

Re-training refugee and other overseas doctors: re-qualification through the United Examining Board examination

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ABSTRACT – The Professional and Linguistic Assessments Board test is well suited to overseas doctors who have migrated for reasons of career development but less so for groups such as refugees who have not had time to prepare for migration and may not speak English. We describe a 12-month structured clinical course leading to re-qualification, for 70 refugee and other overseas doctors. Between 1996 and 2003, 69 of the 70 overseas doctors on the course (27 of whom were refugees) re-qualified through the examination of the United Examining Board. We report on early and later outcomes of these 69 doctors who, by achieving provisional registration, were entitled to pre-registration house officer posts. Of the 69, 33 are now principals in general practice or GPs in training; a further 32 are in NHS hospital posts. Opportunities for disadvantaged overseas doctors to re-train are severely lacking; yet in the UK there are significant numbers who warrant special help. A very modest investment of resources could help them re-qualify and contribute to the health and economy of the nation.

KEY WORDS: Professional and Linguistic Assessments Board (PLAB) test, refugee doctors, re-qualification, United Examining Board (UEB) examination

There are significant numbers of refugee doctors in the UK. They could make a useful contribution to the NHS workforce but on arrival none possesses a medical qualification that allows registration with the General Medical Council (GMC). As they are likely to remain in the UK, these doctors need a secure educational route to full registration.

The Professional and Linguistic Assessments Board (PLAB) test is designed to enable overseas doctors to demonstrate their competence to practise. If successful, the doctors can apply for limited registration once appointed to a suitable post. The PLAB test is appropriate for the majority of migrating doctors but for most refugee doctors we believe it to be less suitable.¹

In September 2005, there were 1,047 doctors (770 male, 277 female) on the British Medical Association (BMA)/Refugee Council Refugee Doctor database.² For the refugee doctor unable to pass PLAB, or find a place on a course leading to the United Examining Board (UEB) examination (the only non-university route to obtaining a primary medical qualification in the UK), there is only one other route to registration – enrolling for a full (4- or 5-year) undergraduate medical course.

In 1999, we reported on our course at St George's, University of London, for refugee and other overseas doctors, and published details on the first 18 enrollees.³ We now report on the experience of the 70 overseas doctors who studied on the course between 1995 and 2002. Twenty-seven of the 70 were refugees.

The United Examining Board course at St George's and the participants

Recruitment, selection and funding

Between 1994 and 2002, the UEB referred around 250 overseas-qualified UK-based doctors to St George's for assessment and interview. The selection process³ was designed to assess whether the doctors' English was adequate (sufficient for assessment of medical knowledge and attitude), and whether their knowledge of medicine was at least that of a final year student. Doctors were not accepted if it was felt that they were unlikely to pass the examination within 6–12 months. The International English Language Testing System (IELTS) test, using the level required by PLAB candidates as the standard, was used as a filter but where knowledge of English was inadequate for assessment of medical knowledge, we re-interviewed after 3–6 months. Priority was given to those whose departure from their country was a hurried necessity and not simply planned migration for professional reasons. Recruitment was restricted to doctors already in the UK. In the first year, we accepted six doctors; later the numbers rose to a maximum of 12 doctors a year. Three doctors offered a place declined it on grounds of cost.

The course fee was set at the clinical under-

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Table 1. Country of origin.

Geographical region	Refugee doctors		Non-refugee doctors	
	n	Country of origin	n	Country of origin
Middle East	10	Iraq 6, Iran 2, Afghanistan 1, Lebanon 1	18	Syria 8, Iran 4, Iraq 3, Egypt 1, Jordan 1, Palestine 1
Africa	10	Sudan 3, Uganda 2, Algeria 1, Congo 1, Ethiopia 1, Nigeria 1, Sierra Leone 1	6	Ghana 2, Algeria 1, Morocco 1, Nigeria 1, Sudan 1
Indian sub-continent	2	Sri Lanka 2	12	Bangladesh 5, Sri Lanka 4, India 2, Pakistan 1
Europe and Soviet Union	5	Bosnia 1, Bulgaria 1, Croatia 1, Former Yugoslavia 1, Ukraine 1	7	Poland 6, Lithuania 1
Total	27		43	

Table 2. Language of medical course.

