

'... a stranger in a strange land':¹

The plight of refugee doctors in the UK

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Of the 17 million displaced persons worldwide, 12 million live in the world's poorest countries, many in camps in conditions of extreme poverty and deprivation.² The closure of state frontiers, the introduction of passports and the sheer volume of displaced people has eroded the right to asylum, which was considered an honour, and even the norm, in previous centuries. 'Intake reduction measures' aimed at asylum seekers made headline news in the recent UK General Election and illustrate how far we have slipped from that ideal. But per head of population, the UK is only eleventh in the European asylum seekers' league and admits less than half the number of asylum seekers admitted by Austria and Ireland; less than 2% of the world's refugees are in the UK.³ Some feel we have gone too far in restricting access to refugees and are in danger of developing a fortress mentality.⁴

Both physical and psychological diseases are common in refugee groups. Many come from countries riven by war and famine where the medical systems may have all but collapsed. Their plight may be worsened by confinement in detention centres, dispersal away from supportive communities, the very process of seeking asylum, and restricted access to healthcare.⁵ One in 10 has post-traumatic stress syndrome, one in 20, major depressive illness.⁶

Historic attitudes to refugee doctors

Among refugees coming to the UK are many qualified and experienced doctors and scientists. In the past they have enriched our health services and achieved positions of eminence.⁷ Their numbers include four Nobel Prize winners: Chain, Krebs, Katz and Perutz; and well known names such as Anna and Sigmund Freud, Michael Balint and Rodrigo Lopez (see Box 1). But it has never been easy for them and, in the past, the record of the medical profession's relations with refugees has not been to its credit. In 1933, the then President of the Royal College of Physicians (RCP), Lord Dawson, said to the Home Secretary 'the number [of refugee doctors] that could be usefully absorbed or teach us anything could be counted on the fingers of one hand'.⁸ In 1938, the leader of the Medical Practitioners Union (MPU) was quoted as saying 'British medicine has nothing

to gain from new blood and much to lose from foreign dilution',⁹ and after 1945 the MPU attempted unsuccessfully to have refugee doctors expelled.¹⁰ Objections to refugees practising as doctors may have centred on language and training methods. (Dawson, in his Cavendish Lectures said of doctors trained in Germany: 'We do not wish to imitate a system under which the patient is apt to be regarded as a piece of machinery, resulting too often in a callous disregard for the feelings of the sick'.¹¹) But professional jealousy may also have played a part. These sentiments, alien to us now but characteristic of their time, emphasise the importance of dealing positively with refugees and refugee health workers today.

The current situation

Much has improved for the 1,000 or more refugee doctors currently in the UK. The Department of Health (DH) has given £2 million over the past four years to support 30 refugee projects for health workers. In 2000, the report of the DH Working Group on Refugee Doctors and Dentists made a number of recommendations,¹² which included setting up a voluntary database for refugee doctors; making available more information for refugees; making clinical attachments free; and reducing General Medical Council (GMC) fees for the Professional and Linguistic Assessment Board's (PLAB) exam and for registration. Progress has been made against all these targets. The NHS-led ROSE website managed by the North East London Strategic Health Authority (www.rose.nhs.uk) has been established and is a valuable resource listing national and

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Box 1. Rodrigo Lopez.

In past times, one of the more famous immigrant refugee doctors was Rodrigo Lopez, a Jewish-Portuguese doctor driven from Portugal by the Inquisition at the beginning of Elizabeth I's reign. He became house physician at St Bartholomew's Hospital and rose to become personal physician to the Queen. Sadly, confession of involvement in a plot to poison the Queen (although almost certainly untrue) was forced from him and he was hung, drawn and quartered in 1594 before a jeering London crowd; an end which fortunately has not befallen any other King or Queen's physician to this day.

local initiatives and contact addresses. The British Medical Association (BMA) provides excellent advice and maintains a database of over 1,000 refugee doctors and issues a quarterly newsletter.¹³ The Jewish Council for Racial Equality (JCORE) guide for refugee doctors, in its fifth edition, provides an exemplary resource; it explains the workings of the NHS and gives organisational details, funding sources and lists of local initiatives including study clubs.¹⁴

Concern about whether enough, or even too much, was being done led to the setting up of the Refugee Doctors Evaluation Network which draws data from a number of programme providers for refugee doctors.¹⁵ Their report showed that of 740 refugee doctors from 62 countries known to be resident in London 21% were from Iraq, with significant numbers from Afghanistan (10%), Pakistan (7%) and Iran (5%). Of the 740 refugee doctors, 21% were working in the NHS, a figure higher than previously thought. However, those in employment had spent on average 69 months unemployed before obtaining their first post, five months in their home country, 45 months preparing for the International English Language Testing System (IELTS), and 19 months preparing for PLAB, Parts 1 and 2.

For those refugees with previous experience of medical specialties, or looking for a career in medicine, the recent report by Matthew Foster of the International Department of the RCP makes informative reading.¹⁶ The report is based on a questionnaire sent to 153 refugee doctors on the BMA database who had worked in medical specialties in their home country. It contains information for refugee doctors including contact details and website addresses. Acting on the results of the questionnaire, the College has published an advice handbook available on the College website¹⁷ and has negotiated free access to the RCP website, the library, the Jerwood Medical Education Resource Centre and concessionary fees for MRCP(UK) Part 1 for refugee doctors.

