Reache North West:

education and training for refugee healthcare
professionals in the UK, and the development of
language and communication skills training

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Justification

The thesis is presented to the criteria of the Regulations and Procedures Governing the Award of the Degrees of: Doctor of Philosophy by Published Work and Doctor of Philosophy by Practice and is written for assessment to the criteria of ‘The University of Bolton (hereinafter referred to as the University). The University shall award the degree of Doctor of Philosophy (PhD) on the basis of published work or professional or creative practice to registered candidates, provided that there is clear evidence to the satisfaction of the examiners that the candidate has carried out a critical investigation and evaluation of an appropriate topic(s) or theme(s) which has led to an independent and original contribution to knowledge and demonstrated an understanding of research methods appropriate to the chosen field’ (1.2 Principles).
Abstract

My original contribution to the body of knowledge is a portfolio of evidence which includes:

- An evaluation of Reache (Refugee and Asylum seekers Centre for Healthcare professionals Education) North West using a PEST (Political, Economic, Social and Technological) analysis and Thematic Content Analysis of semi-structured interviews which led to the development of the Reache North West model of education and training for refugee healthcare professionals.

- The development of a course entitled Safe and Effective Clinical Communication Skills and the dissemination of this course via conference posters, oral presentations and a published journal article. In the case of the conference posters, the course was identified as good practice on two occasions.

- A business case which led to the development of the Salford Communication and Language Assessment Resource (SCoLAR).

This thesis analyses and critically appraises the action research, ideas, reports and publications, from 10 years of organizational experience. This also includes over ten years of personal experience teaching and managing education programmes for international students, and over four years of working with refugee
healthcare professionals, assisting them in returning to their professional role in
the UK.

The evaluation of Reache North West sought to answer the research question
‘Are we effectively preparing refugee doctors for work in the NHS?’ Although
there were only 5 respondents the evaluation answered this question positively.

Also discussed is the process for the development of the safe and effective clin-
ical communication course and the difficulty in this course to other groups of in-
ternationally trained doctors. My observations and experience of working with
International Medical Graduates who have encountered language and commu-
nication difficulties are also discussed with the acknowledgement that more ro-
bust research processes are needed for future research.
Contribution to knowledge

Education provision and support for Refugee Healthcare Professionals was identified as a growth area that could provide long-term solutions for hard to fill posts in the North West of England. As such Reache North West was founded in 2003.

An external report was produced in 2006 to evaluate Reache North West as a service for continued funding, engaging a variety of stakeholders to gauge the impact of the programme. Since that report very little has been written about Reache North West.

In 2009 I was employed as a Language Tutor and was promoted to Lead Language and Communication Skills Tutor and then Business Manager for the organisation. In 2010, as we began to approach Reache North West’s 10th anniversary, I felt that another report was needed that could be used to inform stakeholders and funding bodies. This document gave a business context for Reache North West and was the first report that engaged refugee doctors who had completed the educational programme at Reache North West and returned to work in their professional roles.

This document is the most comprehensive report on Reache North West that has been written and as such provides an original contribution to knowledge detailing the context in which Reache North West operates and details of the programme and can be found in appendix A. From this report I developed the
Reache North West model of Education and Training for Refugee Healthcare Professionals.

During this time I worked alongside multidisciplinary colleagues to design and teach a clinical communications course that would better prepare the refugee doctors for clinical work placements. This work has been published and presented and gained national recognition in 2011 from the Royal College of General Practitioners' Conference and in 2012 from the Bradford Institute of Health Research.

The course engaged the learners through the teaching of general language skills before being placed into a clinical context, with feedback and formative assessment through a mock ward round.

In 2010 I was employed by the London Deanery to work as a language and communication skills consultant for the Language and Communication Resource Unit (LaCRU). This unit was subsumed into the Professional Development Unit. From this work I developed the business case for the Salford Communication and Language Assessment Resource (SCoLAR), which has led to commissioning of GP training and national use of our communication skills and preparing for work training in induction programmes for international medical graduates.

The commentary following provides appraisal and analysis of the unique yet nationally recognised award winning project which has supported refugee
healthcare professionals in their return to employment. The evaluation of Reache North West, the safe and effective clinical communication course and the business case constitute an independent and original contribution to the understanding of refugee healthcare professionals and their education and training in returning to work in the UK.
Introduction

This review explores the central thread of ideas, experiences, and themes through 4 years of personal experience working at Reache North West and 10 years of institutional experience. During these four years I progressed from being an International English Language Testing System (IELTS) teacher, to the Lead Language and Communication Skills Tutor and also the Business Manager for Reache North West. Preceding my time at Reache North West, I taught English both in the UK and China and have managed several language programmes and institutions.

In 2009, I joined the Reache team as language tutor preparing refugee and asylum seeking healthcare professionals for the IELTS examination, this being the first step towards re-qualification before proceeding onto their professional bodies’ examination and registration process.

Within my first year I identified the need for a comprehensive report on Reache North West, which would undertake interviews and a review with refugee doctors who had recently completed the Reache North West programme and had returned to their professional roles as doctors. The research question for the evaluation in the report was ‘Are we effectively preparing refugee doctors for work in the NHS?’ From the interviews I was looking for insights into what Reache North West did well in preparing the refugee doctors for work in the NHS and what they thought we needed to incorporate into the training to better prepare them for their roles.
I undertook the interview processes and review, as I had had either no contact with these doctors or limited contact with these doctors as they were in the final stages of their registration/re-qualifying process. Doctors were chosen to partake in the evaluation as they were the overwhelming healthcare group that had come to Reache North West and successfully returned to work, due to refugee nurses and dentists being unable to acquire appropriate vocational training placements to meet regulatory requirements.

This evaluation report of Reache North West as a service aimed to give a business context for Reache North West, in a UK context, and bring together the personal experiences of refugee doctors who had undertaken the programme into a single document that could be presented to the Strategic Health Authority, the core funder at the time of writing. The evaluation was completed in 2012 and aimed to give the context in which Reache North West was operating and also give the refugee doctors an opportunity to ‘voice’ their experiences of the programme as stated in the introduction of the report, which can be found in Appendix A.

1. The first section sets the present and past context for Reache Northwest from 2003 up until 2012. As Reache functions effectively through a multi-disciplinary 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.
2. 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.

Whilst preparing for and undertaking the review of Reache North West’s services with former students, the teaching staff at Reache North West, including myself, had undertaken teaching assignments for a national refugee doctors programme that fed into the work at Reache North West. From this work we developed a multi-disciplinary approach to planning and delivering a course entitled ‘Safe and Effective Clinical Communication (SECC)’.

Language teachers and clinicians analysed a clinical scenario, in this case a ward round, for functional language skills, such as giving advice, summarising, gathering information, giving information to colleagues. The tutors then developed a teaching programme that analysed the ward round into individual elements that focussed on language skills in a general context to ensure that students understood the concept of the skill before placing the teaching materials into a clinical context. All of these skills were then put back together for a simulated ward round to practise these skills. This multidisciplinary approach was new to the educational staff at Reache North West, and is a work in progress as we continue to develop our teaching.

Dr Ann Smalldridge and I led the development of this work and an article Improving written and verbal communication skills for international medical gradu-
ates: A linguistic and medical approach detailing the initial programme was published in the Medical Teacher in 2011. This article is evidence for the portfolio and can be found in Appendix B.

Also included as evidence are 2 posters which detail and disseminate this work. The first poster, A combined linguistic and medical approach to improve written and verbal communication skills for International Medical Graduates (IMGs) – was presented at the Association of Medical Education in Europe Conference 2011 and the Royal College of General Practitioners (RCGP) Conference 2011. This poster was awarded the RCGP Best Education Poster prize and the poster and certificate for this are in Appendix C.

The second poster was authored by the wider team at Reache North West and entitled Safe Communication Skills for International Doctors. This was presented at the Patient Safety Conference 2012 and in Appendix D along with a request from the Bradford Institute of Health Research to use the poster as evidence of innovation and good practice for an online resource. Further evidence of the dissemination of this work is a presentation which I gave and the acceptance letter at the Communication Medicine and Ethics (COMET) conference in Trondheim, and these can be found in Appendix E.

The final piece of evidence in the practice based portfolio is the business case for the Salford Communication and Language Assessment Resource (SCoLAR), a national programme that provides communication courses and induc-
tion programmes for international medical graduates. This can be found in Appendix F.

From 2010 until 2013 I was employed as a Language consultant in the Language and Communication Resource Unit (LaCRU) and the Professional Support Unit (PSU) of the London Deanery, which provided support for a range of international medical graduates in training posts and returning to work after a career gap. This period of employment gave me the opportunity to explore the option of creating a similar unit with Reache North West.

I hope to explore the strengths and weaknesses of Reache North West’s work and reflect on the methodologies and approaches undertaken. My reflections will be from a ‘practitioner’ perspective, in that through my range of roles at Reache North West I am a hybrid of teacher, researcher, and manager.
Methodology

My work roles at Reache North West and the qualifications I have undertaken have affected the methodologies used in undertaking my research and writing. I seek to set out a narrative that explores: the background to Reache North West, distinctions between asylum seekers and refugees, the evaluation of Reache North West, the development of the safe and effective clinical communications skills and the creation of the Salford Communication and Language Assessment Resource. As such there will be varying reflections within this review to highlight my role as a researcher, teacher and manager. As the language teacher I will therefore reflect more on the linguistic contributions to the safe and effective clinical communications.

Practice and Action Research

In order to clarify my position and experiences whilst undertaking this work, Practice and Action Research must be discussed before reviewing the evidence for the portfolio of practice.

Practice can be seen as theory of social interactions and intention that create and transform the world in which we live. From these interactions power can be identified in the transformations and experiences of our world.

Bordieu (1980, 1984, 1986) identified this power as ‘habitus’, the socialised norms and inclinations that guide our behaviour and thinking. It can also be
seen in the manner in which society becomes a core element of individuals in our trained and structured capacity to think, act, and feel which guides us further in our social interactions. This social process leads to transferable models of behaviour, which are transferable between contexts, yet also give a level of flexibility as situations become context dependent and transform over time. Habitus is created through interplay between societal dispositions that are fashioned by past actions and constructions, which shape our current actions (or practices) and constructions that condition and colour our perceptions about our contemporary existence. An example of this may be our interactions with doctors either in the UK or in an international setting. When we seek treatment, we are guided by our socialised norms and transfer the expectations in our encounters across countries and cultures.

Bordieu’s second concept ‘capital’ transcends the material assets and instead looks to the abstract of social, cultural or symbolic power, which may be accumulated or transferred between contexts or social interactions. The power relationships may transform with this concept as economic hierarchy may stand aside for cultural dominance. However, this shift in power from economic to cultural or symbolic capital may conceal the foundations of inequality. An example of this can be seen with the doctors at Reache North West who leave their native countries with social and symbolic power, who then gain the title of refugees or asylum seekers when entering the UK and may lose that social or symbolic capital.
Bordieu’s third concept ‘fields’ is comprised of the multitude of social and institutional arenas, such as: educational, cultural, political etc., in which individuals articulate their habitus differently within their multiple social relationships and networks. In the context of the portfolio of evidence, ‘fields’ here describes the medical or clinical communication education, and the language education which are coming together to engage refugee doctors in learning the language and communication ‘habitus’ in a UK healthcare setting.

Bordieu’s final concept was of ‘doxa’. Doxa is the assumptions or intuitive presuppositions, which are internalised and construed as the only natural reality to be observed, the deep-seated and unconscious views held within a specific field. For an international doctor and many UK doctors there may be a doxa of doctor-centred-care, whilst in the UK today there is a much wider movement towards patient-centred-care.

Bordieu’s concepts can be seen in Reache North West’s everyday practice and there will be elements of reflection on this in the review.

Action research at its simplest level uses a cycle of reflection that includes planning, action, monitoring and reflection to investigate and develop practice.

There is stimulation within action research that encourages development within the practitioner to not only be a knowledge user but to aspire to become a knowledge maker. The output of the Action Research at Reache North West was initially intended to be for internal review and to develop our education pro-
grammes to help us support refugee healthcare professionals more thoroughly. However, much of the work is being communicated externally as Reache North West, as an organisation, realises the value of the work.

The planned changes within an action research cycle are undertaken, monitored and then analysed or reflected upon. As the research is undertaken, further levels of complexity may be discovered that may or may not have been anticipated during the initial planning phase of the research, which may either develop the researcher’s practice or lead to an iterative process of further action research for further development.

An example of this cycle is the PDSA (Plan, Do, Study, Act) cycle, which is used within the NHS. Salford Royal Foundation NHS Trust, the host organisation for Reache North West, uses quality improvement methodologies for Action Research and to measure tests of change. The model for improvement asks three questions to prompt reflection on what is being evaluated for change or improvement.
MODEL FOR IMPROVEMENT (NHS Institute, 2014)

PDSA CYCLE (Advancing Recovery, 2014)
The process of enquiry for action research is flexible in that it may be applied to a variety of professional contexts with the principles remaining the same. As the action research undertaken at Reache North West is grounded in education, it is important to reflect on how it can be applied in an educational context.

“The process of enquiry for action research is flexible in that it may be applied to a variety of professional contexts with the principles remaining the same. As the action research undertaken at Reache North West is grounded in education, it is important to reflect on how it can be applied in an educational context. However, there is an implication that the relationship is one of cause and effect. In their same work Carr and Kemis (1986, p113) swiftly clarify that

“The twin assumptions that all ‘theory’ is non-practical and all ‘practice’ is non-theoretical are, therefore, entirely misguided..... ‘Theories’ are not bodies of knowledge that can be generated out of a practical vacuum and teaching is not some kind of robot-like mechanical performance that is devoid of any theoretical reflection. Both are practical undertakings whose guiding theory consists of the reflective consciousness of their respective practitioners.”
The reciprocal nature of the relationship between practice and theory is an important element to the development of the teaching, with practice and theory simultaneously generating form for the thoughts and ideas which may be explored, extended consolidated, or even contradicted.

For this review it is important to clarify the context of several terms. ‘Collaborative’ is seen as work between professionals of the same discipline or ‘field’ e.g. language teachers discussing classes or GPs discussing communication skills. ‘Multidisciplinary’ is seen as teaching or research with professionals from different disciplines/fields contributing to the development of material for a session with both elements of language and communications skills from the perspective of a language teacher and a GP. The use of a multidisciplinary approach has been an important part in the development of the communication skills training for internationally trained refugee doctors that was developed at Reache North West.
Reache North West

The Refugee and Asylum Seeking Centre for Healthcare Professionals Education (Reache North West) provides education, training and support to refugees and asylum seekers who enter the United Kingdom with medical qualifications that can be registered with appropriate professional organisations, for example The General Medical Council (GMC), the General Dental Council (GDC), and the Nursing and Midwifery Council (NMC). Established in 2003 and hosted by Salford Royal Foundation NHS Trust (SRFT), Reache North West employs a variety of staff, including: a director, a nurse tutor, a GP tutor, and language tutors. The team is also supported by a group of dedicated volunteers, which includes: consultants, GPs, nurses, external agencies, Human Resource professionals, medical students, members of staff at SRFT, Health Education England, and the general public.

Reache North West’s placement in a hospital environment distinguishes it from other organisations supporting refugee healthcare professionals in the United Kingdom. Reache North West is also the only organisation in England which provides education and training for all stages of the journey to return to work in one venue from English language teaching to medical equivalency examinations alongside preparation for employment. Other UK based organisations which support Refugee Healthcare Professionals include: Building Bridges London, Wales Asylum seeking and Refugee Doctors (WARD), Refugee Doctors’ Programme - NHS Education for Scotland, Refugee Healthcare Profes-
All of these organisations fund, commission or provide elements of the route to returning to work for the refugee healthcare professionals.

Beyond the remit of employment skills, Reache North West also provides social support for a group who have an impact on the integration of the wider refugee community. With respected members of communities struggling to find employment, morale within these communities can be low. If the educated are seen to be struggling to integrate then there can be a wider impact on morale for those who feel that they have no opportunities available to them.

With the unique structure of Reache North West, the multi-disciplinary team (language teachers, GPs, Nurses, Consultants) contribute greatly to education for asylum seeking and refugee healthcare professionals. With the changes to the structure of health education in England, it seemed remiss that we did not explore whether those skills could be transferable to undergraduate and postgraduate medical education for international medical graduates as well. As such there will be some reflection later in this review on how our work has been transferable to other settings.

Defining asylum seekers and refugees

For many people in the United Kingdom the distinction between asylum seekers and refugees is unclear. The United Nations defines an asylum seeker as people who move across borders in search of protection, but who may not fulfil the strict criteria laid down by the 1951 Convention (UNESCO, 2014). As such, asy-
lum seeker describes someone who has applied for protection as a refugee and is awaiting the determination of his or her status, whilst a refugee is someone who has been granted protection (UNHCR, 2014). The 1951 United Nations Convention states a refugee, *is someone who is unable or unwilling to return to their country of origin owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion* (UNHCR, 2014). This conversion of status is often misunderstood with politicians and the media profiling refugees and asylum seekers in an unfavourable manner to influence personal beliefs (Hartmann and Husband, 1974, O’Rourke and Sinnott 2006, Fang and Zikic 2007, Constant et al 2009) and in some cases to further political agendas (Khosravinik, 2009, Weiss and Wodak, 2003:13, Greenslade, 2005).

Asylum seekers face a range of issues when entering a country, political and media influences aside. Employment, housing, food, transport, legal aid and education are just some of the areas to which asylum seekers have restricted access in the UK. However, it is important to note that this limited access to services and resources occurs in other countries (Cohn et al, 2006, Asylum Seeker Resource Centre, 2012).

The Refugee Council has produced a variety of guides, which highlight the facts and myths that surround refugees and asylum seekers. In their latest publication *Tell It Like It Is: The Truth About Asylum* (2012), The Refugee Council highlights the various ‘facts’ which have been misunderstood and poorly communicated, and have contributed to the mistaken perceptions around asylum. For
example, they challenge the notion that the UK asylum system is weak and abused with evidence from the Home Office that the majority of asylum claims are rejected. They also highlight that refugees are only initially given permission to stay in the UK for five years. This creates a level of uncertainty and prevents people from making long-term plans as their case may be reviewed at any point during those five years and their status revoked. This uncertainty also affects asylum seekers, as they are often living under extreme circumstances with insecurity and fears while decisions about their claims are made (Cohn et al, 2006).

Reache North West provides education and training for asylum seeking and refugee healthcare professionals. However, it must be noted that the ultimate purpose of Reache North West is to assist them in returning to work. As asylum seekers do not have the required legal permission to work in the UK, only refugees were included in the report as they had attained legal status and permission to work.
Reache North West and Refugee Healthcare

Professionals

Reache North West has seen refugee healthcare professionals within the asylum seeking process for up to 8 years. This has had devastating effects, especially with regards to mental health, as applicants and their families are unsure if they are going to be sent back to their country of origin and whilst waiting there is uncertainty with regards to housing and financial support. Set routines of education or support cannot be readily established, as the United Kingdom Border Agency can often change appointment times and dates at short notice. If asylum claims are rejected, periods of poverty and destitution may occur while appeals are considered. Of those who submit appeals, some may have been detained by the UK Border Agency until a decision had been made, which in some cases meant that these refugee healthcare professionals faced the dilemma of returning to their country of origin or staying illegally in the UK and sacrificing the possibility of returning to their careers.

Reache North West also saw members’ housing arrangements change very rapidly. During the early years of Reache North West, this occurred to a large number of the members frequently. However, even as recently as 2011 we saw a member have their housing arrangements changed four times in four weeks. Each move was disruptive, as when they had just become familiar with the area they were moved once again. Fortunately, this member was granted refugee
status at the end of the four-week period. This example of distress is not rare and past members have been moved across the country at short notice.