	All		Refugees	
	n	%	n	%
English	37	52.9	15	55.6
Arabic*	9	12.9	0	0
Polish	6	8.6	0	0
Russian*	5	7.1	4	14.8
Farsi*	5	7.1	2	7.4
French	3	4.3	2	7.4
Serbo-Croat	3	4.3	3	11.1
Bulgarian*	1	1.4	1	3.7
Lithuanian	1	1.4	0	0
Total	70	100	27	100

*Languages with non-Roman script.

graduate level for overseas medical students (then £14,100), and had to be found by the doctors themselves. The fee rose annually to a maximum of £14,955 per annum; no doctor, whether on the course for a prolonged period or not, paid more than this figure in total. Some doctors were awarded grants by refugee groups or medical charities; other funds were in the form of loans, sometimes from a housing association or local council. The majority of the doctors were still in debt to the medical school when they passed the UEB examination, and several will continue their repayments for some years.

The doctors selected

The 70 individuals (32 men, 38 women) selected in total were from 27 countries (Table 1). The mean age was 31.5 years (range 22–50), with refugees mean age 33.16 (SD 4.76) years (males 33.8, females 32.6), and non-refugees 30.39 (SD 6.09) years (males 30.2, females 30.5). The age difference between the refugees and non-refugees was statistically significant ($p = 0.049$). One of the female refugees was a final year student, from Jaffna medical school (Sri

Key Points

At least 1,000 refugee doctors in the UK are not working as doctors

Refugee doctors, having migrated as an urgent necessity, have not had time to prepare for migration so have particular difficulty in achieving General Medical Council registration quickly

Problems of refugee doctors include lack of English language skills and the number of years out of clinical practice

An educational route to registration for these disadvantaged overseas doctors has proved successful

Lanka), whose studies had been interrupted repeatedly by civil disorder. The remaining 69 were medically qualified.

Of the 70 doctors, 37 (15 of the 27 refugees; 22 of the 43 non-refugees) had undertaken their medical course in English (Table 2). Of the 33 training in a language other than English, 20 had used non-Roman script. Four of the 27 refugees were already refugees on arrival in the UK, and a further 10 were originally asylum-seekers. The other 13 had arrived in the UK as visitors, students, or with leave to remain.

Break in career before and after migration

Many of those fleeing persecution and danger suffered personal and family upheaval and disruption, and before finding a country of refuge had been unable to practise medicine for some time. Refugees had often had to leave in a hurry when the opportunity arose, and their arrival in the UK had been followed by a significant period out of clinical practice. None had a degree that allowed automatic registration with the GMC, and many had inadequate English. There were often severe financial difficulties.

Figure 1 shows the length of break in career before starting our course. Doctors in the non-refugee group applied for our course for several reasons – some because they had failed the PLAB test, others because they valued the opportunity of taking

a course providing clinical experience; many had not taken PLAB. In all, 27 of the 70 doctors took the PLAB test – the majority while they were doing the course; 15 were successful (and so entitled to apply for senior house officer (SHO) posts), all but one of whom nevertheless decided to undertake pre-registration house officer (PRHO) posts once re-qualified. Three were ineligible for the PLAB test: two had not undertaken PRHO posts, and one was a final year medical student.

For 68 of the 69 doctors (final year student excluded) joining the course, the total time not practising was 269 years – 27 outside the UK, 242 in the UK (Fig 1). The average time not practising after arrival in the UK was 3.96 years, and was greater for the refugee doctors.

