Helping refugee doctors get their first jobs: the pan-London clinical attachment scheme

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Refugee doctors are a potentially valuable addition to the medical workforce in the UK. Despite this, they often have trouble getting jobs. An innovative structured clinical attachment scheme resulted in 17 out of 29 refugee doctors being appointed to jobs. Details of the scheme and the factors which may have influenced this outcome are discussed in this article.

INTRODUCTION

There are 848 refugee doctors living in the UK and registered on the British Medical Association's database. These doctors face a number of difficulties in trying to establish their medical careers in the UK, as well as feeling isolated and possibly traumatized by past events (Berlin et al, 1997; Elliot, 1998; Ezsias, 1998; Adams and Borman, 2000; Cheeroth et al, 2000; Rumani, 2001; Stewart, 2002).

Clinical attachments (unpaid observerships) have been recommended as an effective step to medical re-employment (Advisory Group on Medical and Dental Education Training and Staffing, 2000) and there is a general impression that they play an important role in preparing refugee doctors for employment (Cheeroth and Berlin, 2001; Berlin and Cheeroth, 2002). They usually consist of an individual sitting in with a consultant, joining ward rounds and attending educational meetings. The length, timing and learning opportunities vary greatly with each attachment.

The overseas office of London Deanery was regularly contacted by refugee doctors asking for such attachments to be set up, often for a second or third time, as they had not been able to move on to substantive employment. In order to make clinical attachments more effective, a new approach was developed, the major features of which were that the learning took place in groups, was under the supervision of a tutor, covered a defined curriculum, and involved exposure to more than one specialty and setting.

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SETTING UP THE SCHEME

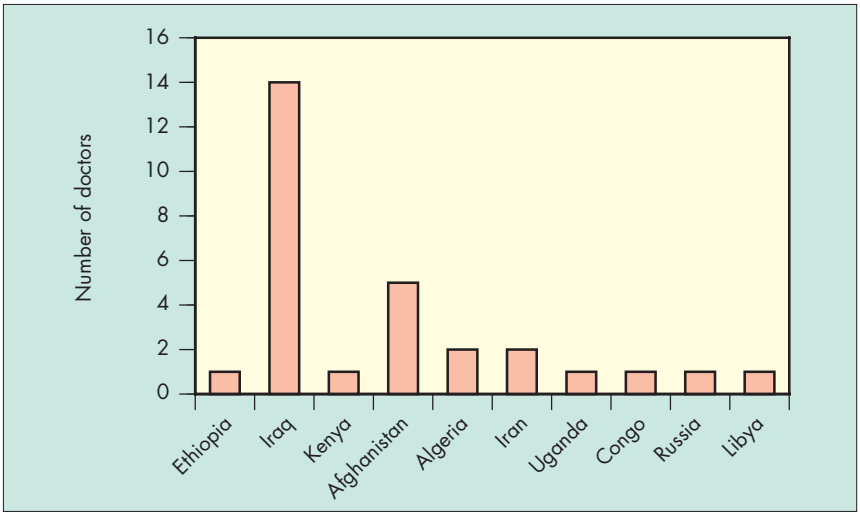
A steering committee was convened, composed of clinical tutors, associate postgraduate deans and a refugee doctor. Its task was to develop the structure

TABLE 1.
Core curriculum items

Routine clinical items	History-taking skills and physical examination (with consent when appropriate)
	Presentation of case
	Good prescribing practice
	Blood and infection control, interpretation of blood results, ECGs and X-rays
	Treatment decisions; doctor–patient partnership, autonomy and consent
Primary care experience	Sit in on surgeries
	Attend GP teaching events
ALS/ILS course	Dealt with centrally by the Deanery; however, trusts able to provide in-house training received the appropriate funding
Educational and personal skills	Clinical audit project or teaching on audit skills
	How to be a member of the multidisciplinary/ward team
	Dealing with difficult patients
	Managing death and bereavement

ALS = Advanced Life Support; ECG = electrocardiogram; ILS = Intermediate Life Support

Figure 1. Participants' country of origin.



and content of the scheme. The learning outcomes were agreed to be an understanding of working in the NHS and the clinical and personal skills required to obtain jobs in open competition.