For female refugee healthcare professionals, there are often additional factors which impact on their return to work. For some, childcare can become an issue, particularly if their partners are going through the same re-qualification route. Women are often expected to put their careers on hold to look after children while the man completes his journey to re-employment first. In some cases, this has been a cultural expectation. Another scenario is with regard to those women who have become single mothers and may no longer have, or be able to access, support from a wider family network. Sometimes the previous two scenarios can create longer career breaks for female refugee healthcare professionals. In some cases, a female student may be more capable or competent than her husband and this can create resentment. All of these circumstances have been seen at Reache North West, with women also placing their careers on hold for non-medical partners who are likely to have less success in gaining employment due to lack of UK experience.

Bates et al (2011), a research group from Oxford University, produced a working paper for their Master of Science degrees in Forced Migration. They found supporting evidence for Cohn et al (2006), but also found that childcare issues were generally only a problem for the female refugee doctors when the children were under the age of 6. They also identified financial issues, responsibilities for household chores, language and communication skills, loss of skills due to career gaps and self-esteem as being central concerns to returning to work for
female refugee healthcare professionals. However, these concerns are often mirrored by male refugee healthcare professionals at Reache North West.

Aside from the above concerns, Refugee Healthcare Professionals also face a myriad of other concerns, which may hinder their return to employment. Other issues may include: torture, mental health issues, the humiliation of claiming benefits and financial support, loss of status, lack of permission to work and older children who have their own issues. Mental health problems not only affect the refugee healthcare professionals but also family members, especially partners, and this may delay a return to work as they care for and support partners and other members of their family.

**Support for Refugee Healthcare Professionals in the UK**

With exact numbers of refugee healthcare professionals not being known (Berlin et al, 1997), the support made available to this subset of refugees is limited. In 2006, during the first evaluation of Reache North West, there were approximately 18 organisations nationally that supported refugee healthcare professionals. As of August 2012 this had been reduced to five: The London Deanery for medical education and their collaboration with the Refugee Assessment and Guidance Unit (RAGU), The Welsh Asylum seeker and Refugee Doctors (WARD) support group based in Cardiff, Refugee Healthcare Professionals North East Project, NHS Education for Scotland Refugee Doctors’ Programme, and Reache North West.
With this limited number of organisations in the UK, we believe that there is likely to be a larger number of unsupported refugee doctors and other healthcare professionals who may never return to professional practice due to lack of support. Cohn et al. (2006) identified the lack of clear centralised information as being a hindrance to returning to work, as individuals could not access the information required. Steps were taken to address this issue with the national ‘Refugees and overseas qualified health professionals into employment in health and social care’ (ROSE) website in 2004. The ROSE website was originally an information portal for refugee healthcare professionals and international medical graduates and was created by North East London Health Authority. The management of the site was taken over by NHS employers in the mid-2000s and Reache North West rewrote and took over management of this site in 2011.

**Support for Refugee Doctors Internationally**

There are numerous programmes internationally that support refugee healthcare professionals in returning to their professional roles. In the United States of America (USA), all international medical graduates must undertake a 7-step process to gain a licence to practise. The diagram on the following page details this process.
The Education Commission for Foreign Medical Graduates confirms eligibility for the process before starting the journey to gaining a licence to practise in the USA. Qualifications are verified and the first two parts of the United States Medical Licensing Examination (USMLE) must be completed before an individual applies for residency, which then leads to the completion of part 3 of the USMLE and then application for a licence. This is a completely different registration process from the one in the UK and as such the support offered is very different. The next section discusses the requirements for doctors in the UK but first I would like to give an example of some of the programmes that run in the USA.
The Welcome Back Initiative provides information and resources to trained healthcare professionals who received their education and training outside of the USA. Whilst their services are not limited to refugees, they have undertaken programmes to support refugee healthcare professionals. There are currently 10 centres across the USA which provide language support and preparation for the first 2 stages of the USMLE. They also provide counselling services, access to education and advice and guidance regarding alternative careers.

Another programme supporting refugees is the Refugee/Entrant Vocational Education Services Training Program (REVEST) at Miami Dade College in Florida. This programme does not specifically deal with refugee healthcare professionals but provides wide-ranging services for refugees. They do, however, provide language training and test preparation for the USMLE.

Australia has a similar system to the UK, whereby an English examination must be completed, which is then followed by the Australian Medical Council (AMC) qualifying examinations before gaining registration. The AMC also has advertised bridging programmes for international medical graduates, though none of these are specifically for refugee doctors. At the time of writing, Internet links to these bridging programmes were no longer functional and further information was not available.
As mentioned in the introduction, Reache North West helps and supports a range of refugee healthcare professionals including doctors, dentists, pharmacists and nurses. The vast majority of refugee healthcare professionals that Reache North West has worked with and supported back to employment have been doctors. This has been due to difficulties in finding vocational training placements for dentists, pharmacists and nurses seeking to return to employment in their professional roles. As such, only process for refugee doctors will be described.

For many refugee doctors studying at Reache North West language, specifically the IELTS examination is seen as a barrier in their return to employment created by General Medical Council and other professional organisations. The refugee healthcare professionals at Reache North West often hold the view that the IELTS is deliberate discrimination to exclude them from competing for work with European doctors. However, they often do not understand that the regulatory bodies have not been in a legal position to challenge the language capabilities of the European healthcare professionals. The GMC raised IELTS requirements for registration in 2014 and this action also applies to European doctors whose primary medical qualification was gained outside of the UK. Beyond seeing IELTS as discriminatory, they often view the IELTS examination as a hurdle with cultural elements of communication also contributing to their frustration. This view is supported more widely across the refugee healthcare professionals’ community (Cohn et al, 2006).
Bates et al (2011), in their interviews with female refugee healthcare professionals, found this was still seen as a barrier, with participants of their study believing that the language requirements were ‘overly strict and unfair’. Reache North West works with its refugee healthcare professionals in trying to change the mentality surrounding the exam with ‘barrier’ being changed to ‘requirement’. This change of focus can often help the doctors’ move away from a sense of injustice regarding being prevented from practising their profession. Coaching techniques including the GROW model (Goals, Reality, Opportunities/Obstacles and Will/Desire) help the refugee doctors to gain focus and understanding of their situation, though in some cases a sense of injustice regarding their situation remains and we signpost to GPs and psychological therapies.

The real change in mentality around language is not often understood until the refugee doctors are working in a UK environment. This was highlighted in the interviews during the evaluation, as the refugee doctors on reflection understood the context of the Reache North West teaching and why it was so important for when they started work (Appendix A pages 49-66).

The Professional Linguistic Assessment Board (PLAB) examination on medical theory and practice is not seen as an obstacle, as the doctors are usually secure in their own medical knowledge and feel that they can pass the examination. Those with weaker language skills often struggle with the communication element of the examination, especially if colloquial language is used by simulated patients. Financial barriers and time restrictions are often factors that affect refugee doctors seeking to undertake the PLAB examination.
Once the theoretical element of PLAB has been attained, many doctors seek a clinical attachment. These are usually one-month placements, which offer the doctors an opportunity to shadow members of clinical staff and give them an insight into UK working practice. These placements vary in availability and in standards. Cohn et al (2006) found that many doctors struggled to find placements on their own.

Reache North West offers highly structured placements that are arranged and planned with Consultants and departments to ensure the refugee doctors observe appropriate practice. These can then be followed by apprenticeship schemes once the doctor has completed the practical element of PLAB and gained full GMC registration. These 3-month supernumerary unpaid placements (Clinical Apprenticeship Scheme, CAPS) give the doctors supported supervised practice in the UK before applying for a post in the NHS. Some doctors may only gain provisional registration, as they may not have completed a sufficient clinical internship that satisfies the GMC requirements for full registration. If this is the case, then they must apply to the NHS foundation programme and undertake the appropriate supervised clinical practice, as they are not eligible for the CAPS programme.

All of the doctors who have undertaken the clinical apprenticeship scheme (CAPS) have gained employment within three months of completion. Employment for those who do not undertake the CAPS scheme is often more elusive and Reache North West has seen doctors unemployed 18 months after receiving GMC registration. Those that choose not to undertake the CAPS scheme
usually have a multitude of reasons for not doing so. Very often there is a financial incentive to work for locum agencies. However, as they do not have UK clinical experience and the organisation does not give references for clinical work unless there is support from an educational and clinical supervisor from their clinical apprenticeship scheme, they struggle to find a first post. Many of the doctors do not realise how much they have to learn after gaining registration and the CAPS scheme helps them transition through the stages of competence from unconscious incompetence, conscious incompetence and conscious competence pointing them in the right direction to gain unconscious competence in UK practice. There is much debate about the origins of the conscious-competence model, though many recognise that it was created by an employee (Noel Burch) of, the US based organisation, Gordon Training International in the 1970s.

Reache North West strongly believes that the focus should not just be on passing examinations but on practising safely, although many of the students are very examination focussed. However, once they have passed their PLAB examinations and have undertaken clinical attachments they then begin to understand the reality of clinical care in the NHS and the reasons for the insistence on the need to focus on safe working practices.

There are a variety of justifications for Reache North West’s ethos regarding safe practice. They include national priorities for patient centred care and shared decision making but also the concept of a process curriculum rather than a product curriculum.
Teahouse (1975 p142) gave a tentative definition that ‘A curriculum is an attempt to communicate the essential principles and features of an educational proposal in such a form that it is open to critical scrutiny and capable of effective translation into practice’.

Reache North West as an organisation strongly feels that it is the translation into practice that is important. Learning examination techniques will not necessarily prepare you for the real world, as the false interactions with examiners and simulated patients are scripted and do not properly prepare you for working life in the NHS. By undertaking a product approach, e.g. being concerned with only passing the examinations, refugee healthcare professionals lose the richness and vibrancy of the social and professional interactions, and clinical communications that take place during your working career.

The experience at Reache North West has been that if the learners undertake a process-orientated education they are much better prepared to engage effectively and safely when starting work in the NHS, as their ‘habitus, capital, fields and doxa’ are challenged during the teaching to prepare them for the interactions that will challenge their beliefs in the working environment.

The diagram below shows the ‘Reache North West model of education and training for Refugee Healthcare Professionals’.
The central figure of the ‘safe and effective practitioner’ is what Reache North West aims to produce through its education and training programme, which is guided by the regulatory process of the professional bodies.

The outer ring describes the elements of the education process, which Reache North West uses as a guide to constructing the education and training process for the refugee healthcare professionals. This ring of education and training themes are not sequential. Reache North West strongly advocates that the
Refugee Healthcare Professionals take part in all of the education and training activities during their re-qualifying process at Reache North West to gain a rounded experience before they gain employment in the NHS.

The themes have not been defined in the model, as Reache North West recognises that there is some fluidity in what may taught due to the changing nature of medical education and the structure of the NHS. However, below are some examples of defined teaching areas, which are currently taught at Reache North West.

NHS Culture – Patient Centred Care, Shared Decision Making, Professional Development.

Preparing for work in the NHS – Ethics, Clinical Governance, Team-working.


This model is equally applicable to other healthcare systems that do not have a national health service and the term Health Care System could be used to replace NHS.
In 2006, Reache North West commissioned an external evaluation to appraise the services provided for asylum seeking and refugee healthcare professionals. This process engaged stakeholders in a realistic programme evaluation of the service as a tool to guide the organisation’s developmental process and to provide funders with a report on the value of supporting refugee healthcare professional.

In 2010, as the lead language and communication skills tutor, I began to undertake an evaluation of Reache North West to assess the impact of our training on refugee healthcare professionals who had returned to work. This was published in 2012 and can be found in appendix A.

As Reache North West is the only hospital-based centre for Refugee Healthcare Professionals in England and is the only programme which offers: language training, medical training and employment training in one location, the evaluation (appendix A) presents a contextual basis for Reache North West and the first evidence from working refugee doctors who had received training from Reache North West. This report gave the previous commissioning organisation (NHS North) a document which provides contextual data for supporting refugee healthcare professionals in terms of social responsibility and the impact that the programme has on this particular vulnerable group’s employment integration into the National Health Service. The report was also exceedingly important as a background document to Reache North West for the new clinical commission-
The evaluation of Reache North West is an important milestone for the organisation as it celebrates ten years of work with refugee and asylum seeking healthcare professionals. While feedback has been sought from course participants on individual elements of the programme, a holistic approach to evaluation had not been sought from those healthcare professionals who have successfully returned to the workplace. The evaluation report as a whole is the first analysis of Reache North West using previous programme participants and using qualitative methodology to analyse the responses. As the majority of the staff at Reache North West are clinicians, who have a predisposition to quantitative methodology via their clinical training, the qualitative approach was extremely different from their previous research experience, with the value and validity of such research being questioned due to the lack of quantitative data. Qualitative data is often under-valued as it is more difficult to determine which aspects of programmes have led to success, when there may be more than one contributing factor, which may be difficult to measure statistically. Most of the feedback at Reache has been measured using quantitative methods regarding returning to employment or Likert scales giving ratings to teaching, accommodation, and course content, gained immediately after each of the courses had been delivered.

Much of the feedback that had been obtained from previous participants was informal and classed as anecdotal as the qualitative data was not analysed and
much of the feedback was given informally and in passing. Reache North West
has struggled to gain feedback from previous participants, as they have gained
employment in a variety of locations across the country and were no longer re-
required to up-date their contact details once they had ceased to participate with
Reache North West. As such the sample group was limited to those members
whose current contact details were available.

This limitation in the number of participants may have positively skewed the da-
ta from the report to those members who felt that their experience with Reache
North West was positive and wished to remain in contact. However, the doctors
interviewed appeared to be comfortable discussing their ideas or opinions on
how Reache North West could have managed their journey more effectively or
how they felt personally about the programme and the contribution to their lives.

Crouch and Mckenzie (2006) discuss the logic of small sample sizes and cite
Drehler (1994:286) as a proponent of naturalistic settings and small samples
which permit repeated contacts with respondents which enhance validity and
reliability. Crouch and Mckenzie also discuss the participants’ role as cases and
their meaningful experiences with one case, in principle, leading to new insights
if they are recognized as instances of social reality.

My role as an interviewer was appropriate at the time the interviews were un-
dertaken. Of the five doctors who were interviewed, three of the doctors were
known to me prior to the interviews taking place. Two of these doctors were
awaiting GMC registration when I was initially employed at Reache North West
and therefore I had extremely limited contact with them. The third doctor passed through the training journey extremely quickly, meaning that, once again, my contact with this doctor was limited. After this group of interviews, it became clear to me that this would essentially be the only time I would be able to act as an interviewer with the doctors going through the Reache North West programme for evaluation purposes. Personal involvement with the doctors would give me insight into their experiences and would in future potentially allow to me to wittingly and unwittingly guide the interviewees in their answers.

The research and teaching programme undertaken at Reache North West has historically been reactive and practice based to ensure that we are effectively preparing our membership to be safe healthcare practitioners on their return to employment in their professional roles within the NHS. The reactive nature of Reache North West’s action research has allowed the project to quickly develop and adjust programmes of study and teaching to better reflect the clinical working environment. This has ensured that weaknesses displayed by individual refugee doctors supported by Reache North West in work placements on working wards are addressed in a timely fashion. It has allowed Reache North West to address training gaps in language and clinical communication skills which have generated additional working concerns on wards that employ refugee doctors and host clinical work placements for the members of Reache North West. The difficulties faced by other professionals in finding appropriate vocational training placements led to ward based practice being the focus of training needs, due to first medical jobs in the UK being ward based and being a pre-requisite for General Practice training.
This evaluation of Reache North West has two components which contributed to the overall analysis: part 1 dealt with the contextual setting of Reache North West, part 2 analysed qualitative data. The following sections discuss context setting for the report and thematic content analysis for understanding the interviews from the 5 refugee doctors.

Context setting

The first report that Reache North West commissioned was completed in 2006 by Butler and Eversley, used Realistic Evaluation and engaged with a large range of stakeholders, including staff, funding agencies, staff from the host organisation and refugee healthcare professionals who were attending Reache North West but who had not yet completed the stages required by the registration bodies.

Realistic Evaluation (Pawson and Tilley, 1997) is defined through its investigation of the nature of programmes and the theories that created them with the ultimate purpose of refining those programmes in a contextualised manner, not simply asking what works but delving more deeply to ascertain: who benefits, in what circumstances, in what manner and how this is achieved.

Initially realistic evaluation as a model for the evaluation seemed appropriate. However, the evaluation in ‘appendix A’ only engaged with 5 refugee doctors and did not engage with all of Reache North West’s stakeholders in the same manner in which the first evaluation had. Therefore, the evaluation could not
engage Pawson and Tilley’s questions to realistically evaluate Reache North West as a programme.

It was, however, important to place Reache North West into context and this was achieved using business analysis tools; the previous evaluation in 2006 (Butler) used a Political, Economic, Social, Technological, Legal and Environmental (PESTLE) model of analysis, after three years of operation, as part of the realistic evaluation. The 2012 evaluation in appendix A, used a Political, Economic, Social and Technological (PEST) analysis, subsuming the legal and environmental factors into the other areas as much of the information crossed boundaries and was covered sufficiently in the four remaining factors.

The PEST analysis in my evaluation of Reache North West was much more comprehensive than the initial evaluation. This was partly due to the length of time that Reache North West as a programme had been in existence, and the changing nature of not only the UK political climate but also increased instances of conflict that brought refugees to the United Kingdom. Understandably, there was also more research available around refugees and asylum seekers, especially around the media’s influence on public and political opinion as mentioned in the introduction.

A PEST analysis is a valuable tool; it allowed me to collate a logical and comprehensive picture of the environment in which Reache North West was operating and identified external contextual factors. Such contextual factors may affect or influence an organisation’s development but remain outside of their control or
influence. All of these external factors and intertwining relationships of contextual data add levels of complexity, richness and accuracy alongside levels of uncertainty in determining the environment in which one works.

The PEST analysis was essential in being able to place Reache North West in its current overall context and map the changes in the political and economic climate since Reache North West’s founding and the previous evaluation. The climate at the time was especially important with the changing structure of health education and how it was funded in England. The strategic health authorities were dissolved and in their place local education training boards were established and managed overall by Health Education England.

The multi-disciplinary team’s input, enthusiasm and passion for high quality education and training for refugee healthcare professionals has been demonstrated and has led to presenting research at conferences and winning awards for the work undertaken as can be seen from the posters and supporting letters in the appendices.

In 2008 Reache North West won the Adult Learners’ Week award for Outstanding Learning Provider in the Healthcare Sector and in 2014 Reache North West was awarded the first City of Sanctuary National Health Stream Award. All of this influences the context of Reache North West. The staff enable and constrain the individual capacities of participants who may or may not fully understand the expectations of the UK healthcare system and how they can integrate
into the system in a seamless manner ensuring that they do not negatively influence the sustainability of their employment.

Further aspects of context also depend on the multiple interventions that take place externally from Reache North West e.g. taster placements, clinical attachments, clinical apprenticeship schemes, and those internal interventions such as: IELTS, and Preparing for Work in the NHS. Motivation and the culture of Reache North West is also important to the context as the primary purpose has developed from simply passing the PLAB examination in 2003 to preparing safe and effective healthcare professionals for employment in the NHS in 2012. It was hoped that the refugee doctors would be able to shed light on those contexts during the interviews that were undertaken for the second part of the evaluation.

