do you think that you are at disadvantage because you’re not a native speaker and you don’t know how it works?

2.10.9 Interviewee: I think you need to have connections, either you need to have connections or someone who has gone through the path before to show you, it’s like even reading books you have the library you don’t know, which one to go for, you get advise from your colleagues who have done this before. I mean there are always your colleagues they encourage you look up at them and say if they are there you can be there. So it’s everything that one needs really.

2.10.10 Interviewer: Okay. So there’s nothing else that you can think of to say about Reache?

2.10.11 Interviewee: I just don’t know sometimes I wonder without Reache I don’t think I could have gone back to my work and I hope really Reache can, I wish we had more Reache around the country not just Manchester because I was living in Ipswich and the area was covered by Cambridge what we had there from BMA for refugee doctors was twice yearly meeting that was all and I attended two, or three sessions when I was an asylum seeker I haven’t done anything I couldn’t do anything and whenever I would go to the session there was like around table doctors sitting and saying what they have done and I had nothing to tell I would say I haven’t done anything I haven’t found any English classes and I am just struggling with my life, pass next one so that was it in Cambridge no practice no practice….

2.10.12 Interviewer: And so here so that was different.
Interviewee: Oh I came to Reache and I said wow I mean you have classes there Monday, Sunday, Tuesday, Friday’s everything has been arranged this is the library, these are the books you can have I’d wish we have our own books you can borrow these are the tutors that can give you advise. It’s like everything is ready I mean one may wonder Cambridge is one of the big centres educationally university wise but, all we had was meetings and even the doctor himself who was managing the session he was paying for sandwiches, he was a nice GP so that was all giving us sort of motivation, which really didn’t help me because I needed some practical help I didn’t lack motivation my situation was so difficult I needed help and practical support not just motivation.”

“All I could say Reache. I felt Reache is really very supportive in organisation for doctor, nurse pharmacist and I think we have some difficulty to attend classes at Reache and also we have some difficulty and our own difficulties, but if you got chance I think it’s better off to come to attend every minute at the Reache before you start work that is my advice. Because when you come here you can speak to your colleagues socialise and learn English or learning to further studies and improve your communication skill and improve your clinical knowledge as well.”

Interviewer: Is there anything else you like to say about Reache or your journey through Reache back to work?

Interviewee: Not really it was really helpful I can’t, it depends actually some people it’s really vital, it’s really vital and in some people it is supportive that’s the minimum thing you can say about Reache and the maximum always it would be vital for them to get into work but, in minority or small groups it will be supportive and no one can deny that it’s supportive.”

“I don’t know where I’d be if it wasn’t for Reache to make me a doctor I really don’t.”

Interviewer: And do you think there’s anything more that we could do?

Interviewee: What you could do? It’s... No it’s not like you can do... It’s, I’m asking myself what I should for Reache, you know?”
2.10.20  “And I think that Reache had a lot to do with how I got there (work) and even that that was suitable for me because they looked into it. You know they didn’t just throw me into something and leave me to sink or swim.”

2.10.21  “Reache has taught me that I can rise to different challenges and when I started looking for jobs I did not look for jobs just in Manchester and the Manchester area it was good for me to have the first job here because then I still had the support. But I’m aware that the next job could be anywhere.”
3. **Other Reache Activity and the future**

3.1 Reache North West has been recognised as an excellent centre for refugee healthcare professionals’ education and training. In 2005, Reache North West won the Education, Training and Development Category of the Greater Manchester NHS Awards. In 2008, Dr Keaney received the Salford Mayor’s Citizen Award for founding Reache and this was followed in the same year by Reache being awarded the Outstanding Learning Provider in the Healthcare Sector award at the Adult Learners' Week Awards. Reache North West also came joint second in the Guardian Public Sector Awards in 2008.

3.2 The staff at Reache North West not only help to train asylum seeking and refugee healthcare professionals but they also contribute across both undergraduate and postgraduate medical education regionally and nationally. Our GP tutors, past and present, have worked extensively in the recruitment and training of GP candidates in the North West, with our clinical tutors teaching and examining medical students at Salford Royal Foundation Trust. Our English teachers’ train and support trainee teachers alongside a trainee social worker who benefits greatly from the input of a multi-disciplinary team.

3.3 Our lead language and communication skills tutor has been working with the London Deanery and University College London on a freelance basis. Originally this was with the Language and Communication Resource Unit (LaCRU) supporting international doctors in all training grades and this has now developed to working with the Performance Support Unit (PSU) working with all training and non-training grade doctors across London. This work has led to the creation of the Salford Communication and Language Assessment Resource (SCoLAR), which provides support and training to doctors across the country. A support programme for internationally trained medical graduates in the GP training programme is currently being used by GP training programmes across Greater Manchester utilising a combined linguistic and medical approach to improving communication skills. Further information on SCoLAR can be found in the “SCoLAR Business Case” produced at Reache North West.

3.4 The team has also been engaged in publishing and presenting the work we have done and in 2011 had an article published in the Medical Teacher, presented a poster at the Association of Medical Educators in Europe (AMEE) in Vienna and the same poster won the best education prize at the Royal College of GPs (RCGP) conference in Liverpool.

3.5 2012 appears to be a promising year with the acceptance of a presentation at the Communication, Medicine and Ethics (COMET) conference in Norway with other articles and presentations currently being peer-reviewed.
3.6 Reache North West has an uncertain future in some respects, with changing political landscapes and an economic crisis gripping the United Kingdom. However, there are growing opportunities to use the specialist skills we have acquired and honed over the last nine years in a wider educational context for International Medical Graduates. Our multi-disciplinary team have researched and developed programmes (often intuitively) in a microenvironment where we have been able to adapt quickly and resiliently to the changing nature of the workplace and the internationally trained asylum seeking and refugee healthcare professionals. While as a group they are particularly vulnerable the same education and training is still appropriate and applicable for the economic migrant group of international medical graduates. Whilst they have arrived in the United Kingdom under very different circumstances they still have similar needs concerning language, communication and cultural integration.

3.7 Reache North West expects to continue providing education and training to asylum seeking and refugee healthcare professionals for the foreseeable future and will undertake a variety of activities to not only promote Reache’s work and research, but also offer its services as a consultant and education and training provider to ensure that income is generated to help secure future funding and stability for Reache and its members.
References


This is Leicestershire.co.uk (2012) last accessed