Items for the core curriculum (*Table 1*) were drawn from experience of the members of the steering committee and from a model used for a pre-employment programme in Australia (Sullivan et al, 2002). The curriculum was validated informally by asking the views of a range of clinical tutors in different specialties. It was agreed to place doctors in cohorts of 5–6 doctors per hospital rather than the traditional individual attachments to provide group support for participating doctors and make best use of trainers' time. The scheme would last 3 months.

Eligibility for the scheme was limited to those refugee doctors who were 'job ready', i.e. having achieved or being exempt from Professional and Linguistic Assessments Board (PLAB) and International English Language Testing System (IELTS), as these doctors could move straight from the scheme into jobs. Doctors who had previously undertaken an old-style clinical attachment were not excluded as this scheme was felt to offer something different.

In order to identify individual factors that might impact on subsequent success in gaining jobs, additional information was collected at the initial interview. This included personal details, the number of attempts at passing IELTS and PLAB, support from family and organizations in the UK, and previous experience of a clinical attachment. Two optional self-rating questionnaires were also included in order to assess any psychological distress present which might affect their success in gaining employment. These were Beck's Depression Inventory (BDI) (Beck et al, 1961) and the Post Traumatic Stress Disorder Symptom (PTSD) scale (Foa et al, 1993; Dunmore et al, 1999). Ethical committee approval for using these instruments was obtained.

All acute hospitals in London were invited to participate by taking a cohort of 5–6 refugee doctors, and the first one in each of the five sectors of London to show interest was chosen. Each of these was then asked to appoint a refugee project tutor whose responsibility was to act as educational supervisor for their cohort and ensure the core curriculum would be delivered along with exposure to more than one specialty during the attachment.

RUNNING THE SCHEME

Invitations were sent out to those refugee doctors on the British Medical Association database who were known to have passed the requisite hurdles to be allowed to work as a registered medical practitioner in the UK. Each doctor who applied was interviewed by the associate dean and office manager of the deanery overseas office. At this interview doctors were given the choice of joining the scheme or of being placed in an old-style individual clinical attachment. They were also invited to complete the optional BDI and PTSD questionnaires.

Once the participants had been identified, an induction day was arranged for the entire group. This included talks on the structure of the NHS and its values; communication skills, including informal medical English; culturally sensitive ways of breaking bad news and curriculum vitae writing. The doctors then went to their separate hospitals for the next 3 months. Regular contact was kept between the tutors, refugee doctors and deanery team throughout the attachments, and advice and support offered where necessary.

At the end of the scheme, closure meetings were held for the doctors and their tutors during which an evaluation of the scheme was carried out. This involved discussion and questionnaire feedback from participants and tutors. The questionnaires were designed to rate the features of the scheme (on a scale of 1 to 5 with 5 being excellent) and offer plenty of opportunity for free text comments.

The scheme was funded through a grant of £49 500 from the Department of Health, which was mainly used to cover sessional payments to the tutors, and Advanced Life Support courses for the participants.

PROFILE OF PARTICIPANTS AND OUTCOME

A total of 37 doctors applied to join the scheme. All filled in the BDI and PTSD scale. One doctor requested an individual attachment which was arranged. Another five withdrew because they obtained locum posts through an agency, and one because he had obtained a pre-registration house officer post. The eighth doctor could not be contacted after interview. Of the 29 doctors who participated, 20 were male. The mean age of male doctors was 32.2 years and of female doctors was 36.5 years. Twenty-one had been out of medical employment for 2–4 years and the rest for 5–10 years. Their country of origin is shown in *Figure 1*.

Twenty six of the 29 doctors scored symptoms on the PTSD scale. Three scored above the cut-off score, placing them in the clinical threshold of suffering from post traumatic stress disorder. Only two doctors scored on the BDI and neither were in the clinical threshold. Nineteen had undertaken individual clinical attachments before this scheme. The length of attachment time ranging from 2 weeks to 3 months.

Three doctors dropped out of the scheme once it had started, one for marital and visa problems and one for financial reasons. The third could not be contacted, despite considerable effort, from shortly after the scheme started.