**Research Question**

The research question for the evaluation of the report was ‘Are we effectively preparing refugee doctors for work in the NHS?’ From the interviews I was looking for insights into what Reache North West did well in preparing the refugee doctors for work in the NHS and what they thought we needed to incorporate into the training to better prepare them for their roles.
Semi-structured Interviews

As mentioned earlier, the first evaluation of Reache North West engaged a wide range of stakeholders. The 2012 evaluation was conducted through semi-structured interviews with previous participants of the programmes who had gained professional registration and were employed in NHS posts. Of the 25 doctors who were contacted, eight doctors replied and only five doctors were able to arrange an interview around their clinical commitments.

Whilst feedback from current members is valid, their perceptions of what they need to be taught can often be skewed by their experiences of medicine and training in their native countries or in the foreign countries where they trained. It was felt that only those doctors who had completed the programme and had gained employment in the National Health Service could give a more informed review of the training provided by Reache North West and its relevance to the workplace (Part two of the evaluation in appendix A).

The semi-structured interviews began with some general directed questions around the background of the participant. Whilst questions regarding personal details were asked, to give the participants the opportunity to tell their story from the beginning of their narrative as an asylum seeker transitioning into a refugee, this information was not used for the evaluation. This was due to ethical considerations regarding avoiding harm (Israel and Hain, 2006) and ensuring that appropriate signposting could be given to minimize any distress that may have occurred when recounting personal stories. Reache North West does not initiate
discussions or research regarding the personal experiences of the refugee health care professions. As an organization it does not have appropriately trained staff to support the members if they need psychological support, however staff are aware of appropriate healthcare professionals who are more suitably qualified to support them psychologically.

Directed questions concerning the structure of their journey to re-qualify were asked with further questions used as necessary to elicit more information during the interview. A list of questions around each element of the journey was constructed, and can be found in appendix A2, to use as a prompt if the participant was struggling to focus or missed out stages of their re-training. On reflection, the use of more open questions could have possibly elicited more information from the participants and focussed more on their experience rather than on what I thought was important as researcher in developing the services and teaching at Reache North West.

Thematic Content Analysis

All five interviews were recorded and transcribed. Once transcriptions were completed, they were checked against the recordings for misunderstandings and corrections. Due to issues of confidentiality, the full transcriptions have not and will not be published in their entirety. This was due to concerns being raised around specific information identifying the refugees in a wider context of employment and the refugee doctors expressed their concern that the interviews could affect future employment and medical training posts. As the report was
aimed at informing funders of the experiences of the Reache North West programme, there was no requirement for identifiable information within the report. Statements and quotations were kept anonymous to ensure confidentiality.

There had also been a previous concern raised by a refugee doctor who had agreed to personal statements regarding their experiences being placed on the ROSE website when it was hosted by NHS employers. When the website was handed over to Reache North West, the doctor contacted us and asked us to remove the information as they felt it could be used to identify them by a small minority of international medical graduates working in the UK. NHS Employers had gained informed consent at the time, but it highlighted the issue that consent could be withdrawn at any time (GMC, 2010). All of the doctors who undertook the interview were keen to stress that they did not foresee a point when they would withdraw consent as they felt it was important to support a programme which had helped their transition into UK life and employment, and that it was an essential service for future refugee doctors.

Coding and identification of themes was undertaken by myself, which included personal themes within the interviews but was mainly driven by the distinct themes of the journey to returning to work e.g. language, PLAB 1, PLAB 2, GMC Registration, Clinical Placements, Preparing for Work in the NHS. This theoretical thematic analysis of coding was chosen as I was looking at a particular research question, rather than allowing a research question to arise from the data and use an inductive analysis. This could also be seen as a weakness to the research as it would appear that ‘questions put to participants identify the
However, the journey for refugee doctors is structured around a regulatory process, which in essence defines the themes and gives a guide to the questions being asked. This makes analysis difficult in this setting. However, not all of the extracts in the report were identified as themes from specific questions. Themes still had to be coded and I identified one example of this in the report in paragraphs 2.5.1.3 to 2.5.1.11 where the participant reflects on their journey and how they could have made it easier, yet it is identified under the theme of English teaching.

2.5.1.3 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.

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

2.5.1.5 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.

2.5.1.6 Interviewer: Why do you think taking English more seriously?

2.5.1.7 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.

2.5.1.8 Interviewer: In English?

2.5.1.9 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.

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

2.5.1.11 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”.

The identification of themes was undertaken over a two-month period, with other members of staff at Reache North West reading the interviews. This allowed staff members to see highlighted themes and add additions or highlight areas of the interviews that I may not have coded as a theme.
As mentioned above, the report was written for a specific audience, funding agencies. As such, it sought to gain evidence and opinion from refugee doctors who had gone through the programme to endorse or refute the framework that Reache North West uses to prepare refugee doctors for the workplace. Decisions were then made with regards to presenting the extracts of data.

An essentialist method (Braun and Clarke, 2006), the view that there are a set of attributes prescribed to the entity studied to shape its identity and function (Cartwright, 1968) was used to report experiences, meanings and the realities of the participants that were interviewed at a semantic level presenting the data at one level. Though at times critical realism, identifying the extensive nature of the phenomena without investigating their origins (Sayer 2004, Willig, 1999) was used appropriately to acknowledge the manner in which participants comprehended their experience, latent levels of analysis were not addressed in the report as elements of context were not seen as relevant to the funders.

It was felt that some of the fears would be seen as irrational and funders were not necessarily interested in some of the extreme and often irrational emotional constructions, as they could not be addressed or supported by work placements or Reache North West because funding is specifically provided for education and training to return to work not for therapy for emotional distress. However, Reache North West does signpost participants to relevant medical and psychiatric services as appropriate.
One particular example of critical realism came to light when one of the participants discussed that they felt that their induction for a 4-week placement was not long or thorough enough (2/3 days). This was seen as an unrealistic expectation for a 4-week clinical attachment. In a realistic work environment a two-week induction for 2 further weeks of work was not feasible. What was not analysed or discussed was the fear of returning to work, or the isolation this doctor felt in this circumstance as he struggled with his fears of returning to work after an extended career break and returning to employment in a foreign environment.

In contrast, another doctor raised concerns regarding monetary issues and how going for a coffee could impact on a weekly budget alongside knowing what was appropriate work wear and the worry of being able to afford new clothes. These issues could be dealt with through financial assistance from the programme as loans and grants could be offered from endowment funds available to the programme.

As mentioned earlier, the limited number of participants for the evaluation of Reache North West may have skewed the interview data and raised concerns with regards to the reliability and validity of interview data. Mason (1996) believed that validity required you to observe, identify or measure what you say you are. The research question ‘Are we effectively preparing refugee doctors for work in the NHS?’ identified or measured the participants’ responses in the interviews, demonstrating a level of validity to the research question. Their thoughts on what had prepared them for work and what they believed needed to
be included measured their belief that they were prepared for work in the NHS by undertaking the programme at Reache North West. However the level of validity may be questioned as the cohort of participants were low in number and the reliability may also be questioned in whether this could be replicated not only with similar cohorts at Reache North West who had returned to work but also with cohorts with other agencies providing similar training.

LeCompte and Goetz (1982) held a different view in the interpretation of validity and reliability. They held that there were internal and external factors which would affect validity and reliability. External reliability explores the concept of replicability and internal reliability explores whether there is agreement on what is seen or heard. Internal validity explores whether there is a good match between observations and the development of theory whilst external validity is the degree in which findings can be generalised social settings.

From LeCompte and Goetz’s views, I believe that the interviews and report have both external and internal reliability as the majority of the interview questions in Appendix A2 could be asked by any researcher, with slight adjustments for refugee doctors who have had training with other organisations. The PEST analysis to give context to Reache North West could also be replicated to give context to refugee healthcare professionals in the UK. Internal reliability was demonstrated by more than one member of staff at Reache North West reading the interviews and agreeing the identified themes. Both internal and external validity may be called into question with LeCompte and Goetz’s views as there was no development of theory within the report and interviews but observations
on the structure of the training programme in preparation for work and the small number of participants limited the generalisability across settings.

Lincoln and Guba (1985) suggested two alternative criteria for evaluating qualitative research; trustworthiness and authenticity. For Lincoln and Guba, trustworthiness had a list of 4 criteria: credibility, transferability, dependability and confirmability. The first three - credibility, transferability, dependability - show parallels with internal validity, external validity and reliability. The fourth criterion - confirmability - refers to the transparency that researchers have been as objective as possible.

Authenticity refers not only to the research as being genuine and credible but also to the political and social impact of the research. There is a movement away from reliability and validity and an exploration of the value of research and how that impacts on members of the community being researched. The review and interviews steer more towards authenticity as it sought to gain a fair view from the refugee doctors in gaining understanding of their perspectives in the preparation of returning to work. As the report was for a specific audience, there were levels of authenticity missing in improving the understanding of their social situations and their empowerment.
Reache North West was contracted by NHS Employers to work on the Refugee Healthcare Professional Programme and the Assisting Refugees Return Into Viable Employment (ARRIVE) project, which was a national programme of work to aid Refugee Healthcare Professionals return to work. The ARRIVE project was funded by the Home Office and the European Refugee Fund Phase III, over a two year period during 2008-2010. In year two of the project, Reache North West was designated as the sole provider of training courses nationally.

As part of the ARRIVE project, linguists worked alongside clinicians to prepare a two-day national course around clinical communication skills, adding a more linguistic focus to the training.

Details of this initial course were published in the Medical Teacher in July 2011 and the article can be found in appendix A. This course was also presented at the Association of Medical Educators in Europe (AMEE) conference in Vienna, Austria (August, 2011), in the form of a poster. This poster was also shown at the Royal College of General Practitioners (RCGP) conference in Liverpool (October, 2011) and won best education poster prize. The poster can be seen in appendix B alongside the certificate confirming best education poster prize in Appendix C.

This course was entitled “Introduction to Safe and Effective Communication Skills” and was the first course at Reache North West that analysed a clinical
scenario as a multidisciplinary team of clinicians and English teachers, and then analysed the event into individual linguistic elements of the encounter. This analysis included the breaking down of the different clinical communication skills and then identifying the functional language, such as identifying what skills were used when taking notes from a telephone conversation in relation to clinical information.

A particular clinical scenario, in this case a hospital ward round, was identified through discussions and semi-structured interviews with consultants who had supervised a Reache North West refugee doctor on a clinical attachment or clinical apprenticeship scheme. These interviews, with consultants, were conducted as part of a review by the clinical tutors to evaluate the clinical placements and as such they are not part of this review.

Our Introduction to Safe and Effective Clinical Communication skills has evolved and developed over a two-year period and in June 2012 I was the main author and presenter of the updated format of the course at the Communication, Medicine and Ethics (COMET) in Trondheim, Norway. The acceptance letter and the presentation can be found in appendix E. The evolution of the course followed the PDSA cycle structure of analysis and reflection mentioned earlier, which also mirrors Schon (1983) and Gibbs (1988) reflective cycles.

During this conference, we were approached by the European Association of Communication in Healthcare (EACH) to publish our resources on their website. 2012 also saw our return to the AMEE conference in August in Lyon, France,
where we undertook a workshop in working with IMGs. The following month Dr. Ann Smalldridge, presented our work on identifying language and communication problems with IMGs at the bi-annual EACH conference in St Andrews. This presentation was a modified version of the presentation written for the COMET conference, with a more clinical emphasis.

**Process**

As mentioned earlier, a ward round was chosen because of the high percentage of doctors who were being supported by Reache North West in comparison to other healthcare professionals, and hospital jobs would be the first post of employment in the NHS. The feedback from the consultants highlighted that the international doctors struggled with the pace of a hospital ward round and there were particular skills they performed poorly in comparison to the native speaker medical students and junior doctors, with comments and further feedback suggesting there were language and cultural barriers that affected their performance.

Perdue (1984) highlighted the social and cultural contexts which can make language acquisition difficult when the target language speakers, in this case fluent English speaking doctors, hold negative views or hostility to poor communicative ability. While exposure to the processes of communication in English were seen as important, the differing cultural values and conventions of communication in the clinical setting may have negatively impacted upon the refugee doctors and hindered their performance using English in a ward round setting.
From the consultant feedback, there appeared to be too many tasks occurring at the same time for the refugee doctors to acquire the skills to communicate safely and effectively. However, the assumptions, context and interpretation of the communication episodes may not have matched the refugee doctors’ cultural working expectations or schemata for communicating in a clinical ward round, with linguistic clues being overlooked or misinterpreted (Perdue, 1984). This led me towards the theory of Task complexity, whereby sequenced tasks in a teaching environment mimic the real world expectations placed upon the learner: Robinson (2003). This also supported Perdue’s (1984) thoughts on play-acting or role-play giving participant’s insight into the communication events, repair strategies, and feedback.

A typical ward round was analysed, by the tutors, for the functional language tasks that were performed during the clinical encounter which included: taking a history, summarising information, handing over information, using the telephone, breaking bad news, communicating with a team. Once these tasks were identified, language teacher, were able to identify the functional language skills used in the daily situations and then with colleagues sequence the skills to develop the foundations of their language before putting this into functional clinical scenarios. This breakdown of the functional skills enabled the development and design of a course that could give the refugee doctors the foundational basis to analyse their own difficulties once they had returned to employment and seek language support to ensure that they could demonstrate their competence in clinical communication skills.
Biggs (2003) 3 P (Presage, Process and Production, or Prepare, Practice, Produce) model of teaching and learning was also used in designing the course to mimic the sequencing to address the issue of task complexity. The initial linguistic input prepared the students with the clinically-adapted material allowing the learners to practise the skills in an interactive manner, with the production of skills being undertaken several days later during the mock ward round.

The identified tasks involved communication of information between not only patients but also colleagues, and as such it was important to cover all of these tasks within the course. We were also very aware that these short courses could not give them every skill that would be needed. As such, tutors were keen for participants to develop resilience in their language with the ability to adapt and question the language that a colleague or patient may use, if they did not understand the vernacular.

Thinking back to teacher training and some of the theories that were used to demonstrate modalities of teaching, it was appropriate to review some of these theories when thinking about the development of the teaching. Long’s interaction theory (1982, 1996) guided some of our thoughts. Long’s theory made assertions regarding features of interaction, which could enable the learner to traverse the communicative episode and negotiate solutions to linguistic challenges such as comprehension checks, confirmation checks and clarification requests. This theory held a strong appeal, as it offered the kind of skills and resilience that we were hoping that refugee doctors would develop when in the workplace and faced with communication difficulties.
Long (1981), however, did note that there are conditions which need to be met before native speakers will adapt their language in the interaction to facilitate comprehension. One of those conditions has a direct impact on the training at Reache North West with both Refugee and Asylum seeking health care professionals and also with international doctors. Long noted that native speakers are more likely to modify their language into Foreigner Talk (Ferguson, 1975) if the native speaker thinks that they are of a higher social status than the non-native speaker. This however raises issues around the language used by native speaking patients when dealing with international doctors, as many of them may see doctors as having a higher social status and would therefore be less willing to adjust their speech to accommodate the doctors’ communication challenges. As we were not undertaking a language research project, but developing a language and communication skills course, we were not looking to investigate these issues. We were looking to ensure that the learners had been exposed to strategies for clarification to ensure comprehension.

In developing the course for the Refugee doctors, we were aware of the differing levels of language skills and how that would impact on the classroom when teaching the skills required for the ward round. Our approach to teaching was to ‘prepare’ the learners by reviewing and exploring the language used in the specific skills, ensuring that learners understood the basic linguistic skills that were required e.g. summarising a paragraph by identifying key information and appropriately creating a concise relevant summary. In this case, it was a holiday advert. The tasks gradually became more difficult and were then put into context via clinical material e.g. summarising a patient’s notes. One particular ac-
tivity, which simulated real world experience, was a three-stage dictation. Learners had to either read and speak, or listen and write during the three stages. The 1<sup>st</sup> stage included verbatim reading with verbatim written recording, the 2<sup>nd</sup> stage included reading and summarising verbally while the listener recorded verbatim. The 3<sup>rd</sup> stage included summarisation of reading and speaking and summarising what was heard for the written record. This simulated a telephone conversation where different levels of information may need to be recorded.

These activities led to further clinical input in an interactional manner between; learners, language teachers, clinical tutors and actors/simulated patients, which ensured that the learners had the opportunity to use their skills in a communicative task e.g. summarising and giving clinical information over the telephone, summarising information to a patient during history taking and handing over information to a consultant.
In 2010, whilst working at Reache North West, I was approached by the London Deanery to work as a language consultant on their pilot project, the Language and Communication Resource Unit (LaCRU), as they sought to address the increasing problems associated with IMGs in training posts in the Greater London area. The unit was successful in securing support and funding and is now a part of the Professional Development Unit (PDU) of the London Deanery and University College London. During my time at the London Deanery I was also asked to work on two other programmes of work, Fresh Start, a programme for doctors who had completed their medical training and wished to revisit or review their skills, or in some cases refresh skills due to a career gap. The second programme, Frontier, is a programme for staff and associate specialist grade doctor across London who are not within the training cycle. It was the first time for both programmes that a linguist had been asked to offer input on the course as a tutor. International doctors on the courses gave positive feedback regarding the inclusion of a linguist. I worked as a consultant tutor for the PDU and they now have a permanent linguist attached to the Professional Development Unit.

The transferable nature of Reache North West’s training courses for RHPs to IMGs became extremely clear to me during this period. Whilst the two groups had arrived in the UK under different social and economic circumstances, and decision-making processes, there were similarities regarding gaps in the
knowledge required to practise effectively in the UK. I had gained incredibly useful experience working with the London Deanery and my reflection and insight led to the creation of a similar support unit at Salford Royal Foundation NHS Trust. The Salford Communication and Language Assessment Resource (SCoLAR) was established in 2011 and the business plan, which I developed, for this unit can be found in appendix F. With increased political (2012 government consultation on language and responsible officers) and media attention (regarding GP trainees) on international medical graduates, it has been extremely important that SCoLAR and Reache North West manage their skills and ensure that the Trusts in North West of England know what support is available. In 2012, the multidisciplinary team ran workshops at; the North West Deanery undergraduate trainee conference for GPs, Association of Medical Educators in Europe (AMEE) in France, presented a poster at the Patient Safety Congress in Birmingham, and presented oral papers at the Communication and Medical Ethics (COMET) conference in Norway and the European Association of Communication in Healthcare (EACH) in St Andrews.

As mentioned in the previous paragraphs, we presented some of our early work for SCoLAR in a poster at the Patient Safety Congress 2012 in Birmingham, UK, which can be found in appendix D. This poster was later identified as an example of innovation and best practice by the NHS Health Innovation and Education Cluster, based at the Bradford Institute of Health Research. The letter inviting us to share our poster on an open access website on patient safety can be seen in appendix D.
The following sections discuss the context for the business case for SCoLAR and the work SCoLAR has undertaken since its inception in October 2011. The first section gives context for the development of the unit and the surrounding issues that are currently encountered with international medical graduates, which served as the foundation for the business case in appendix F. While the second section discusses the pilot projects and some common themes that were observed during our pilot projects when teaching general practitioner trainees, this latter section is not evidence for the portfolio of practice. Rather, it gives an outline of what was undertaken, and observations, thoughts and reflections on how the work may be taken forward in future teaching sessions.

**Context for development of the unit**

In 2011 the General Medical Council (GMC) reported that there were 239,084 registered doctors on their list of medical practitioners, with 37.3% (89,178) of those doctors having obtained their primary qualification overseas. Of the total number of registered doctors, 59,727 are registered as GPs, with the remaining number being split over the other specialties.

