

A successful initiative for getting refugee doctors back into medical employment: the PRIME project

Refugee doctors find it difficult to get back to medical work in their new countries. This article describes the setting up and evaluation of the Placing Refugee doctors In Medical Employment (PRIME) project which resulted in 15 out of 25 participants getting substantive jobs in open competition within a year, and suggests this approach should be more widely adopted.

Introduction

Refugee doctors are a potential addition to the medical workforce whose clinical skills should be valued (Department of Health, 2000). Unfortunately, many refugee doctors find it hard to return to practice in the countries where they have gained asylum and become a wasted resource (Berlin et al, 1997).

In the UK, several national and local initiatives have attempted to help refugee doctors gain medical employment and are listed on the NHS-led ROSE website (www.rose.nhs.uk). The Refugee Doctors Evaluation Network is evaluating most projects (Butler and Eversley, 2005). The stages faced by refugee doctors along the 'long and winding road' (Millar, 2001) of their career pathway back to medical employment have been summarized (Borman, 2004).

Various projects support these different stages and career advice and mentoring (Katembe and Prince, 2003) are provided by the Refugee Education and Training Advisory Service. Despite these efforts, the British Medical Association's UK database currently lists 1072 refugee doctors of whom only 77 are currently working in the NHS. An additional 220 refugee doctors have met all the requirements of the General Medical Council (GMC) and are eligible to apply for work, but have not so far been able to get a job.

Competition for training posts is currently intense and there is unemployment among both international medical graduates and UK graduates competing for senior house officer (SHO)-level jobs.

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Without help, refugee doctors find it difficult to get back to medical employment, especially in secondary care.

Around half of the refugee doctors on the British Medical Association database are living in London. The London Deanery has made special efforts to help, developing initiatives to prepare refugee doctors for work in both primary (Kiernan and Trafford, 2004) and secondary care (Ong et al, 2004).

A hospital-based scheme (Ong and Gayen, 2003) of attachments (observerships) proved successful in enabling 17 of the 29 refugee doctors participating in the scheme to compete successfully for medical jobs.

The scheme identified the need for more intensive and prolonged clinical exposure for the remaining unsuccessful doctors. For these doctors being an observer was insufficient experience, as it did not allow them to renew their clinical skills in hands-on situations and regain their confidence. Several had been out of medicine for many years and most had psychological symptoms as a result of traumatic experiences, which may have affected their confidence.

The PRIME project

The posts

The PRIME (Placing Refugee doctors In Medical Employment) project involved directly placing selected refugee doctors into 25 specially created and funded supernumerary SHO posts for 6 months. Because the posts were supernumerary, it was possible to ensure close supervision and graded responsibility. Supervising consultants were able to assess clinical skills and identify further training requirements without putting patients at risk. Funds did not stretch to paying for out of hours work, however, it was felt that it was safer for these doctors to work when most staff were around and supervision was available.

Project tutors

In order to ensure that the doctors formed a mutually supportive cohort, the posts were clustered within just three trusts, two acute and one mental health. In each trust a project tutor was appointed to provide educational and pastoral support. Two of the project tutors were consultants. The third was a non-medical postgraduate medical education manager. Funding of £17 000 was obtained from the Refugee Health Professionals Steering Group for remunerating project tutors for their time, and for start-up costs.

Selection of participants

These training opportunities were advertised as offering employment at the basic salary of an SHO, with no out of hours duty. Refugee status was an essential criterion. Thirty-two refugee doctors applied and were interviewed. Interviews included a discussion of vignettes of clinical problems designed to assess clinical knowledge and organizational skills. The highest ranked were offered a 6-month SHO placement in the specialty of their choice.

The seven unsuccessful doctors were given individual feedback about their performance and encouraged to continue with personal study and to undertake further clinical attachments. Of the 25 successful doctors, 16 were male and 9 female. Their mean age was 41 years. Twenty had been out of medical employment for up to 5 years and the remainder for 6–14 years. Nine of the refugee doctors were from Iraq, five from Iran, two from Kosovo, and the remaining nine were all from different countries.

Specialty choices

The refugee doctors' choice was based on their previous training in their home countries and their experience doing structured clinical attachments in the UK, where they

were exposed to at least two specialities and the career opportunities were discussed. The specialty choices of the successful applicants are shown in *Figure 1*.

Induction day

An important feature of the PRIME project was the induction day arranged for all participants about the workings of the NHS, clinical governance and multi-professional working. Topics were selected from items highly rated by international medical graduates during the evaluation of other induction programmes (Ong et al, 2002; Ong and McFadden, 2003). Twenty three doctors attended and all reported the day as useful. It gave them a chance to air anxieties about working after several years out of work and about working in a different health system.

Evaluation

At the end of the project, several meetings were arranged to capture the views of participants, consultants and project tutors about how the project had gone. In addition a confidential questionnaire was given to the participants, for analysis by the deanery.

Tutors' views

The postgraduate medical education manager felt that a non-medical person could carry out the project tutor's responsibilities only if there was strong support from consultants. In one instance, when difficult clinical issues arose between a supervising consultant and a refugee doctor, the tutor had to seek help from the deanery. Similar situations involving under-performing doctors in the other two trusts were handled directly by the consultant project tutors. The consultant project tutor in the acute trust found it difficult to meet with the doctors placed in specialities outside his department.