Disappointingly, the RCP report showed that, despite an average of four and a half years in the UK, only 15% of the doctors were practising medicine and 47% had not yet passed IELTS. The four and a half years of unemployment for this group and almost six years for those who were successful in obtaining posts in the London Evaluation Network survey must be a deeply demoralising and depressing time for doctors, many of whom are already traumatised by their experiences before coming to the UK. Can the profession help? Mentoring and the provision of clinical attachments are emphasised in the RCP report and in the JCORE and BMA reports. As pointed out in the RCP report, mentoring is beneficial to both parties. But many view clinical attachments as a drain on departments already struggling to accommodate medical students and foundation year doctors. However, clinical attachments do provide an opportunity to observe the skills of doctors and judge their suitability for locum or definitive posts and are the only way overseas doctors can obtain even the beginnings of a hands-on introduction to the NHS. For refugee doctors as well as non-refugee International Medical Graduates (IMGs), access to clinical attachments must be improved. Their provision is at present *ad hoc* and unfortunately likely to remain so despite their critical role in training a

Box 2. Examinations.

History has come full circle. It was the Conjoint Board exam that refugee doctors had to take in the 1930s before they could practise in this country, much to the alarm of Dawson who tried to force the Home and Scottish Offices to raise the admission requirements.⁹ Some refugee doctors were also able to sit a shorter exam for internationally qualified doctors in London and, in addition, medical colleges for refugees were established – a Polish one in Edinburgh and a Czech one in Bristol.⁸

third of the NHS's junior doctors.¹⁸ The College is in a unique position through its Regional Offices and Regional Advisers to encourage consultants and trusts to mentor overseas graduates and accept clinical attachments.

Even for those refugee doctors who pass IELTS and PLAB and succeed in obtaining a clinical attachment, there remains the substantial hurdle of obtaining a first post in the NHS. For the fortunate few, this will be a recognised training post but for many it will be a non-training 'trust post'. The difficulties arise because the number of refugee doctors is dwarfed by the number of non-refugee IMGs passing PLAB Part 2. In 2004, 6,392 passed PLAB Part 2, more than five times as many as in 2000 and more than the number of UK graduates passing MB. Unemployment amongst IMGs is high and competition for all UK posts intense, with more than 200 applications per advertisement for junior posts and many now attracting more than 1,000 applicants.¹⁸ The warning issued by the RCP and the Academy of Royal Colleges in February 2005 alerting IMGs to the high levels of competition and unemployment in the UK, whilst helpful to IMGs thinking of coming voluntarily to the UK, will have been of little use to those forced to come as refugees.¹⁹

When applying for junior posts, refugee doctors may be discriminated against because of longer periods spent unemployed and language difficulties; and many may not wish to return to demanding junior posts so long after qualifying (the average age of the RCP refugee cohort was 38 years, 10 years older than most non-refugee IMGs). The RCP report bravely but correctly points out that, for some, passing IELTS and PLAB and obtaining a training post in the UK may be an unattainable aim. This does not preclude employment in the health service in an alternative capacity and the ROSE website gives advice on other career paths for refugee doctors, ranging from physician's assistant to phlebotomist.

Is there a better way of integrating and assessing refugee doctors? The Queen Mary University of London Refugee Doctor Training Scheme assists integration by registering refugees as University of London students and so allowing access to libraries and social activities.²⁰ But, for the majority, studying for PLAB is an isolating and demoralising experience. There is no educational guidance before PLAB and the exam is designed to test minimal competencies rather than advance the education or integration of overseas doctors. The United Examining Board (UEB) exam (the successor to the Scottish triple, conjoint, and

Society of Apothecaries qualification) offers an alternative (see Box 2). Supported by a pioneering course at St George's Hospital Medical School in 1994,²¹ refugee doctors, after passing IELTS and a selection interview, enrol for a one- to two-year course alongside UK medical students. Integration takes place throughout the course and at course-end candidates take the final year assessments alongside UK MBBS students. Successful candidates are granted the primary medical qualifications of the constituent bodies of the UEB which allows them to apply directly for pre-registration posts. The course was discontinued in 2002 but is to restart this year in partnership with the Strategic Health Authority and South London Deanery.²² Eleven refugee doctors will enrol in June, expanding to 20 per year from 2006. Similar schemes from different universities could offer real hope for those refugees prepared to study for the UEB exam and start work at pre-registration level.

For some refugees, IELTS, PLAB or the UEB exam will be insurmountable hurdles. Mentoring could identify those who are unlikely to succeed in these exams and allow earlier discussion of career alternatives. For some, the stumbling block will be the intense competition for junior posts. Supernumerary positions may be the answer and the London Deanery is piloting such posts.²³ But unless some way can be found to increase the number of junior training posts or reduce the number of IMGs passing PLAB, competition will remain intense and become even more so from 2006 when the first UK doctors graduate from the new UK medical schools. There is no immediate solution. But the RCP report did show that contact and advice from practising physicians was the most important contribution we could make to help refugee doctors and this, at least, is achievable at local level, with central help from deans, colleges and the DH.

We look now with surprise at our predecessors' approach to refugee doctors 70 years ago. Our hope must be that history will judge us in a better light.

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