The General Medical Council (GMC) commissioned the Warwick report (2009) to look into problems experienced by International Medical Graduates (IMGs) which identified areas of concern with regards to IMGs’ language and communication skills, including question formation, colloquial language and appropriate word choices to express empathy. These concerns were also found in Pilotto et al’s (2007) systematic review of literature on IMGs.
Further evidence from Australia on language work with IMGs has also been developed: Dr Robyn Woodward-Kron, a linguist, has worked on the development of Communication and Language Feedback (CALF) forms (Woodward Kron et al, 2011) to assess language and communication issues and give feedback in the workplace. Dr Woodward-Kron also manages the www.doctorsspeakup.com project, which gives IMGs in Australia an online resource to develop language and communication skills once the IMGs’ issues have been identified.

The GMC Report “The State of Medical Education and Practice in the UK” (September 2011) documented the difficulties faced by some overseas doctors in adapting to practice in the NHS and called for improved competency testing and induction by employers. Research shows that doctors whose primary medical qualification is from overseas are more likely to fail UK postgraduate examinations and be reported to regulatory bodies.

The Royal College of General Practitioners (RCGP) Clinical Skills Assessment (CSA) examination for completion of GP training has a high rate of failure among overseas trained doctors. In 2010 the RCGP reported a 46.5% failure rate of overseas doctors (including European Economic Area, EEA) compared to 16.3% of UK graduates. 16 of the 20 Deaneries in the United Kingdom have a failure rate higher than 40% for Non-UK graduates. The RCGP commissioned research with Professor Roberts in 2011 to analyse the linguistic and cultural factors which may affect performance in the CSA. These problems are likely to impact on individual doctors, patients and services. A lack of success in the postgraduate examinations will influence doctors both in their careers and psy-
chologically, a view supported by Slowther et al (2012) from their interviews with IMGs.

This research is ongoing, though initial findings were reported at the COMET conference in Norway, June 2012. Many of the doctor scenarios analysed indicated problems with displaying empathy and list/tickbox style consultations. This research indicates some parity with our experience. We believe some of these issues could be resolved with specific language and communication teaching generally and also to deal with areas, in our experience, that IMGs find difficult to communicate e.g. death, sexual history, sexuality etc. Failure in examinations is not limited to GP training with other Royal Colleges seeking to analyse their own data. The Royal College of Psychiatrists has undertaken work and at the time of writing are in the process of submitting data and articles for publication.

The issue of communication problems is not, of course, restricted to IMGs. The 2002 Picker report on Patient Services in General Practice reported that 13% of patients wished to complain, and 11% felt that their GP did not consider their opinions seriously. 91% of patients reported that their GP listened to them most of the time or always, 9% felt that their doctor did not listen to them. Of the patients who felt that they could ask questions (approximately 90%), one fifth of them reported that their questions were not answered. 23 % of patients also reported that they were unhappy to see at least one doctor in their practice. This report could be hiding issues around international medical graduates.
Patient satisfaction, confidence in services and possibly the care they receive (if important information is missed) may be negatively affected. As the number of doctors in training is based upon expected need, services may have reduced effectiveness due to a shortfall if doctors are not progressing to completion of training in the planned time. Additionally, the costs of supporting the doctors who have to retake examinations are considerable. Current GP training extensions cost £35,000 per trainee. In 2011 the RCGP reported 53 failed CSA examinations in the North West leading to a cost of £1,855,000 in extended training for non-UK graduate GP trainees.

In 2014 the General Medical Council amended “Good Medical Practice” to include a passage for all doctors stating ‘You must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK.’ This step forward is an important milestone in ensuring that doctors can be challenged not only on the application of their clinical knowledge but also the language in which they are expected to practise to ensure patient safety.

**Pilot Projects**

The initial work with SCoLAR centred on General Practitioner (GP) trainees who had been having difficulty passing the Clinical Skills Assessment (CSA) examination or who had been identified by their trainer as having communication difficulties. Further work has been an extension of the safe and effective clinical
communication skills programme, which has been adapted for induction pro-
grammes for international medical graduates.

Reache North West has collaborated with the East Midlands Deanery and the
North West Deanery providing models of communication skills assessment and
remediation for International Medical Graduates in GP training and other spe-
cialty training

Three pilot projects have been completed to date:

The first pilot was an assessment session for the East Midlands Deanery and
this included 8 GP trainees from the second and third year of training who had
been identified as struggling with language and communication issues. This
was undertaken in November 2011 at Salford Royal Foundation NHS Trust. For
the assessment, three role plays similar to Observed Structured Clinical Exami-
nations (OSCEs) were selected for a team of linguists and clinicians to observe,
with the simulated patients (actors) giving feedback from the patient perspec-
tive. The first scenario involved taking a history from a patient, the second sce-
nario followed on from this initial encounter and the trainee was required to give
a clinician a summary (hand over) of all the relevant information obtained from
the simulated patient. The third scenario was unrelated and required the trainee
to give and explain information about a condition. Each of the observers took
notes and written reports were sent to the East Midlands Deanery within 15
working days. Each of the assessment sessions lasted for approximately three
hours and two assessments sessions were run on the day.
The second pilot programme with the North West Deanery was a joint assessment and intervention, once again with 8 GP trainees from the second and third year of training, which was based at Salford Royal Foundation Trust in March 2012. For this day, a more relaxed approach was taken, with feedback being given immediately to all of the trainees. Feedback was given verbally and some of the tutors provided simultaneous written feedback. For the assessment portion of the day, trainees were grouped with other trainees, a simulated patient, a clinical tutor and a linguist. OSCE type scenarios were undertaken, with verbal feedback being given from the patient, tutors and in some cases the other trainees. The opportunity to rewind the scenarios to specific points of difficulty was available and the trainees were given the opportunity to try the situation again, having engaged with the feedback. For the intervention session, each trainee was paired with a simulated patient and either a clinician or a linguist, role plays were undertaken with feedback and rehearsal opportunities before moving on to work with another tutor. Common linguistic feedback given on this intervention included issues around formulaic language and prosody.

**Formulaic language** - a sequence, continuous or discontinuous, of words or other meaning elements, which is, or appears to be, prefabricated: that is stored and retrieved whole from memory at the time of use, rather than being subject to generation or analysis by the language grammar (Wray and Perkins, 2000).

**Prosody** – Elements of speech such as rhythm, intonation, pitch and emotional context conveyed through language (Cutler et al, 1997).
The trainees spent an equal amount of time with clinicians and linguists to ensure a maximum amount of input and feedback could be given and acted upon. The feedback from the second pilot was that the trainees’ ‘wished that they had more of this training and feedback and at an earlier stage as it provided useful insights’.

The third pilot was undertaken in 2012/2013 during the transition period from the strategic health authorities to Health Education England and was developed from the reflective cycles on the first two interventions. This was a lengthier intervention, which aimed to help GP trainees in their final year of training before they took the Clinical Skills Assessment (CSA). This intervention was run over a four-month period, with a half-day teaching session each month. The first three teaching sessions addressed specific parts of the consultations, with the last day being used to integrate the skills.

As mentioned earlier, the team at Reach North West utilised a 3 P model of teaching (Biggs, 1996) in the Safe and Effective Clinical communication course, which allowed sequencing of tasks to mirror real life complexity. This model was used again during the third pilot. This model ensures that trainees have sufficient information to understand the tasks required, and as they are international students with English as a second language, attention is paid to the language that the facilitators use to describe concepts. For example, in the first session, the format of not only the course but also of the consultation was broken down to include a more detailed explanation of what was expected, with restricted language to ensure that international medical graduates understood what was
required of them. Other facilitators queried understanding and comprehension of colloquial language and cultural concepts to ensure that the trainees knew that they could ask questions in a safe environment. For example, one of the facilitators used an example which involved leprechauns. None of the international doctors queried what a leprechaun was until I raised the point. This first session also had a practical component where the trainees were offered the opportunity to work with simulated patients (actors) to start the consultation and focus on gathering information.

The second and third sessions utilised a more practical component, allowing trainees to practise with simulated patients (actors) after they had had the opportunity to practise phrases and language around specific consultation skills. For example, the second teaching session focussed on summarising and sharing information with the patient, whilst the third session focussed on negotiating a management plan. The trainees were also observed by a linguist and a clinician to ensure that they had multidisciplinary feedback. This ensures that feedback is relevant and focussed to ensure development of consultation skills. The fourth session was also highly practical, focussing on integrating the individual sections into a consolidated consultation.

During the second session, one of the doctors stated that they now knew what they were supposed to be observing and understood the model better once it had been broken down to explain concepts and language surrounding ideas, concerns and expectations.
Further feedback and results from this intervention were expected in the summer of 2013, as GP trainees would have taken the CSA examination. However, due to the transition and changes in management structure, feedback was limited. 4 of the twelve international medical graduates that undertook the intervention passed the CSA examination. A similar proportion of those international medical graduates who did not attend the course also passed the CSA examination. From this comparison, we could not conclude that the training course helped the trainees pass the CSA examination.

From the training days undertaken at Reache North West, common language and communication themes emerged that impacted on the International Medical Graduates’ ability to demonstrate empathy, connect with patients, move beyond formulaic consultation styles, and integrate patients’ questions and concerns into their consultation.

Dahm (2011) found issues in Australia with consultations being formulaic, and at times more interrogative, with inappropriate use of empathic statements without true understanding of the situation e.g.

IMG: What about your family? How is it at home?

SP: My father is very demanding.

IMG: I see. I’m very sorry to hear that. And how about things at school and with your friends?
An example that was seen and recorded during the pilot in an advice-giving scenario can be seen below.

IMG: Do you take a lot of salt?
SP: NO
IMG: Maybe a bit down then in your food.

In this example, the doctor had repeatedly asked closed questions using the same construction ‘do you take a lot of’. The simulated patient was very emphatic with their response of ‘no’. However, the doctor continued to give advice on salt reduction despite the simulated patient making it clear that they didn’t use a lot of salt. This appeared to indicate that the doctor either was not listening or had a prepared formula for giving advice around hypertension. There were also issues around sentence construction.

Other examples included concerns over mortality and the doctor not understanding the colloquial phrase ‘popping your clogs’ for death, and therefore not responding to cues from the simulated patient. This left the simulated patient feeling that their concerns had been dismissed and that the doctor did not listen to them. In another example, smiling at inappropriate points of the consultation left the simulated patient ‘feeling like they were being laughed at’.

These examples appeared to support Dahm’s view of formulaic consultations. However, with a limited number of participants and non-standard recording of
the consultations, it is difficult to give generalisations regarding language and communication skills issues.

The pilot project also successfully used a multi-disciplinary team in assessing and teaching trainees in a practical manner. This was an important factor in reflecting on the success of the course and how we would adapt them in the future. We felt that, for the international medical graduates to obtain full benefit from a consultation skills course, there needed to be a linguist and a clinician giving feedback on both language and communication skills. This was due to the linguist and clinician observing things from a different perspective and being able to give targeted advice for progression. It should be noted that at times it was difficult to assess communication skills as a lack of clinical knowledge left the international medical graduates unable to express themselves.

As stated earlier, from the pilot day of assessment and intervention 1 of 4 trainees successfully passed the Clinical Skills Assessment, with their GP trainer reporting being surprised at how much they had improved in such a short space of time. If this success could be replicated, the expected saving at this rate from a cohort of 24 trainees would be £200,000. From the RCGP figures of 53 trainee extensions savings of £455,000 could be made. The national failure rate reported by the RCGP was 628 international trainees at a training cost of £21,980,000. With the potential national saving being calculated at £5,783,750 from the one-day intervention piloted by Reache North West.
Results from the limited cohort were positive and we are seeking funding to extend this work to run a larger scale pilot programme with international medical graduate GP trainees in their final year of training.

Feedback from the pilot programme with the East Midlands Deanery can be seen at the end of the business plan (Appendix F).
Engagement with communication models

The following section discusses and reflects on my observations as a language teacher on the communication models that have been used by GP trainees and that are being used more widely in medical education for communication skills teaching. These observations and reflections come from my role as a consultant at the London Deanery and also as the Lead Language tutor at Reache North West and SCoLAR. These observations and reflections are limited, in that they are based on my in the moment observations and written records and as such may seem anecdotal. They may also appear reductionist, as my observations and written records were only concerned with what I considered, in that moment, to be the most important feature of language or communication to give feedback on. This was to raise the doctor’s awareness of the issues and create a development plan rather than tackling underlying social and emotional issues which may also have been affecting their language and communication skills. These reflections highlight the need for further research in this area to support international medical graduates in the use of communication models.

The Royal College of General Practitioners (RGCP) has moved away from a purely medical model of practice (Simon, 2009); whereby the patient accepts and respects the doctor’s explanations and decision. Instead, GP trainees are taught a variety of approaches and communication models that serve to give trainees an effective framework in which to help gain satisfactory outcomes for not only the doctor but also the patient. These models have been developed from observations of consultations. The Oxford Handbook of General Practice
(3rd Ed) (Simon et al 2010) identifies 15 consultation models, which are seen as the most appropriate approaches to developing flexible and resilient consultations.

Since the 1950s there have been a range of models developed and taught to help trainees develop effective communication styles to help their patients. Some of them have had more impact on medical education than others. The following exploration of 7 consultation models highlight some of the issues that have been observed and recorded with international medical graduates with my work at Reache North West and the London Deanery.

With greater acceptance that psycho-social factors have an impact on physical health, Balint (1957) took an approach to understanding the interaction and relationship between doctor and patient. Balint believed that personality and training produced unique manners in which doctors dealt with patients. However, there were factors which could impact upon patients in a negative way; doctors who did not seek to examine themselves, in a non-clinical manner as a person, in their performance as doctors tended to develop rigid styles of behaviour in their interactions with patients. Balint also believed that doctors developed beliefs and expectations with regards to how a patient should behave when ill and how they should respond not only to the doctor but also in their compliance with treatment and advice. Balint groups were developed to allow groups of doctors to reflect on consultations which may have been complicated, confusing, exciting or frustrating. The group discuss the relationship between the doctor and
patient to develop an awareness or understanding of the emotional responses to the patient.

Observation of international doctors has highlighted that identification of difficult issues for the doctor can be hindered due to cultural values and/or a restricted range of vocabulary. For example, an international doctor in a recent teaching session admitted that they did not understand the difference between an alcoholic and someone who was drunk. This lack of understanding was partly due to culture and language. As the doctor came from a culture where alcohol is not ingested, language and issues surrounding health related issues was alien to them. This left them in a quandary when dealing with alcohol in consultations and they did not know how to address the issue within their training. A further issue surrounding alcohol was seen when observing paired scenarios. These included a consultation with a suicidal patient, which was followed by a handover to a senior colleague. In this particular scenario, the patient had attempted suicide by overdosing on paracetamol and vodka. Only 1 of the 12 doctors I observed understood the significance of the amount of vodka and questioned the patient on the size of the bottle. The other doctors all made assumptions about the amount of vodka consumed and incorrectly reported this when handing over information to the senior doctor.

Other issues similarly identified included; homosexuality, domestic abuse, disability. One doctor asked ‘why is so much money wasted on those disableds’ (sic), as in his country no money or support was available for people living with a disability. These issues are of major concern when international doctors have
limited understanding of the social and cultural values of the United Kingdom and in some cases the laws that protect patients.

In 1964 Eric Berne, published *Games People Play: The Psychology of Human Relationships*, which dealt with transactional analysis and three roles which people may play, Parent, Adult and Child. The book also dealt with the games that were played as people switched between these three roles to achieve their goals. This was extremely relevant in the consultation as both patients and doctors were seen to migrate between these roles to meet their own motivations and agendas.

International doctors from some countries who are used to a medical model of practice tend to find adapting to UK practice difficult as the social transactions are more equally balanced. With a loss of status and power with patients, international doctors may encounter issues if they lean towards a more dominating parental role treating patients like children rather than working with patients as adults. With the national NHS priorities being patient centred care and shared decision making, international doctors have been observed to struggle with the concept of patients as experts on their own health and circumstances. An example of this struggle was seen during a scenario with an actor, which required negotiation concerning a treatment plan. The doctor clearly directed the patient to what they thought was the best, and only, medical intervention, in this case surgery. At no point were other options discussed with the patient or how they felt about this route with the doctor acting as ‘parent’ who knows best. The patient rejected this in a ‘child’ role, leaving the doctor feeling frustrated that they
were being ignored as an expert. The doctor clearly not understanding the patient perspective. The patient had concerns about the recovery time and the cost of not being paid for time off work. When this was explored in an ‘adult’ conversation, the doctor understood the patient’s concerns more fully and offered surgery as a last resort if alternative treatments did not work first.

Further issues encountered were identified within the Royal College of General Practitioners’ (RCGP) Triaxial model (1972), whereby patients’ problems should be addressed in terms of physical, psychological and social issues. This model was developed through an RCGP working party as they defined the role of the general practitioner. Social issues are dependent on local culture, and for many international doctors social issues in the United Kingdom are extremely different from their native countries. For example, in a recent observation a doctor did not tackle social issues with regards to a female dementia patient. The patient arrived in an unkempt fashion with her blouse buttons not aligning and her underwear showing, she also had lipstick drawn on her cheeks. The doctor did not address the patient’s appearance and did not understand the implications of this patient living alone, and the associated risks of caring for herself. The doctor did not understand the significance of this situation as they came from a culture where extended family cared for sick and elderly relatives. Another doctor, in an OSCE situation, specialising in psychiatry, tried to forcibly admit a patient for suicide risk and place their children with social services when the simulated patient had said on five occasions that they had too much to live for, they didn’t want to kill themselves but they felt low. The doctor did not understand the colloquial phrases the patient used and therefore missed verbal cues to the real
situation. The doctor also did not understand the impact of his threat of social services to a patient who was feeling low, not suicidal and was therefore unprepared for the hostile reaction from the patient. Both instances could potentially also be explained due to native cultural expectations of doctors leaning towards a more medical model of practice.

Becker and Maiman (1975) developed the Health Belief model, which had a tremendous impact on communication skills training for medical students as they were introduced to the concept of asking for patients’ Ideas, Concerns and Expectations (ICE). This model focused on five elements surrounding the patient’s beliefs around health; health motivation, perceived vulnerability, perceived seriousness, perceived costs/benefits of an action, cues to action – stimuli/triggers for belief. The model is very popular but has become more of a tick box exercise when trainees use it within a consultation, with anecdotal reports of students saying ‘I ICEd them!’ While the trainees may have asked for the patients Ideas, Concerns and Expectations, they may not have actually addressed them and engaged the patient within the consultation. The idea of ICE has been twisted from an aid to a tick box tool, which many of the trainees, especially international trainees, do not really understand, as a lack of knowledge of language and culture may impede their ability to actually address the patient’s ideas, concerns and expectations once they have been gathered.

International doctors have been observed asking for the patient’s ideas, concerns and expectations but due to language or cultural issues they have not been fully integrated into the consultation. For example, a recent observation,
during an OSCE, saw an international doctor ignore the patient's concerns and questions by saying, 'I'll come back to that'. The doctor never addressed the issue and felt that they had covered all the medical information that they needed, but they had ignored the psychological and social factors and were surprised at the patient's dissatisfaction with the doctor when feedback was given. Further explanations around why international doctors do not fully integrate patients' answers into the consultation may lie in that they do not understand the underpinning elements of the model; only taking ICE as the important factors and not truly understanding the model.

Pendleton, Schofield, Tate and Havelock (1984) published *The Consultation - An Approach to Learning and Teaching*, which defined seven tasks which, when undertaken together, form comprehensive and coherent aims for a consultation. The first task was to define the reason for the patient's attendance, including: the nature and history of the problems, their aetiology, the patient's ideas, concerns and expectations and the effects of the problems. The second task seeks to consider other problems, such as continuing problems and at-risk factors. Thirdly, the doctor should, with the patient, choose an appropriate action for each problem. This leads to the fourth task of achieving a shared understanding of the problems with the patient. The fifth task aims to involve the patient in the management and encourage the patient to accept appropriate responsibility. The penultimate task aims to use time and resources appropriately, not only in the consultation but also in the long term. And lastly, the doctor should establish or maintain a relationship with the patient, which helps to achieve the other tasks. The earlier examples can also be highlighted
with this model in particular; when one doctor sought to address the patient’s concerns at a later point in the consultation, they harmed their rapport as it became a doctor-centred approach because the patient became more detached from the consultation as the doctor led the conversation without involving the patient.