Supervising consultants' views

Most consultants felt that the project should have the flexibility to allow doctors who had demonstrated their competence a chance to participate in out of hours duties. This would aid their preparation for substantive jobs. It would also allow a fuller evaluation of the doctors' capabilities. Consultants would have liked additional support in handling those doctors who at the end of placements were not ready for

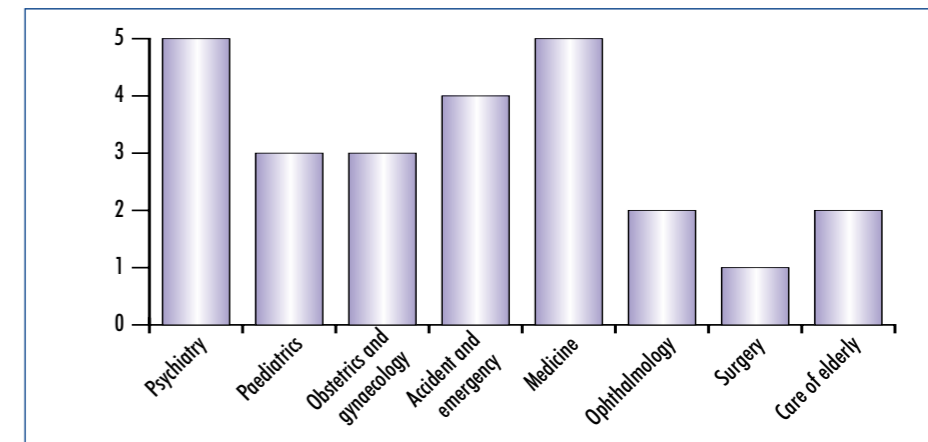


Figure 1. Participants' specialities.

substantive jobs and in some instances were thought to be unfit to practise.

The participants' views

The themes emerging from the group discussions and the confidential questionnaires were as follows:

- All participants agreed the placements had improved their confidence and knowledge
- All felt able to establish and maintain close working relationships and thus capitalize on networking opportunities and obtain local references
- Some felt a need for a 2-week observership at the beginning of placements, before taking on any responsibility
- Others reported a need for a clearer job description
- Many reported an improvement in their use of medical terminology and their communication skills
- Some felt the 'nine to five' work structure of placements allowed them flexibility and opportunities to continue applying for other jobs while others expressed a wish to work out of hours in order to be fully integrated into the NHS
- Except for the placements in psychiatry the other doctors had not met regularly as a cohort as planned and expressed a need to meet as a group at regular intervals
- A number felt that the term 'refugee doctors' should be removed from the project's title as it was seen to carry a negative stigma.

Outcome

Three months and 12 months after completion of their supernumerary placements all participating doctors were contacted

with regard to their current employment status. *Table 1* shows the outcome.

Those in substantive jobs were in specialties shown in *Table 2*. Analysis of personal data of the 15 doctors who successfully gained substantive posts compared with the 10 doctors that did not, showed no significant differences. There was no association between the number of years out of medicine and the success of getting a substantive post.

Discussion

This project attempted to help only those refugee doctors, the minority, who were 'job-ready' having already done all that was required to be eligible for GMC registration. They were all interested in furthering their training in secondary care. They were therefore a highly selected group of refugee doctors. They were, however, doctors whose previous attempts to return to work had been unsuccessful. They had all already undertaken at least one structured clinical attachment but had failed to find employment following it. Five had not worked as a doctor for over 5 years. So while the numbers in this project were small, the outcomes in terms of participants going on to get employment in open

Table 1. Refugee doctors in posts

Posts	Number of doctors	
	At 3 months	At 12 months
Substantive	11	15
Locum	11	5
Unemployed	2	4
On maternity leave	1	1
	25	25

Table 2. Specialities in which refugee doctors gained posts

Specialty	No of doctors	
	At 3 months	At 12 months
Accident and emergency	2	2
General practice vocational scheme	5	6
Medicine	1	2
Ophthalmology	1	1
Preregistration house officer	1	0
Psychiatry	1	2
Paediatrics	0	2
Total	11	15

competition were sufficiently positive to suggest this approach should be more widely explored. An unexpected outcome was that despite this project being designed for those with experience and interest in secondary care, a year later six had joined training schemes for general practice. Possibly they recognized that the specialty of first choice was an unrealistic or uncongenial career aim.

Conclusions

The PRIME project proved an effective intervention in enabling most of the participants to get back into medical employment, despite their previous failure, in some cases over many years, to do so.

However, the project was not cheap, and for it to become the standard way back to work for the majority of 'job ready' refugee doctors will require increased, secure and continued investment. The gains will be enabling this potential workforce to contribute to health care, contribute economically, and participate fully in the community that has offered them asylum and move 'from marginal aliens to established professionals' (Wendling, 1998). **BJHM**

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KEY POINTS

- The Placing Refugee Doctors in Medical Employment (PRIME) project offered training placements in secondary care to unemployed doctors with refugee status.
- The placements were for 6 months at senior house officer level, in the specialty of the successful applicant's choice.
- The 25 placements were distributed within three trusts, managed by three project tutors.
- Participants all felt they gained from the experience.
- Within 12 months, 15 out of 25 refugee doctors had gained substantive posts in open competition, six of whom were in general practice vocational training schemes.
- Success in gaining employment was not related to years out of medical employment.