During the course of the scheme, two doctors obtained substantive jobs, two moved on to supernumerary placements and two were appointed as locums. Following completion of the scheme a further 11 doctors gained substantive jobs. A total of 17 out of the 29 participants had gained jobs in open competition by 8 months after the scheme had started. Two were preregistration house officers, one a trust grade doctor in medicine, and the rest were senior house officers in accident and emergency, obstetrics and gynaecology, psychiatry and medicine for the elderly. More than half of these had undertaken individual unstructured informal clinical attachments before this scheme and hitherto had been unsuccessful in gaining employment.

EVALUATION OF THE SCHEME BY TUTORS AND DOCTORS

The evaluation forms completed by the tutors and doctors and an analysis of the discussion during the closure meetings revealed both strengths and weaknesses in the scheme. All refugee doctors rated the scheme as a whole good to excellent with scores of 4 or 5. All agreed that the cohort concept worked well. They commented that it gave them a sense of support to be in a group, especially if they sensed a lack of interest from staff in a department. Regular meetings encouraged ongoing discussion of the difficulties they faced regarding employment and their status as refugee doctors.

Tutors felt that by teaching a group they were able to cover a greater range of topics and that the topics in the core curriculum were well chosen. The doctors found that having a tutor was more useful than having a mentor, which some had experienced previously. Tutors felt that at the end of the scheme they could write realistic references, based on feedback from consultants who participated in attachments and their own regular contact with their cohort.

Exposure to more than one specialty during the attachment was seen as useful by both tutors and participants. It gave refugee doctors a better understanding of the workings of the NHS and insight to the competitiveness of certain specialties. Three doctors felt a change of specialty was necessary as a result of this. The majority of refugee doctors (26 out of 29) reported the scheme increased their self-esteem.

The main problem encountered was the expectation of the refugee doctors that a substantive job should and would be found for them at the end of the attachment. This view was repeated by doctors at every meeting with the deanery team and to their tutors. Three tutors commented that they felt pressured by doctors' expectations. The deanery discouraged this view, continually reminding doctors that jobs in the UK are obtained in open competition.

RESULTS AND DISCUSSION

The authors looked for individual factors associated with success in getting a job, but were unable to identify any in this small group. Age, gender, years out of medicine and family support were not significantly associated with success. All doctors had received social and educational support from statutory and voluntary organizations in the UK while seeking asylum and establishing refugee status. There was a trend towards an inverse relationship between the number of attempts at passing the language test and getting a job but the small numbers involved meant no clear conclusion could be drawn. The number of attempts before passing the clinical test was no different in the group that were successful and those who were not. None of the three doctors exempt from the clinical test (PLAB) were successful in gaining a job. The three doctors at the clinical threshold of suffering from post traumatic stress disorder were all successful in obtaining posts.

From the evaluation forms and discussions at meetings it was possible to identify what the participants and tutors found useful. The cohort system, regular tutorials covering a curriculum, the ability to write and get realistic references, and an exposure to more than one specialty were clearly favoured. The majority reported the scheme increased their self esteem as refugee doctors. One doctor described the structure as giving 'fluency to medical learning'.

The outcome of 17 of the 29 doctors gaining medical employment in open competition in 8 months will be regarded as a good outcome by those experienced in working with refugee doctors. There is no standard against which to judge this outcome, as there are no similar studies available at present.

KEY POINTS

- A structured clinical attachment scheme for cohorts of refugee doctors has been developed.
- The scheme included induction, group learning, a curriculum, and a tutor with dedicated time and support who was able to provide an informed reference at the end.
- Over half of the doctors in the scheme gained posts in open competition.
- The majority reported that the scheme increased their self esteem.
- The scheme required funding but the outcome more than justified the cost.

CONCLUSION

This scheme is the first to provide structured clinical attachments to cohorts of doctors under the supervision of a tutor and covering a relevant core curriculum. It has been well received and is a possible useful step towards employment in the NHS. It required resources but the outcome of over half of the participants finding NHS employment during or soon after the course more than justified the expense. If such schemes become more widespread this may help shorten the 'long and winding road' (Millar, 2001) for refugee doctors getting back to medical employment. HM

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