Neighbour’s (1987, 2004) *Inner consultation* viewed the doctor-patient encounter as a journey with five checkpoints. The five checkpoints involved connecting with the patient, summarising the patient’s reason for seeing the doctor, handing over information and negotiating a management plan, safety netting with the patient to ensure plans are in place for the unexpected and finally housekeeping to ensure that the doctor is aware of their own emotions. Recent observation of an international doctor in an OSCE situation saw the safety netting section of the consultation break down as the doctor did not understand the implications of a patient being admitted for surgery. The patient in question cared for an elderly parent who required a lot of support and care. Being admitted for surgery would mean that the elderly parent would need to be placed in a care home while the patient recovered. The doctor did not understand the distress of the patient or the distress and disorientation that this temporary change of circumstance may cause to the elderly parent. Despite this concern being raised several times, the doctor didn’t pick up on the linguistic cues or recognise the cultural differences and difficulties in caring for family members in the UK. In this case, the doctor assumed there was an extended family and support network that could help in these difficult times as would be the case in their native country.
The Calgary Cambridge Observation Guides (Kurtz and Silverman, 1996) approach was developed as an extensive toolbox of communication techniques, which could be used and adapted as a teaching tool that is dependent on the patient and the scenario. The consultation is divided into five tasks or areas of the consultation: *initiating the session*, *gathering information*, *building the relationship*, *explaining and planning*, and *closing the session*. With over 70 skills within these areas, the Calgary Cambridge method is a comprehensive model that allows trainees and doctors to choose the most appropriate points for the consultation. The five tasks are further expanded, with the 70 skills being delegated to these subdivisions, for example, in task area 1 (initiating the session) two subdivisions are identified – *establishing initial rapport* and *identifying the reason or reasons for the consultation*. The following diagram shows the details of skills 1-7.
Initiating the Session

<table>
<thead>
<tr>
<th>Establishing initial rapport</th>
<th>1. <strong>Greets</strong> patient and obtains patient’s name</th>
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<tbody>
<tr>
<td></td>
<td>2. <strong>Introduces</strong> self role and nature of interview; obtains consent if necessary</td>
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<tr>
<td></td>
<td>3. <strong>Demonstrates respect</strong> and interest, attends to patient’s physical comfort</td>
</tr>
<tr>
<td>Identifying the reason(s) for the consultation</td>
<td>4. <strong>Identifies</strong> the patient’s problems or the issues that the patient wishes to address with appropriate <strong>opening question</strong> (e.g. “What problems brought you to the hospital?” or “What would you like to discuss today?” or “What questions did you hope to get answered today?”)</td>
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<tr>
<td></td>
<td>5. <strong>Listens</strong> attentively to the patient’s opening statement, without interrupting or directing patient’s response</td>
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<tr>
<td></td>
<td>6. <strong>Confirms and list and screens</strong> for further problems (e.g. “so that’s headaches and tiredness; anything else……?”)</td>
</tr>
<tr>
<td></td>
<td>7. <strong>Negotiates agenda</strong> taking both patient’s and physician’s needs into account</td>
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</tbody>
</table>

Many of the international doctors that have been observed manage to initiate the session. However, due to language and cultural issues, many struggle to effectively gather information, build the relationship, or plan and explain effectively to the patient. For example, not knowing colloquial language hinders their ability to gather information if they do not know or successfully use clarification techniques. A recent observation saw a doctor who did not clarify what the pa-
tient meant when they said ‘it’s (my leg) been giving me a bit of jip recently’. As the doctor didn’t clarify what the patient meant by ‘jip’, in this case pain, the doctor failed to gather pertinent information and failed to build the relationship with the patient.
Reflections

The work that Reache North West has undertaken with Refugee Healthcare Professional has been original in England and the UK. Whilst members of the Refugee Doctors Liaison groups have acknowledged that all of the stages of the registration process are important for the progression of the doctors returning to work, none of those member organisations have been in the position to offer all of the training via one organisation with a multidisciplinary team of clinicians and linguists engaged in all stages of the teaching and learning process.

Funding the different strands of the registration process and commissioning different providers across a city, as in London, disadvantages refugee healthcare professionals. Whilst the staff may be well qualified and provide an enriching, yet isolating, learning experience, the refugee healthcare professionals do not encounter a true multidisciplinary working environment that may be mirrored in their employment in the NHS with nurses, domestic staff, allied healthcare professionals and administrative staff.

The evaluation of Reache North West brings together the teaching and learning experiences of refugee doctors who have been through a training programme from beginning to end with one organization that has been able to effectively prepare for the transition of personal professional habitus and doxa for work in the UK. The multidisciplinary team has not been preparing refugee healthcare professionals in an abstract and disjointed manner, they have been supporting
an ethos that is validated by the seamless transition between stages with educators that know the whole process of registration intimately. An intimacy gained through the constant review, evaluation and modification of teaching programmes ensuring that learners are engaged in relevant training that prepares them for the ever changing NHS.

This approach is original to the education of refugee healthcare professional in the UK as other organisations have not had the financial or physical resources to provide this service. The evaluation and analysis have reviewed practice in the UK and internationally and have not found any evidence that the model used by Reache North West is in practice elsewhere, though there is evidence that there is a movement towards this model of integrated education for refugee healthcare professionals.

From our action research and work with international doctors at Reache North West, a variety of issues have been identified that impact on the consultation. If we take for example the Calgary Cambridge toolbox, language and culture can have an enormous impact on all aspects of the consultation. Developing rapport can be impeded due to cultural expectations of eye contact or power relations, with identification of reasons for the consultation stalling when language issues arise, such as: lack of lay vocabulary, colloquial language, intonation. Gathering information, as discussed above, can be stalled due to a lack of clarification techniques when patients use unknown language or even when the doctor is unwilling to seek clarification.
However, cultural knowledge or attitudes may also impact on gathering information e.g. a recent observation of a doctor; when quizzing a patient on alcohol came across to the patient and the observer as judgemental, as the tone of their voice alongside their body language showed extreme disapproval of alcohol. This judgemental manner made the patient uncomfortable and reluctant to impart information, as the doctor’s questions around social issues then became leading e.g. ‘how many do you smoke?’ when in fact the doctor hadn’t even asked if the patient smoked. This then led to a breakdown of the relationship as the patient became hostile to the doctor’s line of questioning. As the doctor was not gaining sufficient information from the patient due to the breakdown in the relationship, they could not sufficiently explain and plan with the patient, with the close of the session being awkward but welcomed by the patient so that they could leave. This type of miscommunication can lead to poor relationships and increased patient dissatisfaction with doctors.

Explaining and planning is an area which can also be hindered due to language and cultural issues. With a lack of lay language, international doctors observed struggled to explain medical terminology in an easily understandable manner. Often there is confusion and struggle around explaining in a manner which allows the patient choice but at the same time satisfies the doctor’s desire for the best course of treatment. I have also observed communication issues around offering choice when the choice is limited to either have treatment or do not have treatment. For many of the international doctors that we have worked with there is no choice in this scenario, you have the treatment.
The observations and reflections have given me an indication of the following issues with a linguistic basis, which may raise concerns of performance and competence in the clinical consultation process:

Formulaic language - a sequence, continuous or discontinuous, of words or other meaning elements, which is, or appears to be, prefabricated: that is stored and retrieved whole from memory at the time of use, rather than being subject to generation or analysis by the language grammar (Wray and Perkins, 2000).

Prosody – Elements of speech such as rhythm, intonation, pitch and emotional context conveyed through language (Cutler et al, 1997).

Initial observations suggest that many IMGs have learnt sequences of language that may be used inappropriately and do not match the output of native speaking patients. Examples seen by Dahm (2011) and through our observations support that formulaic language is a wide-ranging phenomenon that works across data sets (Wray, 1999). For example, during OSCE observations an international trainee said to every patient ‘you’re looking anxious’ when this wasn’t the case. The trainee also used ‘the good news is’ when there was no bad news to be given, which raised the patient’s anxiety as they were waiting for the bad news.

Prosodic features that have been observed include raised intonation at the end of every sentence in a questioning manner which has left patients and col-
leagues confused as to whether the doctor was asking for information, making a statement or giving a professional opinion.

A blended example of formulaic language and prosodic features has also been observed, with a doctor telling a simulated patient that Viagra was not available on the NHS and stating that ‘it was tough’. The doctor had tried to convey the meaning of empathy that she understood ‘it was tough’ meaning difficult for the patient but instead conveyed the meaning of having to accept the fact it was not available and therefore, it’s tough luck. This change of meaning was due to a flat intonation with no stress on any of the words, which therefore meant there was no variation in tone or emotion conveyed.

I witnessed a considerable number of language-related episodes which affected the consultation. Whilst there was sequencing within our teaching, to address task complexity, of breaking down the consultation into focussed tasks of summarising, sharing data, negotiating etc., there was clearly a need for greater sequencing in the language input. Some of the errors were as fundamental as doctors on the programme misreading OSCE instructions with a clear focus on what was expected in the scenario, even though they had been given a very thorough introduction of what was the focus of the day. This implies that they did not understand the introductory presentation, which leads to the supposition that their lack of comprehension may be due to limited a range of vocabulary or language skills resulting in a failure to read and understand clear clinical information in a timely fashion.
Clearly, there are other factors that influence the communication between doctor and patient and the above reflections come from my position as a language teacher identifying errors and potential solutions when giving in the moment feedback. As mentioned earlier, further rigorous and robust research is needed to identify issues with consultation skills.
Conclusions

Reache North West has, as an organisation, demonstrated the need for support for refugee and asylum seeking healthcare professionals. The multidisciplinary team bring their experiences and views e.g. medical, educational and feminism, to the development of the organization’s praxis as do the refugee healthcare professionals when they transpose their feeling of victimization in the asylum-refugee process to the process of professional registration. Reache North West has a unique position being part of the educational establishment and at the same time being able to challenge views and processes. The benefits of supporting this vulnerable cohort are wide ranging and not only apply to the individuals in question, but also to wider community groups and society as a whole.

The refugee healthcare professionals reflect the growing diversity in society. Ensuring that skills that they have gained are put to use allows them to contribute not only to the NHS but also to cultural growth in the UK and also the UK tax system.

Reache North West’s original practice compared to other organisations in the UK realizes a continual process towards registration that is supported by one organization in a seamless progression whereby tutors for the different stages of the process work together to ensure that there is integration of teaching at all levels to better prepare the students, rather than approaching the registration process from a compartmentalised teaching process.
The PEST analysis in the evaluation gives appropriate context for Reache North West to operate and the refugees who took part in the evaluation (Appendix A) reflected on how the support they were offered assisted them in gaining employment in their professional roles but also the social benefits and support that they had lost upon entering the UK as asylum seekers and refugees. The thematic analysis in the evaluation allowed a variety of themes to be explored yet understood that they could not necessarily be measured separately as the elements of the programme all contributed to the individual successes.

Financially, the business case for continuing to support such a programme is strong, especially when comparing the costs of training new medical students (approximately £250,000) and refugee doctors (approximately £25,000). Reache North West has received approximately £3 million pounds in funding since 2003. With approximately 170 doctors returning to work, not all of the students keep in touch once they have graduated from Reache North West. The cost differential of training 170 medical graduates is approximately £42,500,000. If it is assumed that all 170 of those doctors are in substantive posts earning at least £20,000, the approximate tax accrued on an annual basis would be £680,000. Many of these doctors have acquired much higher paid posts and therefore the actual benefit to the system is probably much higher.

What appears obvious from these figures is that the long-term benefits of this programme far outweigh the costs. The cost of having refugee healthcare professionals not working is also a difficult arena to navigate, as the costs of
jobseeker’s allowance, child benefit, and housing support all play a part in the calculations.

Reache North West is continually learning and developing its work with refugee and asylum seeking healthcare professionals, using reflection and PDSA cycles. However, it is difficult to assess directions for future research with this cohort with the changes in the NHS. Whilst the evaluation in Appendix A demonstrated that Reache North West is effectively preparing the refugee doctors for employment in the NHS, further evaluations from working members on a more regular basis would allow Reache North West to maintain up-to-date training programmes to ensure that refugee doctors can continue to enter the National Health Service (NHS) in a supported manner. The Reache North West model of education and training for refugee healthcare professionals serves as template not only for Reache North West but also for other organisations preparing refugee healthcare professionals to return to their professional roles.

However, Reache North West does need to consider its future especially in terms of being a commissioned service. Future cost improvement initiatives may require integration into the commissioning agency Health Education England. The need to consider the manner in which it would function within mainstream education services is imperative. Much could be gained from being positioned within the mainstream education circuit including: access to current clinicians, engagement with younger generations of medical educationalists, and increased contact with former members who could be tracked more effectively after entering mainstream training programmes.
The language and communication skills training that Reache North West has undertaken with refugee doctors and international medical graduates provides greater direction and scope to continue our research, teaching and support on a wider scale. Sustainability of Reache North West has also been a consideration. When planning for the future and by transferring teaching to settings with international medical graduates as well as refugee doctors, Reache North West has demonstrated that it can contribute to the wider educational field. With national media and political coverage of issues surrounding internationally trained staff, there is an excellent opportunity to extend this work further and to offer evidence of good practice, especially in respect to the business case for SCoLAR (appendix F). With the addition of the language statement in the GMC’s ‘Good Medical Practice’, the creation of the unit and the teaching programmes have been justified, as there is a recognised need for international medical graduates to maintain their language skills for clinical contact with patients.

Much of the work undertaken with refugee doctors has been reactive and as such in the future Reache North West needs to be taking a more proactive approach to developing teaching. Programmes of teaching that have been developed address the linguistic and communication skill limitations sometimes displayed when working in the clinical environment. This has helped to provide an introduction to language and communication for both refugee doctors and international medical graduates in preparing them to work more safely in the NHS. More work could be undertaken to develop these skills with in situ teaching and learning taking place whilst undertaking work placements so that tutors could guide the refugee doctors in a real life teaching environment.
As the work on communication skills is more widely recognised by NHS trusts, further research with larger cohorts will allow the organisation to think about the validity and reliability of the work and how it undertakes teaching and research. This must be balanced with the commissioning process and how the organisation wishes to move to forward as it tackles the desire to undertake research and look at recording simulated consultation sessions and coded transcriptions, which may take time to decipher alongside the commissioners’ desire for instant solutions to improve patient safety.

There are weaknesses in the observations of clinical scenarios with regards to the language and communication skills. The ‘in the moment’ feedback potentially missed other more crucial aspects of language and communication features that may have impacted on the interactions. Further work is clearly needed to identify language and communication skills deficits in clinical and consultation settings and, whilst the observations may be used as a starting point, there is not enough data to make generalisations or assertions to all international medical graduate who are experiencing language or communication issues.

However, as much of this work was undertaken in a teaching setting, the feedback was relevant at the time for learners. Future research must be planned appropriately, potentially with recordings and full transcriptions that could be triangulated with patients/simulated patients, linguists and clinicians. It would also be advisable for Reache North West to engage in collaborative research with institutions to strengthen its credibility with regards to research. This would sup-
port staff in their own personal development as they would have the opportunity to work with academics and develop their research skills.

Commissioners may wish to consider coordinating the development of partnership working with Reache North West, as many main stream institutions and organisations are wary of collaborating with a small commissioned service. The benefits from joint work could provide an array of teaching tools that could support wider the wider international medical graduate communities.

Reache North West, as an organisation, must decide what its focus is and whether it wishes to partner with an institution that would be better suited to develop the research protocols whilst it continues to focus on developing teaching for refugee doctors or whether it wishes to develop its own research profile.

As a researcher and practitioner I must now look to my personal development and engage in wider educational projects. The isolation of working for a fringe educational organisation has been an incredible experience, however my views of medical education are skewed as they come from a specific process that is only for international medical graduates who have had either limited or no training in the UK. Working in mainstream education or in a mainstream healthcare setting would allow me to develop as a practitioner ensuring that my skills are current and relevant if returning to teach international medical graduates.

The personal engagement with the participants and their peers has been insightful during the research process, however for my development as a re-
searcher I must look at engaging with different methodologies and approaches to educational research for my progression in academia.
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Submission Declaration

I Duncan Thomas Cross can confirm that no part of this submission of Doctor of Philosophy on the basis of practice has been submitted for any other award.

Signature

Date
Statements of Collaboration

I Duncan Cross can confirm that the article (Cross, D. & Smallridge, A., 2011. Improving written and verbal communication skills for international medical graduates: A linguistic and medical approach. *Medical Teacher*, 33, pp.e364–e367) was written in collaboration with Ann Smallridge taking the lead on the analysis and design of the clinical element of the project while I lead on the analysis and design of the language element of the project.

I can also confirm that the poster (Cross, D. and Smallridge, A. 2011, A combined linguistic and medical approach to improve written and verbal communication skills for International Medical Graduates (IMGs)) presented at the Association of Medical Education in Europe Conference 2011 and the Royal College of General Practitioners Conference 2011 was co-written with Ann Smallridge and that I designed the poster.

In addition I can confirm that the first draft of the poster (Cross, D., Smallridge, A., Sykes, M., Keaney, M. 2012 *Safe Communication Skills for International Doctors*) was written and designed by myself on behalf of the team with the final version being presented at the Patient Safety Conference 2012.

Finally, the first draft of the conference paper (Cross, D., Smallridge, A., Sykes, M., Keaney, M. 2012, Safe and effective Clinical Communication (SECC) - A skills training course for International Medical Graduates (IMGs)) was written by Duncan with the final version presented by Duncan Cross to communicate the team’s work at the Communication and Medical Ethics Conference.

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I can also confirm that the first draft of the conference paper (Cross, D., Smallbridge, A., Sykes, M., Keaney, M. 2012, Safe and effective Clinical Communication (SECC) - A skills training course for International Medical Graduates (IMGs)) was written by Duncan Cross with the final version presented by Duncan Cross to communicate the team’s work at the Communication and Medical Ethics Conference. I assisted in the verbal preparation of the presentation offering editorial insight.

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I can also confirm that the first draft of the conference paper (Cross, D., Smallbridge, A., Sykes, M., Keaney, M. 2012, Safe and effective Clinical Communication (SECC) - A skills training course for International Medical Graduates (IMGs)) was written by Duncan Cross with the final version being presented at the Communication and Medical Ethics Conference by Duncan Cross to communicate the team’s work and experience. I assisted in the verbal preparation of the presentation offering editorial insight.

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FRC Path  
GMC number 1383229
APPENDIX A
Reache North West

Evaluation 2012

Duncan Cross
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References
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, Economic, 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 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.
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 (March 11 2011). 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 Carib-
bean nurses who were seen as essential to the expanding services that the NHS was providing. There was a repetition of international recruit-
ment 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 profession-
ally 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 retire-
ment. 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 regard-
ing refugees from the 15th Century onwards coming to the UK. The atti-
tudes towards refugee doctors and nurses have also been rife with divid-
ed opinions on the benefits with some being welcomed, while others en-
counter 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 in-
surmountable 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 ap-
propriate 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 Health Education England (HEE)

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 in-
itial 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.

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 coun-
tries. 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 (Jones and Snow, 2010)

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:
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. 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 RA-GU (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 four years or less remains a useful medium term solution’ in relation to training medical students.

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 North West 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 retention 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, Manikavasagar, & 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 Smalldridge, 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 £500,000 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 Health Education England (MEE) is an independent expert organisation which offers advice and guidance on the training and workforce planning of healthcare professionals in England. HEE 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 HEE 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>
</tr>
<tr>
<td>General Dental Council</td>
<td>7</td>
<td>6.5</td>
</tr>
<tr>
<td>General Pharmaceutical Council</td>
<td>7</td>
<td>7</td>
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</tbody>
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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 North West 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 a reference letter

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

1.9.1 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.

1.9.2 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.

1.9.3 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

- Currently training with Reache: 15%
- Working in Professional Role: 46%
- Unknown, Alternative Career, Unemployed or Training alone: 39%
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.

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.

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.
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 straight forward. 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.
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”

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.

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.

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

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?

2.4.7 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 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.
2.4.8 Interviewer: So, do you think it’s a good thing for your colleagues or the refugee doctors to tell people about them being refugees.

2.4.9 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

2.5.1.1 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;

2.5.1.2 “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”

2.5.1.3 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

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

2.5.1.5 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.
Interviewee: Why do you think taking English more seriously?

Interviewer: 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-instate 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 in-
duction 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 impact-ed 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.

2.5.4.10 Interviewer: Why?

2.5.4.11 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

2.5.5.1 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.

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

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

2.5.5.4 “Really useful at that time and I still appreciate the usefulness of it.”
2.5.5.5  “I enjoyed actually those simulation sessions with professional you know actors they’re really useful sessions, they’re really useful “

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

2.5.5.7  “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.”

2.5.5.8  “Communication, effective clinical communication. It was really good.”

2.5.5.9  “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

2.6.1  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.
2.6.2 “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 envi-
ronment. How to deal with a patient and how to be empathy and sympa-
thy 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 dif-
ferent 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”.

2.6.3 “I could say those kind of end of life care we have a good ses-
sion about the end of life care pathway and I’ve looked at ever-
thing during a Reache session and in my renal job I did
many, I mean many people because I work in renal many peo-
ple 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 contra bits. Many of us don’t inte-
grate or not integrate I mean we are not socialising for different rea-
sons 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.”
“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.

2.8.9 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..?.

2.8.10 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.”

2.8.11 “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”

2.8.12 “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 my-
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

2.9.1 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.

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

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

2.9.4 Interviewee: We have.

2.9.5 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 comput-
er, 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.

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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.

2.10.13 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.”

2.10.14 “All I could say 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.”

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

2.10.16 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.”

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

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

2.10.19 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?”
“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.”

“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 presenta-
tion 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 ed-
ucational context for International Medical Graduates. Our multi-
disciplinary team have researched and developed programmes (often in-
tuitively) in a microenvironment where we have been able to adapt quick-
ly and resiliently to the changing nature of the workplace and the interna-
tionally 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 foresee-
able 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


Information Sheet for REACHE Evaluation

June 2011

Dear Reache Graduate

Reache North West is seeking to evaluate itself by asking members who have returned to work about their experiences whilst training and studying with the support of Reache. This would then lead to the creation of a report, which we can show to our current funding and supporting organisations.

The result of this evaluation will help to promote our work and help us to apply for future funding to continue providing support to Refugee Health Professionals. This report will also give our tutors valuable insight into the content of our training courses and help us to adapt them for the future.

The data from this report will provide further information on some areas previously evaluated allowing us to compare some of our processes and will give us the opportunity to inform others about our experiences in teaching and training refugee doctors.

The information from this evaluation will also be used in a PhD thesis, which will be published and a copy kept in the British Library and the awarding institution.

If any further information is required or you would like to see a copy of the evaluation when it is finished please email Duncan at reache@manchester.ac.uk

Regards

Duncan Cross
Consent Form
Reache North West Evaluation 2011
Duncan Cross, Tutor, reache@manchester.ac.uk

Please Read the following questions and tick either yes or no

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.

3. I agree to take part in the above study.

4. I agree to the interview being audio recorded

5. I agree to the use of anonymised quotes in publications

6. I agree that my data gathered in this study may be stored (after it has been anonymised) in a specialist data centre and may be used for future research.

Name of participant ___________________________

Signature ___________________________ Date __________

Name of researcher __________________________

Signature ___________________________ Date __________
APPENDIX A2
Semi-Structured Interview Questions

Name

Nationality

When did you enter UK?

Status on entering UK e.g. asylum seeker, refugee

When did status change?

From entering UK how long till you got back into practise?

How long to get IELTS?

How long for PLAB 1 and 2?

How long for registration? Was it full or provisional?

Did you undertake a clinical attachment/caps – where when/how long? what did you learn? Was it useful?

From registration how long till you undertook 1st paid post?

What kind of post was it? F1/ST/locum etc

How long have you been practising in the UK?

How many posts have you had?

Why did you leave? (each post)

What difference do you think being a member of Reache made;

To your life?

To your return to your profession?

At what point did you contact Reache and gain membership?

Why did you contact Reache?

Who told you about Reache?

Were you with Reache for the whole process of re-qualifying?
What classes did you undertake with Reache?

Did you undertake any of the weekend Reache courses if so which?

Can you remember what you thought of your courses when you were taking them? Did you think they would be useful etc

Once you started work did you think those courses were useful or did you think that you needed other information/training

Did you have any difficulty attending Reache classes? Why?

Do you think the communication skills courses were useful – when you did them?

Once you started work?

Now you are more established in your career?

Now that you have been working for some time what do you think we could change or make better in our training courses.

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

What could we have done?

Have you faced any difficulties in your job that Reache training helped you with?

Have you faced any difficulties in work that could have been helped by training from reache?

What has been the most difficult challenge you have faced?
Did you have a support network when you were going through the process?

Do you think a support network would have helped you?

Since leaving Reache what have you done to address difficult situations or gaps in your knowledge?

Is there anything else you’d like to say about Reache or your journey?
WEB PAPER

Improving written and verbal communication skills for international medical graduates: A linguistic and medical approach

DUNCAN CROSS & ANN SMALLRIDGE
Reahe North West, UK

Abstract

Background: Adapting to UK communication styles can be difficult for International Medical Graduates (IMGs). Reahe Northwest provides education, training and support for internationally trained refugee and asylum seeking health professionals who are looking to return to work in the UK.

Aims: A safe and Effective Communication Skills course was designed by a team of language teachers and clinicians to provide IMGs with an understanding of the written, verbal and summarisation skills required in the UK work environment.

Methods: A series of language exercises adapted to clinical situations was developed. These increased in complexity to the practical application of language skills in clinical settings using simulated patients. The combination of language and clinical tutors meant that feedback could be given from a language teacher’s perspective, the clinical perspective and the cultural context.

Results: The combination of language and clinical tutors meant that analysis of communication difficulties could be made from different perspectives and detailed, specific feedback could be given to each student in these areas.

Conclusion: Using a combined linguistic and clinical approach can provide solutions to clinical communication problems that may otherwise be missed. This strategy could be extended to cover communication areas in other contexts.

Background and context

Reahe Northwest is a hospital based unit which provides education, training and support for internationally trained refugee and asylum seeking health professionals (RHPs) who are looking to return to work in the UK. Since the centre was established in 2003, over 120 doctors have entered work.

Over a third of the current National Health Service (NHS) medical workforce qualified overseas. NHS Employers conducted a workforce survey in May 2010 which showed that 40% of respondents had already undertaken, or were planning to carry out, some form of international recruitment (NHS Employers Website 2010).

The ‘Warwick report’ for the General Medical Council (GMC) summarised the difficulties that International Medical Graduates (IMGs) may have in adapting to the NHS – those who qualified outside the UK may be from countries with very different medical practices in terms of the ethical framework, governance arrangements, cultural expectations of patients and teams, technology and drugs. They may be used to different working arrangements on wards with no formal ward round structure, large differences in the leadership roles of nurses and more private practice with different responses to patient expectations. The report discusses several studies which identified effective communication as a challenge facing IMGs. These include straightforward language barriers but also more complex issues relating to picking up non-verbal cues, concerns about different cultural protocols and the lack of communication skills teaching in their country of qualification. They also documented the patchy provision of induction and language and cultural induction and training provided in the UK (Slawther et al. 2009).

GMC fitness to practise statistics showed that, in 2003-04, 44% of initial complaints involving IMGs were classified as serious and led to a full investigation compared to only 35% of referrals for UK graduates (GMC Annual Statistics 2009).

Over a number of years, Professor Allen examined the GMC fitness to practise procedures. She found that a higher proportion of referrals to the GMC from public bodies were
about IMGs, and that there were differences in the nature of the allegations made. It is acknowledged that the issues are complex but part of the problem was colleagues' inability to understand the cultural background of international doctors. It was felt that although they speak good English, maybe the way it is spoken or maybe the interpretation by the people they work with could be a problem (Allen 2005).

Reache students range from newly qualified doctors who have never practiced to those who have been senior professionals – consultants, professors – some running major public health or other programmes with international organisations for many years.

During our 8 years of experience in teaching RHPs, we have found differences from IMGs in learning needs and learning styles that may create barriers to learning. In general, RHPs have not chosen to come to the UK to establish their profession or enhance their career, they are here from necessity and usually have an expectation of returning to their home country ‘once things have died down’. RHPs may perceive necessities to proving competent in the UK system, e.g. International English Language Testing System and probation periods of employment as barriers and discrimination, whereas IMGs usually have an understanding of the requirements needed to practise in the UK, as they will have considered this before choosing to study or work in the UK, though this does not make the transition any easier.

Reache members tend to be used to formal didactic teaching styles in large lectures and questioning of teachers or discussion is not encouraged. This, coupled with the learning through books is the norm and often our students are not used to either giving or receiving feedback. In addition, RHPs often have had long career gaps – ranging from 1 year to sometimes over 10 years. This may cause lack of confidence as they may be out of date and they may also have mental health problems including Post Traumatic Stress Disorder. There may also be legal problems and many suffer from poverty, housing problems, family problems and social isolation.

Provision of specific Communication teaching for IMGs is patchy in the UK. Leeds University currently runs a project for international medical students in their undergraduate programme, giving them the opportunity to develop their communication skills at an earlier date. The London Deanery established the Language and Communications Resource Unit in 2010 to help trainees of all levels with communication and language difficulties. Experience suggests that trainees with communication difficulties are not being identified and supported in the early stages of their careers. Anecdotal evidence suggests that supervisors are aware of weaknesses but some are unwilling to document them or challenge trainees due to lack of ability to clearly describe the problem or fear of being seen as racist or bigoted. Sometimes, there is an expectation that experience in the role will fix the communication and cultural issues.

Identification of learning needs

Between 2005 and 2007, Reache ran a clinical apprenticeship programme for 17 doctors across four hospitals in Greater Manchester. This scheme allowed Refugee doctors with GMC registration to work as honorary house officers in supervised placements. Formal feedback was obtained from supervising consultants who identified specific weaknesses in some communication skills particularly written and verbal handover skills, history taking and summarisation skills and also explaining their findings and treatment plan to patients. As one of the consultants explained, ‘I think one of the problems is they don’t fully understand what the language suggests to them, as well as being able to translate it. It is one thing to speak the language and the other one is to actually understand what people say to you’. This was reinforced by informal feedback received from consultants providing clinical supervision on attachments and also from colleagues working with Reache members at later stages of their careers.

Our experience of running communication skills courses led to the use of interactive, experiential learning methods with individualised feedback, multiple attempts at skills rehearsal and the use of simulated patients trained in medical education for this course.

Methods

A Safe and Effective Communication Skills course was designed by a multi-disciplinary team of language teachers and clinicians, taking into account a variety of linguistic, cultural and clinical issues to give IMGs an introduction to the communication skills required in the UK work environment. The aim of the course was to improve written and verbal communication skills in a clinical context to a level appropriate for a foundation year 1 doctor.

The course included history taking, summarising, discharge summaries, presentation skills and a communication model (SBIART – Situation, Background, Assessment, Recommendation – Haig et al. 2006). The teaching was delivered through presentations, workshops and practice using linguists and healthcare professionals. All training was placed in a medical context using simulated patients and ‘mock’ records. A total of 20 participants took part on each course.

Session 1 – half day

This focussed on legible, accurate recording of what is said and accurate summarisation of written material. It consisted of a series of three exercises in speaking, listening and summarising using clinical scenarios done in pairs, to allow everyone to do each task and to experience different accents and pronunciation.

For each stage, a different 200-word clinical exposition was presented on screen, one student facing the screen (reader) and the other facing away (scribe).

Exercise 1: the reader had to dictate the expositions completely and the scribe had to write a word for word. Exercise 2: the reader had to summarise the material and give a verbal summary of the key points which had to be written down by the scribe.

Exercise 3: the reader had to make a verbal summary which had to be written as bullet points by the scribe.

The work was peer marked and feedback given from a linguistic and clinical perspective. This focussed on legible, c365
accurate recording of what is said, accurate summarisation of written material and developing the ability to tune out other people in room and concentrate on what is said.

Session 2 – half day
The aim of this session was to integrate the language skills into a clinical context and comprised

- A short presentation about what is expected from note taking in the UK covering content, structure, style and legibility.
- The students were shown two videos of medical encounters on a ward. For each encounter, the students wrote clinical notes as if they were the FY1 doctor. These were then peer marked against pre-prepared ‘correct’ summaries with feedback by tutors.
- A presentation on handover skills using the SBAR method (Haig et al 2006)
- A practical exercise in pairs – verbal handover of the patients they had written notes on, using the SBAR method, with tutor feedback.

Session 3 – full day
This session extended skills into a clinical context using Simulated Patients. Scenarios reflected situations where a patient had been on a ward with one condition but a new problem had arisen (e.g. admitted for appendectomy and developed symptoms of a chest infection). The student role was that they had been called to the ward to make an assessment of a new situation in a patient they had not met. The scenarios were kept medically very simple to allow the focus to be on communication.

The student was briefed verbally as if called by a nurse to a ward, read some pre-prepared notes about the patient, took the history, wrote notes, then handed over the patient verbally to a colleague.

The scenarios were kept short to allow multiple attempts with feedback.

Results
Immediate learner feedback on the course was positive with an overall rating of excellent. Anecdotal tutor feedback after the session was that skills improved during the course. The combination of language and clinical tutors meant that analysis of communication difficulties could be made from different perspectives and detailed, specific feedback could be given to each student in these areas.

In particular, the students initially did not ask for clarification of terms they did not understand or ask for information to be repeated if they did not hear clearly. Part of the teaching and feedback focused on how to avoid lack of clarity when dictating, adjustments to accents and tone of voice, rehearsal of appropriate ways in which one can ask for clarification and techniques for summarising more accurately (scanning, keyword, abbreviations).

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The language teacher analysed their performance linguistically – sometimes small adjustments to syntax, pronunciation and context improved the effectiveness of communication. For example, raised tones at the end of statements caused confusion as they sounded like questions and communicated a sense of hesitancy. The clinician analysed the clinical content and structure required both in the written notes and on verbal handover.

Both tutors addressed the cultural context – how to address a consultant when you wake him/her in the middle of the night to ask for advice, how to address a nurse who requests your attendance to see a patient.

Some activities were initially too complex for the learners, we found that multitasking in communication skills, i.e. listening to the history and preparing feedback to their colleagues at the same time was very difficult – these will be pared down to simpler tasks before being recombined in a future course.

We plan to survey students and their host consultants when they return to work to gain further feedback. This will inform the design of future courses.

Conclusion
The impact of culture (locally, nationally and internationally) on communication skills may be underestimated in training. Many of the learning needs are hidden. The course was developed using a combined linguistic and clinical approach can provide solutions to clinical communication problems that may otherwise be missed. This strategy could be extended to cover communication areas in other contexts.

Acknowledgments
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DUNCAN CROSS, BSc(Hons), PG Cert Cardiac Rehab, PGCE Cert TESOL, DTLS, is an English tutor for Reache and teacher trainer in Greater Manchester who examines for Cambridge University and also teaches and assesses for the London Deenary in the Language and Communications Resource Unit.

References


A combined linguistic and medical approach to improve written and verbal communication skills for International Medical Graduates (IMGs)

Duncan Cross and Ann Smallridge
Reache NorthWest, Salford Royal NHS Foundation Trust, Stott Lane, Salford, M6 8HD, UK

Background
REACHE (Refugee and Asylum Seekers Centre for Healthcare Professionals Education) NorthWest has provided education, training and support for internationally trained Refugee and Asylum seeking Health Professionals (RHPs) since 2002. We have found the challenges include straightforward language barriers but also more complex issues relating to picking up non-verbal cues and concerns about different cultural protocols.

Two videos of medical encounters in a ward were shown. For each encounter the students wrote clinical notes. These were then peer-marked against pre-prepared "correct" summaries with feedback by tutors.

Students were taught the SMB method (Stephanie T Whitton) for handover and as a practical exercise verbal handover using summaries prepared in the previous session were done in pairs with tutor feedback.

A three stage verbal to written communication exercise was undertaken to ensure clinical information could be recorded verbatim and also summarised succinctly in bullet points. Feedback was given focusing on linguistic skills (e.g. pace, pronunciation, spelling) as well as accuracy, legible recording.

Pre-taught skills were consolidated and applied practically in a hospital skills lab using simulated patients. Feedback was given by linguistic and clinical assessors.

Summary
Language teachers and clinicians ran a course for IMGs to improve written and verbal communication skills in a clinical context to a level appropriate for a Foundation Year 1 doctor. It included history taking, summarising and presentation skills. All training was placed in a medical context using simulated patients and 'mock' records.

Communication difficulty can take many forms - language, clinical and cultural. Many of the starting points can be hidden. Using a combined linguistic and clinical approach can provide solutions to clinical communication problems that individual approaches may miss.

Take-home message
Teaching should be practical with multiple opportunities to practice skills in a variety of settings.
Examples of Issues:
Rising tones at ends of sentences suggested constant questioning
Not seeking clarification of terms e.g. “funny turn” or even pronunciation/accent of a word they did not understand
Cultural issues - addressing nursing staff, waking a consultant at 4am

Communication difficulty can take many forms - language, clinical and cultural. Many of the learning needs are hidden. Using a combined linguistic and clinical approach can provide solutions to clinical communication problems that individual approaches may miss.

The combination of language and clinical tutors meant that analysis of communication difficulties could be made from different perspectives and detailed, specific feedback could be given to each student. Sometimes small adjustments to syntax pronunciation and context improved the effectiveness of communication.

Two videos of medical encounters on a ward were shown. For each encounter the students wrote clinical notes. These were then peer marked against prepared “correct” summaries with feedback by tutors.

Students were taught the SBAR method (Hand, Keep, Summarise) for handover and as a practical exercise verbal handover using summaries prepared in the previous session were done in pairs with tutor feedback.

A three stage verbal-to-written summarisation exercise was undertaken to ensure clinical information could be recorded verbatim and also summarised accurately in bullet points. Feedback was given focusing on linguistic skills (e.g. pace, pronunciation, spelling) as well as accurate, legible recording.

Pre-taught skills were consolidated and applied practically in a hospital skills lab using simulated patients. Feedback was given by linguistic and clinical assessors.
This is to certify that

Duncan Cross

Was presented
Best poster- Education

‘A combined linguistic and medical approach to improve written and verbal communication skills for international medical graduates’

at
Royal College of General Practitioners UK
Annual National Primary Care Conference 2011

Diversity in Practice

On 20th-22nd October 2011

at
Arena Convention Centre
Liverpool, England

Authorised by

Dr Clare Gerada MBE FRCP FRCGP MRCPsych
Conference Chair, RCGP
APPENDIX D
Salford Communication and Language Assessment Resource (SCoLAR)
Safe Communication Skills for International Doctors

Duncan Cross, Ann Smallridge, Mick Sykes and Maeve Keaney
Reache North West, Salford Royal NHS Foundation Trust, Stott Lane, Salford, M6 8HD, UK

Summary
Problems with international clinicians’ language and communication skills have been highlighted in the media recently. More attention is now given to preventing errors by staff new to NHS practice. Salford Communication and Language Assessment Resource (SCoLAR) supports clinical staff and helps them improve their communication skills. Assessments are performed in full OSCE settings. They are observed by both linguists and clinicians to identify specific needs. This is supplemented with further training. This resource has been used for the assessment and training of clinicians in specialty training in the Midlands and North West.

Background
Reache North West provides education and training for International Medical Graduates (IMGs) who hold refugee status or who are currently going through the asylum process. Reache has used its experience to establish the Salford Communication and Language Assessment Resource (SCoLAR) to offer support to non-refugee IMGs (including those from the European Union). With increasing concerns over language and communication skills affecting patient safety (Pilottos et al., 2007; Independent, 2010; the 2010 Health Select Committee calling for language testing for European doctors, and the Health Secretary (2012) calling for a legal duty in care in respect of language ability, SCoLAR offers the appropriate advice and support.

SCoLAR uses a multidisciplinary team of linguists and clinicians to observe, assess and feedback on language and communication skills in clinical scenarios to ensure that training and non-training doctors have appropriate support and advice available. A safe structured environment is created by the skilled and experienced tutors to enable feedback to be as direct, safe and to ensure that there are no misunderstandings.

Observed Structured Clinical Examination (OSCE) scenarios are used for assessment and training, integrating the simulated patient (actor) feedback. This gives the doctors the added dimension of an assessment of patient satisfaction with the clinical encounter. Alongside the OSCE style scenario the multi-disciplinary team deconstruct the clinical encounters into linguistic and communication features.

Further Training is available to ensure written communication is accurate and safe. Linguistic skills such as dictation and summarisation are taken out of the clinical context and practised independently before being integrated and consolidated into a clinical scenario (Cross and Smallridge, 2011).

Feedback from participants has been positive:

- Excellent opportunity to practice and get feedback.
- Every possible opportunity was taken to give feedback and also facilitation to reflect.
- Very supportive in correcting the language and suggesting alternative appropriately.
- Good feedback - honest and safe.
- Excellent small group and individual feedback.
- Course was helpful, informative and enjoyable.
- Trainers very supportive.
- Excellent day - could take so much from it.
- Once a month please.

Corresponding Author
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Summary
Problems with International clinicians’ language and communication skills have been highlighted in the media recently. More attention is now given to preventing errors by staff new to NHS practice. Salford Communication and Language Assessment Resource (SCoLaR) supports clinical staff and helps them improve their communication skills. Assessments are performed in full OSCE settings. These are observed by both linguists and clinicians to identify specific needs. This is supplemented with further training. This resource has been used for the assessment and training of clinicians in specialty training in the Midlands and North West.

Background
Reache North West provides education and training for International Medical Graduates (IMGs) who hold refugee status or who are currently going through the asylum process. Reache has used its experience to establish the Salford Communication and Language Assessment Resource (SCoLaR) to offer support to non-refugee IMGs (including those from the European Union). With increasing concerns over language and communication skills affecting patient safety (Pilotto et al., 2007; Independent, 2010) the 2010 Health Select Committee calling for language testing for European doctors, and the Health Secretary (2012) calling for a legal duty of care in respect of language ability, SCoLaR offers the appropriate advice and support.

SCoLaR uses a multidisciplinary team of linguists and clinicians to observe, assess and feedback on language and communication skills in clinical scenarios to ensure that training and non-training doctors have appropriate support and advice available. A safe structured environment is created by the skilled and experienced tutors to enable feedback to be very direct, safe and to ensure that there are no misunderstandings.

Observed Structured Clinical Examination (OSCE) scenarios are used for assessment and training, integrating the simulated patient (actor) feedback. This gives the doctors the added dimension of an assessment of patient satisfaction with the clinical encounter. Alongside the OSCE style scenario the multi-disciplinary team deconstruct the clinical encounters into linguistic and communication features.

Further Training is available to ensure written communication is accurate and safe. Linguistic skills such as dictation and summarisation are taken out of the clinical context and practised independently before being integrated and consolidated into a clinical scenario (Cross and Smallridge, 2011).
Dear Duncan

I am emailing on behalf of the NHS Health Innovation and Education Cluster - Patient Safety Theme - in connection with your poster which was showcased at the 2012 Patient Safety Congress.

We have created a browsable patient safety resource area on the HIEC website (http://yhgiec.org.uk/themes/patient-safety/browse-case-studies/) - and we would like to include your poster as an example of innovation and best practice.

If you are happy for us to use your poster, please reply to this email with permission. If you have any queries or need further information, please get in touch.

We look forward to hearing from you.

Best wishes.

Yours sincerely

Beverley Slater
Innovation & Improvement Manager - HIEC Patient Safety Theme Assistant Director HI EC
Bradford Institute of Health Research
Re: Safe and effective Clinical Communication (SECC) - A skills training course for International Medical Graduates (IMGs)
Ref: COMET/185
Email: reache@manchester.ac.uk

Dear Mr. Duncan Cross,

First of all, we would like to thank you for submitting your proposal to the 10th COMET conference. We received a very ‘healthy’ volume of abstracts. The review committee consisted of 13 international scholars representing a wide range of expertise. Each proposal has been graded along the six published criteria.

We are pleased to inform you that your proposal has been accepted under the category Oral Paper Presentation. We are communicating this decision only to the first-named author, i.e. you. Please notify your co-authors of this acceptance. Please also ensure that as the first-named author you register for the conference by the date indicated below. At a later date we will get in touch to inform you of the exact time of your presentation.

Next steps:
- Please note that the first-named authors must register before May 25th 2012 at the latest. Failure to do so will mean that the presentation cannot be included in the final conference programme.
- Please notify us know via comet@hf.ntnu.no as soon as possible, and no later than April 2nd 2012, to confirm that you intend to present at COMET 2012. Please include your assigned reference number.
- For the early bird discount please register before April 30th 2012.
- Please note that there are discounts for members of the COMET Society. You can renew your membership and become a member by visiting http://www.equinotum.com/AM/user/purchaseSubscription?source=2FCAM%2FEuser%2Fpurchasestubscript {}ion%2Fmembership
- If you have not told us already, please inform us of any technical requirements (e.g. PowerPoint, audio- or video equipment).
- We will require your PowerPoint files to be with us a week before the conference. You will be able to upload your powerpoint file through a link that will be posted on the COMET homepage in March. More details will follow.

IF FOR ANY REASON YOU NEED TO WITHDRAW YOUR PRESENTATION, PLEASE LET US KNOW AS SOON AS POSSIBLE, SO THAT WE CAN INCLUDE ALTERNATIVES FROM THE RESERVE LIST.

In all future correspondence regarding your presentation please use the COMET reference number listed above. We look forward to welcoming you in Trondheim this June.

Very best wishes,

Gærl Thomassen
On behalf of the COMET Conference Committee
Safe and Effective Clinical Communication (SECC)
A skills training course for International Medical Graduates (IMGs)

Duncan Cross, Ann Smalldridge, Michael Sykes and Maeve Keaney (UK)
reache@manchester.ac.uk

Background

- Reache North West - Refugee and Asylum Seekers Centre for Healthcare Professionals Education established 2003
- Based at Salford Royal Foundation NHS Trust, England
- Funded by NHS NorthWest
- Work regionally and nationally to provide education, training and support
Our Results

135 Refugee Healthcare Professionals returned to their Professional Roles in the National Health Service (NHS)

Remediation for International Medical Graduates (IMGs) in post graduate medical training

Context in the UK

- The General Medical Council (2011) reported 239,084 registered doctors
- Of the total number of doctors 33% (78,898) identify themselves as having trained overseas
- Increasing awareness of language, communication difficulties and limited induction with IMGs
- IMGs are over-represented in complaint referrals to GMC

GMC 2011 – Freedom of Information Request
http://www.gmc-uk.org/publications/concerns_about_a_doctor_publications.asp#AnnualStatistics
Why we created the course

Observations from 9 years work with IMGs

Feedback from Consultant supervisors (Clinical Attachments, Clinical Apprenticeship Scheme and Employment)


Supporting Evidence

- UK - Warwick Report¹, Illing et al²
- International - e.g. Pilotto et al³

- IMGs have problems with:
  - question formation
  - colloquial language
  - appropriate word choice (to express empathy or give explanations to patients)

Aim

- To learn Safe and Effective Clinical Communication skills

Methods

- Deconstructing language skills
- Consolidating clinical and linguistic skills
- Using skills SAFELY in simulated clinical practice
- 3 P model of teaching (Prepare, Practice, Produce)
Deconstructing Language

- Communication scenario is analysed for its linguistic composition
- Broken down into tasks and then linguistic elements of productive (writing, speaking) and receptive skills (reading, listening)
- Individual tasks practised/taught in a non-clinical context to ensure understanding

Multi-Disciplinary Approach

- Linguists
- Doctors
- Nurses
- Experienced simulated patients
Safe and Effective Clinical Communication Skills

Prepare and Practice
• Day 1 - History Taking
• Day 2 - Summarisation
• Day 3 - Handover Model - SBAR (Situation, Background, Assessment and Recommendation) and Telephone skills
• Day 4 - Team working
• Day 5 - Ward Round

Produce
• Course needs to run over a short period of time (2-3 weeks)

History Taking

Prepare
• Discussion of what makes a good history in UK (Ideas, Concerns and Expectations (ICE), Patient Centred)

• Active listening exercise

• Demonstrations of good history taking in stages

• Importance of good history - patient safety/complaints/medico-legal

Practice
• Multiple opportunities to practice with actors and clinicians to gain appropriate feedback
Summarisation

Prepare
• 2 Exercises through different stages
• Language focus e.g. holiday brochure
• Clinical context (x-ray report) with a 3 stage dictation
  • Verbatim
  • Reader summarises – Writer Verbatim
  • Both Summarise

Practice
• Clinical Scenarios
  • 3 stages with decreasing time minutes for written summary and then verbally communicate to another student

Situation Background

Assessment Recommendation (SBAR)

Prepare
Reache whispers

Types of communication (written/verbal) and their benefits

SBAR

Practice
Script creation from clinical notes (using summarisation skills from previous day) in an SBAR format

Telephone Skills

Prepare
Good features of telephone skills

Using scripts in an SBAR format from earlier session. Students give information to a tutor with other students observing and feeding back.

Practice
Multiple opportunities to practice with corrections as necessary (purposely scheduled all groups in 1 room to emulate a busy work environment)

Team Working

Prepare
Comparison of different care systems - identify all staff involved in the diagnosis, care and management of a patient with Diabetes (initially only identified role of Dr/nurse then identified 40 professional roles)

Team/Group Dynamics

Practice
Build the tallest freestanding tower out of newspaper and sticky tape that doesn’t collapse or fall down – Reflection on own role in the group and the effectiveness of the team

http://www.belbin.com/ins.asp?id=396
Practical Application of Skills

Hospital skills labs are used to create a ward environment

Consultants and simulated patients used to simulate an emergency admission ward round

Students take histories, and present to a consultant

During day students also assess ill patients (sim-man) and then must call a Consultant giving them information using SBAR format.

After each scenario feedback is given by simulated patient, consultants and tutors

Additional communication sessions

Taught as separate days:

• Breaking bad news (Simulated patients)
• Complaints (Simulated patients)
• Interview skills (Mock panels)
• Presentation skills
Evaluation

From:
Observation (tutors and external specialists)

Questionnaire and Semi-structured interviews (participants now working)

Feedback

'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'

"Reache actually train you for like swimming. They teach you all the skills you need for the time that you need to swim, so that you are able to swim."

"I mean without that (communication skills training), however we could never have worked. I mean yes later on at work you may learned it but, this is different to be really equipped with all this knowledge"
Success Factors

- Multi-disciplinary team (Must have a Linguist/Language teacher)
- Take apart linguistic and clinical aspects then re-integrate
- Based on experience and research
- Time intensive (but time well spent)
- Active learning
- As realistic as possible
- Effective feedback must be clear and direct (not subtle)

SECC

5 day clinical communication skills course run in a relatively short period of time (2-3 weeks)

Uses a Multi-disciplinary team of linguists, clinicians and simulated patients
Thank you for listening.

Any questions?

Reache Whispers

Pass on the message task –

You should take the 5 red pills in the morning, 2 white pills 3 times a day, the blue pill in the evening and the purple pill if you feel sick!
APPENDIX F
BUSINESS CASE

Project: SCoLAR

Salford Communication and Language Assessment Resource

Date: January 2012

Author: Duncan Cross

Owner: Reache North West

Contributors: Dr Ann Smalldridge, Dr Maeve Keaney, Margaret Car-ledge, Mick Sykes, Marilyn Morrison

Client:

Document Ref:

Version No: 8
1 Business Case History

Document Location

This document is only valid on the day it was printed.

The source of the document will be found on the Reache Shared drive in the ‘SCoLAR’ folder.

Revision History

Date of this revision:

Date of Next revision:

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Approvals

This document requires the following approvals.

Signed approval forms are filed in the Management/Specialist/Quality section of the project files.

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<td>Director Reache</td>
<td>18/10/11</td>
<td>1</td>
</tr>
<tr>
<td>Ann Smallridge</td>
<td>GP Tutor</td>
<td>19/10/11</td>
<td>2</td>
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<td>Maeve Keaney, Duncan Cross</td>
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<td>22/10/11</td>
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<tr>
<td>Maeve Keaney, Lars Isaaksen</td>
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<td>David Woods</td>
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<td>Stephen Kennedy</td>
<td>Finance Director</td>
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Executive Summary

Reache North West is an education and training centre for refugee and asylum seeking healthcare professionals who are qualified and registered overseas. Reache staff have experience in assessing and providing support and training for healthcare professionals who have had career gaps and also those who are in need of remediation.

There is a growing national recognition of the need for increased language and communications skills assessment and training for EU doctors and Non EU doctors trained both in the UK and overseas. Reache aims to utilise its experience in this niche market.

Reache can offer a variety of programmes both at Salford Royal NHS Foundation Trust (SRFT) and at external locations. Currently, in the first year of operation, we believe that 12 assessment days would be possible without affecting Reache’s current service, which would offer assessments for 96 doctors at SRFT. We could also offer 1 induction course for overseas doctors, 4 remediation training days and a ‘train the trainer’ course. The table indicates the profit for each.

<table>
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<th>Profit (£)</th>
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<td>12 Assessment Days at SRFT</td>
<td>26940</td>
</tr>
<tr>
<td>Induction Course at SRFT</td>
<td>13410</td>
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<tr>
<td>4 Remediation Training Days at SRFT</td>
<td>27680</td>
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<tr>
<td>Train the Trainers Course at SRFT</td>
<td>3840</td>
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<tr>
<td>Total</td>
<td>71870</td>
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At present, we expect the following timeline for implementation with our first assessment day for East Midlands Deanery taking place the last weekend of November 2011. East Midlands Deanery expects to commission more of these courses as they have currently identified 50 doctors whom they believe would benefit from our assessment.
Business Case

4 Purpose

4.1 To propose the creation and development of a Language and Communication Development unit managed by Reach Northwest and supported by Salford Royal NHS Foundation Trust

4.2 To develop a financial strategy for the unit’s services

5 Reasons

5.1 There is national recognition of the need for language and communication skills assessment and training for international (including EU) health care professionals, particularly medical graduates, who are new to the NHS. UK graduates may also need support in this area. Reache North West, based in SRFT, has 8 years experience providing training for Refugee Health Professionals (RHPs) to help them work safely and effectively in the NHS.
5.2 Since the inception of the NHS in 1948, there has been reliance on overseas healthcare professionals. The 1970s Royal Commission on the NHS reported that an estimated 20,000 doctors registered in the UK were born overseas. 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 reporting the NHS workforce census in 2010 found that 31.5% of doctors working in the NHS obtained a primary medical qualification outside the UK. 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%. Of 239,084 doctors, 59,727 are GPs with the remaining 179,357 being split across the other specialties. The Nursing and Midwifery Council (NMC, 2004) reported a steady increase in the number of overseas nurses and midwives registering with the professional body. In May 2011 approximately 80,000 overseas nurses (including EEA and non EEA) were registered.

5.3 The recent GMC Report “The State of medical education and practice in the UK” (September 2011) has documented the difficulties faced by some overseas doctors in adapting to practice in the NHS and called for improved competency testing and induction by employers. Research shows that, doctors, whose primary medical qualification is from overseas, are more likely to fail UK post graduate examinations and be reported to regulatory bodies. The Health Select committee report, in 2010, called for language testing of all EU doctors to satisfy GMC requirements. The GMC responded by welcoming the recommendation and stating ‘that patient safety must take priority over the free movement of labour’.

5.4 Patient safety is impaired by language and communication difficulties both between the doctor and patient and between clinicians. The introduction of appraisal for medical practitioners, changes in the organisation of junior doctor training and changes in the organisational culture in the NHS have led to an increase in the number of health care practitioners who have themselves recognised difficulties or been found to have communication aspects of their performance in need of development or remediation.

5.5 We know that there can be difficulties identifying and defining performance problems by both educational supervisors and employers. Data is lacking on the numbers of health professionals who have difficulties. Managers, colleagues and supervisors often feel that there is something wrong with a doctor’s behaviour or communication but lack the ability to define the problem. There may be fears of appearing racist. When the doctor is from overseas, sometimes misunderstandings from communication problems are interpreted as a poor atti-
tude in the workplace. When help is requested by Trusts/Consultants, the problem is usually undefined. “I can’t understand her” “He can’t communicate”. Language is seen as the excuse, where there may be other communication issues

5.6 “The spectrum of performance problems is wide and can range from minor, momentary aberrations of behaviour, to major misdemeanours or persistent unprofessional behaviours or even acts of gross criminality. Periods of transition (changing jobs, moving regions, personal life events etc) can be associated with a deterioration of clinical performance, which may require additional vigilance and support. Fortunately, serious performance issues amongst trainees are rare. This infrequency, together with the trainer’s perceived lack of expertise and the increasing requirement for robust evidence, heightens anxiety and concerns amongst those who may have to deal with such matters when they do occur.” (National Association of Clinical Tutors, 2008. Managing trainees in Difficulty)

5.7 Reache North West currently employs a number of tutors with extensive experience in providing high quality education, including language and communication for IELTS (International English Language Testing System), clinical knowledge for PLAB (Professional and Linguistic Assessment Board). Reache also has experience in preparing professionals to work in the NHS by focusing on higher order skills and the skills needed to work safely and effectively in the NHS. These include courses on clinical governance, the ethical framework in the UK, team working and particularly a focus on safe and effective clinical communication - history taking, telephone skills, written and verbal summarisation and handover skills.

5.8 The Reache North West curriculum and provision of courses has adapted to meet the challenges of the changing landscape of the NHS and in response to feedback from doctors who have returned to practice and colleagues who have worked with our members. Reache has successfully run a series of national programmes for RHPs, funded by the Home Office and the European Commission, as well as running an ‘Effective Communication skills’ course for International Medical Graduates (IMGs) for the North West Deanery in September 2007.

5.9 Reache tutors have been collaborating with the London Deanery Language and Communications Resource Unit (LaCRU) and are currently trialling an assessment in partnership with East Midlands Deanery. LaCRU was set up in 2010 for a one year trial and operates assessment days alongside training courses and is available to all doctors covered by the London Deanery. LaCRU reported seeing 150 doctors in their first 10 months of operation and have now been made a permanent part of the performance unit as the London Deanery believes demand for the service will be high. East Midlands Deanery currently has 50 doctors, already identified as in need, whom they believe could benefit from
Given the experiences of these deaneries, we have no reason to believe that the numbers would not be comparable in the North West.

6 Options

6.1 Reache proposes to develop a language and communication assessment and training unit which can support not only overseas doctors but also those who have trained in the UK. Having looked at the LaCRU method of OSCE style scenarios as a basis to assess and offer development opportunities, we have re-structured their format to offer a more in depth investigation of potential language and communication skills issues.

6.2 The initial assessment will include two OSCE style scenarios, at least one of which will be observed by a linguist, a scenario to communicate with a colleague (this may be a senior or another grade of clinical staff) and a written exercise. We intend to video at least the first round of assessments to use them as a training and standardisation tool. This format may be restructured once the assessments are in place.

6.3 A report will be generated which will include:
- An overview of what was undertaken on the day
- Traffic light coding for language, and communication skills
- A brief summary of information pertaining to the doctor being assessed,
- Observations on the scenarios from the simulated patient, a linguist, a clinician and another communication specialist
- Feedback from the multidisciplinary team on the writing exercise
- Any recommendations for support on language and communication difficulties
- Course details with suggestions for local support

6.4 Courses/Workshops for attendees of the assessment day may include but are not limited to:
- History taking
- Summarisation
- Team work
- Assertiveness
- Communication pitfalls
- Cultural competence
- How language and culture affects communication
- Ethics
- Clinical Governance
- Patient centred care
- Consultation styles
• Questioning techniques

All of these courses will use a multi-disciplinary team to ensure that both language and communication skills are broken down for easier comprehension.

6.5 There are several strands, which could be undertaken in this project, all of which may include referrals from the following: self, educational/clinical supervisor, managers, HR staff, appraisers or interviewers.

**Option 1** - Assessing and training healthcare professionals employed at SRFT

**Option 2** - Assessing and training healthcare professionals not employed by SRFT, at SRFT

**Option 3** - Assessing and training healthcare professionals at external locations

**Option 4** - Training healthcare professionals employed and not employed by SRFT, at SRFT

**Option 5** - Training healthcare professionals at external locations

**Option 6** - Train the trainer courses at SRFT

**Option 7** - Train the trainer courses at external locations

**Option 8** - Induction to the NHS for International Health Professionals – a five day course covering a variety of topics including those mentioned in 5.4.

---

7 **Benefits Expected**

7.1 From the options described above in 5.5, we believe the following benefits apply to all options.

• Increased patient safety through safer clinical encounters
• Improved team working and communication
• Reduction of complaints
• Reduction of training failures/remediation costs
- Reduction HR time/costs dealing with problems
- Motivated and supported staff
- Earlier identification of problems and remediation
- Increased national reputation of SRFT/Reache as industry leaders
- Raises profile of Reache North West
- Positive media attention for intervention at SRFT

7.2 The following table identifies additional benefits and the option to which they apply

<table>
<thead>
<tr>
<th>Option</th>
<th>Benefit</th>
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<tbody>
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<td><strong>Option 1</strong> - Assessing and training healthcare professionals employed at SRFT</td>
<td>Requires least effort in organising staff at location</td>
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<tr>
<td><strong>Option 2</strong> - Assessing and training healthcare professionals not employed by SRFT at SRFT</td>
<td>Increased Partnership working with other organisations</td>
</tr>
<tr>
<td><strong>Option 4</strong> - Training healthcare professionals employed and not employed by SRFT at SRFT</td>
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<tr>
<td><strong>Option 6</strong> - Train the trainer courses at SRFT</td>
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</tr>
<tr>
<td><strong>Option 2</strong> - Assessing and training healthcare professionals not employed by SRFT at SRFT</td>
<td></td>
</tr>
<tr>
<td><strong>Option 3</strong> - Assessing and training healthcare professionals at external locations</td>
<td></td>
</tr>
<tr>
<td><strong>Option 4</strong> - Training healthcare professionals employed and not employed by SRFT at SRFT</td>
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<tr>
<td><strong>Option 5</strong> - Training healthcare professionals at external locations</td>
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<tr>
<td><strong>Option 6</strong> - Train the trainer courses at SRFT</td>
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<td><strong>Option 7</strong> - Train the trainer courses at external locations</td>
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<td>Risk</td>
<td>Probability</td>
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<tr>
<td>Dilution of Reach services to refugees</td>
<td>Medium</td>
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<tr>
<td>Reduction of goodwill from Reach volunteers</td>
<td>Low</td>
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<tr>
<td>Under/over pricing</td>
<td>Medium</td>
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<tr>
<td>Rooms not available in Trust during the week</td>
<td>high</td>
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8 Risks

**Option 1** Assessing and training healthcare professionals employed at SRFT
Meeting Room Manager – restrictions to be removed.

Publicity/Low uptake
- Medium
- High
- Good marketing strategy aimed at multiple levels.
- Testing of service

Cash Flow – Using Reache resources without sufficient income
- Medium
- High
- Temporary use of endowment fund.
- Needs to generate income and be self-sufficient

Staff availability
- High
- High
- More funding for Reache to ensure staff availability
- Staff training

Assessor and remedy – conflict of interest
- Medium
- Medium
- Gain credibility through customers e.g. East Midlands Deanery.

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<th>Risk</th>
<th>Probability</th>
<th>Impact</th>
<th>Mitigation</th>
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</thead>
<tbody>
<tr>
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<td>Medium</td>
<td>Medium</td>
<td>Plan in advance for weekday sessions</td>
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<tr>
<td>Dilution of Reache services to refugees</td>
<td>Medium</td>
<td>Medium</td>
<td>Appropriate staffing</td>
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<tr>
<td>Reduction of goodwill from Reache volunteers</td>
<td>Low</td>
<td>Medium</td>
<td>Ensure they are paid if appropriate</td>
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<tr>
<td>Under/over pricing</td>
<td>Medium</td>
<td>Medium</td>
<td>Careful consideration of the current economic environment matched to services provided by professional tutors. Plan in advance for weekday</td>
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<tr>
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<td>High</td>
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<td>Medium</td>
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<td>Unwillingness of candidates to travel</td>
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<td>Market good transport links</td>
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<td>Staff availability</td>
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<td>Medium</td>
<td>Gain credibility through customers e.g. East Midlands Deanery</td>
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**Option 3** - Assessing and training healthcare professionals at external locations

**Option 5** - Training healthcare professionals at external locations

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<td>Market good transport links with extra payment for overnight stay High level of accommodation</td>
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<td>High</td>
<td>More funding for Reache to ensure staff availability</td>
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<td>Needs to be self funding</td>
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<td>High</td>
<td>Seek funding. Ensure full cost recovery for other regions</td>
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<td>------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Under/over pricing</td>
<td>Medium</td>
<td>Medium</td>
<td>Careful consideration of the current economic environment matched to services provided by professional tutors. Plan in advance for weekday Good marketing</td>
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<td>Clients not paying</td>
<td>Medium</td>
<td>High</td>
<td>SRFT Finance department support with SHA Workforce Development Leader supporting Reache</td>
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<tr>
<td>Assessor and remedy – conflict of interest</td>
<td>Medium</td>
<td>Medium</td>
<td>Gain credibility through customers e.g. East Midlands Deanery</td>
</tr>
</tbody>
</table>

**Option 6** - Train the trainer courses at SRFT

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability</th>
<th>Impact</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profit Margin</td>
<td>Medium</td>
<td>Medium</td>
<td>Plan in advance for weekday</td>
</tr>
<tr>
<td>Rooms not available in Trust during the week</td>
<td>high</td>
<td>High</td>
<td>Dates need to be organised months in advance. Meeting Room Manager – restrictions to be removed.</td>
</tr>
<tr>
<td>Unwillingness of candidates to travel</td>
<td>Medium</td>
<td>High</td>
<td>Market good transport links</td>
</tr>
<tr>
<td>Staff availability</td>
<td>High</td>
<td>High</td>
<td>More funding for Reache to ensure staff availability</td>
</tr>
<tr>
<td>Course may create competitor</td>
<td>High</td>
<td>High</td>
<td>Market hospital base to give more credence.</td>
</tr>
</tbody>
</table>
Option 7 - Train the trainer courses at external locations

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability</th>
<th>Impact</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profit Margin</td>
<td>Medium</td>
<td>Medium</td>
<td>Plan in advance for weekday</td>
</tr>
<tr>
<td>Reliance on external organisation for rooms and refreshment</td>
<td>High</td>
<td>High</td>
<td>Advanced planning</td>
</tr>
<tr>
<td>Staff availability and unwillingness to travel</td>
<td>High</td>
<td>High</td>
<td>More funding for reach to ensure staff availability and larger staff base</td>
</tr>
<tr>
<td>Course may create competitor</td>
<td>High</td>
<td>High</td>
<td>Market hospital base to give more credence.</td>
</tr>
<tr>
<td>Needs to be self funding</td>
<td>Medium</td>
<td>High</td>
<td>Seek funding. Ensure full cost recovery for other regions</td>
</tr>
</tbody>
</table>

Option 8 - Induction to the NHS for International Health Professionals at SRFT

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability</th>
<th>Impact</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profit Margin</td>
<td>Medium</td>
<td>Medium</td>
<td>Plan in advance for weekday</td>
</tr>
<tr>
<td>Rooms not available in</td>
<td>High</td>
<td>High</td>
<td>Dates need to be organised</td>
</tr>
<tr>
<td>Topic</td>
<td>Staff availability</td>
<td>Course may create competitor</td>
<td>Needs to be self funding</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------</td>
<td>--------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Trust during the week</td>
<td>High</td>
<td>High</td>
<td>More funding for Reache to ensure staff availability and larger staff base</td>
</tr>
<tr>
<td>Staff availability</td>
<td>High</td>
<td>High</td>
<td>Market hospital base to give more credence.</td>
</tr>
<tr>
<td>Course may create competitor</td>
<td>High</td>
<td>High</td>
<td>Seek funding.</td>
</tr>
<tr>
<td>Needs to be self funding</td>
<td>Medium</td>
<td>High</td>
<td>Ensure full cost recovery for other regions</td>
</tr>
</tbody>
</table>

- Trust during the week: meeting room manager restrictions to be removed.
- Staff availability: high availability and larger staff base.
- Course may create competitor: market hospital base to give more credence.
- Needs to be self funding: seek funding.
Cost

Negative figures are favourable

### Learning Needs Assessment at SRFT

<table>
<thead>
<tr>
<th>Resource</th>
<th>Total Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tutors</td>
<td>2839</td>
</tr>
<tr>
<td>Simulated Patients</td>
<td>852</td>
</tr>
<tr>
<td>Refreshments</td>
<td>319</td>
</tr>
<tr>
<td>Admin</td>
<td>369</td>
</tr>
<tr>
<td>Materials</td>
<td>88</td>
</tr>
<tr>
<td>Tutor to write 8 reports</td>
<td>710</td>
</tr>
<tr>
<td>On Call Tutor</td>
<td>142</td>
</tr>
<tr>
<td>Total Cost</td>
<td>5316</td>
</tr>
<tr>
<td>Income - Total assessment day for 8 participants</td>
<td>-5,600</td>
</tr>
<tr>
<td>30% Contribution to over-heads</td>
<td>-284</td>
</tr>
</tbody>
</table>

### Training Course at SRFT for 16 participants

<table>
<thead>
<tr>
<th>Resource</th>
<th>Total Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tutors</td>
<td>5036</td>
</tr>
<tr>
<td>Simulated Patients</td>
<td>1511</td>
</tr>
<tr>
<td>Refreshments</td>
<td>1511</td>
</tr>
<tr>
<td>Admin</td>
<td>655</td>
</tr>
<tr>
<td>Materials</td>
<td>252</td>
</tr>
<tr>
<td>Total Cost</td>
<td>8964</td>
</tr>
</tbody>
</table>
1 training day | -11200
---|---
30% Contribution to overheads | -2236

This course can be run for a minimum of 9 people

### Learning Need Assessment at External Location

<table>
<thead>
<tr>
<th>Resource</th>
<th>Total Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tutors</td>
<td>2550</td>
</tr>
<tr>
<td>Simulated Patients</td>
<td>332</td>
</tr>
<tr>
<td>Travel</td>
<td>1275</td>
</tr>
<tr>
<td>Admin</td>
<td>332</td>
</tr>
<tr>
<td>Materials</td>
<td>128</td>
</tr>
<tr>
<td>If overnight stay required</td>
<td>510</td>
</tr>
<tr>
<td><strong>Total Cost</strong></td>
<td><strong>5126</strong></td>
</tr>
</tbody>
</table>
| Income – Total assessment today for 8 participants | -5600

### 30% Contribution to overheads

-474

---

### Training Course at External Location

**for 16 participants**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Total Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tutors</td>
<td>4264</td>
</tr>
<tr>
<td>Simulated Patients</td>
<td>1109</td>
</tr>
<tr>
<td>Travel</td>
<td>2132</td>
</tr>
<tr>
<td>Resource</td>
<td>Total Cost (£)</td>
</tr>
<tr>
<td>-------------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Tutors</td>
<td>3701</td>
</tr>
<tr>
<td>Refreshments</td>
<td>1100</td>
</tr>
<tr>
<td>Admin</td>
<td>481</td>
</tr>
<tr>
<td>Materials</td>
<td>555</td>
</tr>
<tr>
<td>Total cost</td>
<td>5848</td>
</tr>
<tr>
<td>Income -1 training day</td>
<td>-7000</td>
</tr>
<tr>
<td>30% Contribution to overheads</td>
<td>-1152</td>
</tr>
</tbody>
</table>

**Train the Trainer at SRFT for 10 participants**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Total Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tutors</td>
<td>3701</td>
</tr>
<tr>
<td>Refreshments</td>
<td>1100</td>
</tr>
<tr>
<td>Admin</td>
<td>481</td>
</tr>
<tr>
<td>Materials</td>
<td>555</td>
</tr>
<tr>
<td>Total cost</td>
<td>5848</td>
</tr>
<tr>
<td>Income -1 training day</td>
<td>-7000</td>
</tr>
<tr>
<td>30% Contribution to overheads</td>
<td>-1152</td>
</tr>
</tbody>
</table>

**Induction Course at SRFT for 16 participants**

<table>
<thead>
<tr>
<th>Resource</th>
<th>Total Cost (£)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tutors</td>
<td>17517</td>
</tr>
<tr>
<td>Refreshments</td>
<td>255</td>
</tr>
<tr>
<td>Admin</td>
<td>1594</td>
</tr>
</tbody>
</table>
With one weekend assessment day a month, Reache could see 96 doctors a year without there being significant impact on Reache’s day to day functions. To increase the assessment days, increased financial support to Reache in the form of staff may be needed.

Courses would also impact on Reache’s services.

### 10 Timescales

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Trial</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pre-implementation</td>
<td></td>
<td></td>
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<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Implementation</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>East Midlands</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Implementation SRFT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10.1 Trial of 1 session of the assessment day takes place on Wednesday 19\textsuperscript{th} October using Reache Students
10.2 1st assessment day with East Midlands Deanery takes place 26th November 2011

10.3 Pre-implementation - Marketing material and strategy developed during November/December 2011

10.4 Launch to SRFT and GP network February/March 2012

11 Governance

11.1 Reache envisages managing the specialist unit, with support from the Trust potentially in the form of an operational liaison group. Reache also expects to be performance managed on the programme though the Reache Executive Steering Group.

11.2 In the management of candidates, Reache will require photograph identification. The following would be acceptable:

- Passport
- Travel Documents
- Driving Licence

12 Key Players

12.1 Dr Maeve Keaney - MB. Bch, BAO, F.R.C.Path, Dip in Medical Education.

Maeve is the Founder and Director of Reache North West, a Consultant Clinical Microbiologist and an Infection Control Doctor. Maeve has extensive experience in education, which includes working as Postgraduate Clinical tutor at SRFT from 1991-1996 and as Associate Postgraduate Dean for International Doctors for the North West Deanery from 1996-2001. Dr Keaney also wrote one of the first versions of the handbook for International Doctors which was used nationally.

12.2 Duncan Cross - BSc (Hons) Psychology with International Relations, PGCE TESOL, PGCert Cardiovascular Rehabilitation, MBPsS, MifL, QTLS, MCIEA.

Duncan is the Lead Language and Communication Skills Tutor at Reache North West. Duncan has over ten years experience in management, lan-
guage teaching and training, having worked in the UK and China. Duncan also works as an examiner for Cambridge University ESOL and as a language consultant for the London Deanery in the performance development unit and was one of the Lead tutors for their pilot *Induction Course for overseas doctors* in July 2011. Alongside his role at Reache Duncan mentors and assesses trainee teachers and trainee social workers and lectures on teacher training courses. Duncan recently had a paper published in the *Medical teacher* with Dr Ann Smallridge on *Improving written and verbal communication skills for international medical graduates: A linguistic and medical approach. This was also presented as a poster at the Association of Medical Educators Europe (AMEE) conference in Vienna 2011 and at the Royal College of General Practitioners’ (RCGP) conference in 2011. This poster won the best education poster prize at the RCGP conference.

12.3 **Reache North West Staff Experience;**
- Foundation Year Support and Teaching
- OSCE Examining
- Consultant assessment and remediation
- GP mentoring and training
- GP remediation
- Nurse education
- ESOL Teaching
- English for Specific and Academic Purpose Teaching
- English Language Examining
- International publishing
- Teacher Training
- Social Work Practice Teaching
- Reache has over 9 years experience in preparing Refugee Healthcare Professionals (mainly Doctors) to work in the NHS. This includes taking them from having no language skills up to being job ready.

*Reache North West*
*Salford Royal Foundation NHS Trust,*
*Stott Lane,*
*Salford*
M6 8HD
reache@manchester.ac.uk
Duncan Cross  
Lead Language and Communication Skills Tutor  
Reache Northwest  
Salford Royal Foundation NHS Trust  
Hope Hospital  
Stott Lane  
Salford  
M6 8HD  

11 January 2012  

Dear Duncan  

REACHE/SCOLAR LEARNING NEEDS ASSESSMENT  

This is to confirm that we commissioned the services of REACHE/SCOLAR to provide a Learning Needs Assessment for seven doctors in training who were experiencing communication difficulties. These difficulties were impacting upon their performance and, in some cases, their ability to pass exams.  

Significant negotiation took place to arrange these assessments and we found your staff to be approachable, enthusiastic and helpful during the process.  

Two of our staff attended the assessment day in Salford and reported that the process was well organised, thorough, well explained to the participants and the room layout was good. Our staff received a debrief on the day and this was extremely useful.  

The reports were received before the agreed deadline and have been well received. The reports were well structured and made areas for development clear to the trainee and the trainer. The ‘patient’ and assessor feedback was particularly useful, as this is not something trainees always directly receive.  

The reports highlighted areas for development and how these could be worked on, although a broader range of recommendations may have been useful.  

In summary, this was an effective model of assessment for our trainees which we would use again in the future.  

Yours sincerely  
Caroline McCarthy  
Head of Training Support
East Midlands Healthcare Workforce Deanery is a part of, and accountable to East Midlands Strategic Health Authority.

What I mean by a ‘broader range of recommendations’ is that we asked you not to mention your courses, so the recommendations were not as specific as they could have been. We realise this was at our request, but maybe in the future, it would be useful to indicate what type of training/courses would be useful in addition to reading resources and work with trainers.

Let me know if you need any further information.

Best wishes

Caroline

(please note my new office telephone number below and amend your records)

Caroline McCarthy
Head of Training Support – Training Support Service

Office: 0115 8474863
Mobile: 07738488565
caroline.mccarthy@nhs.net

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