Course structure

The doctors were taught separately from the final year MBBS students. After introductory 5-week attachments in general

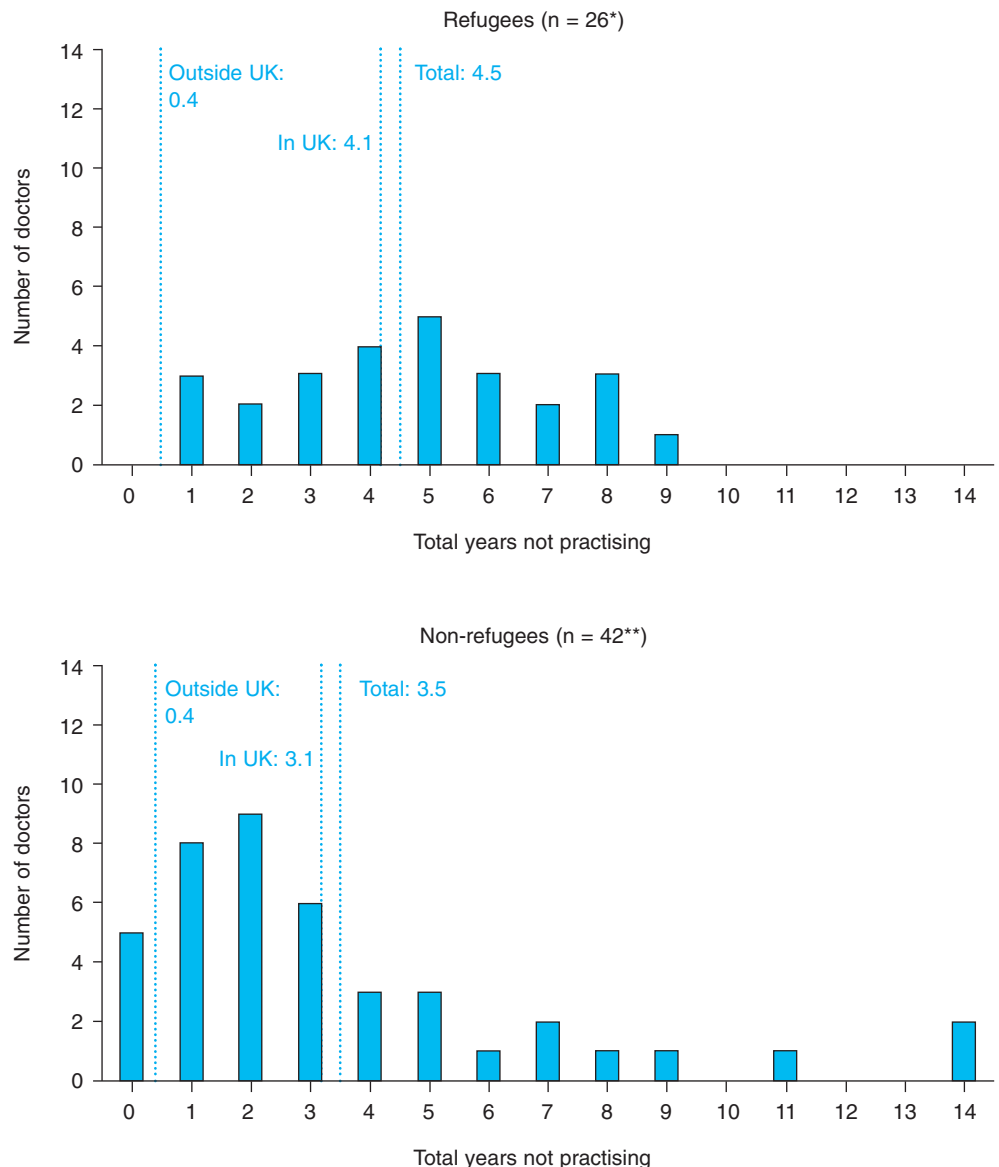
practice, obstetrics and gynaecology and medicine to acquaint the doctors with the NHS³, the eight subject areas were taught as follows: pathology and surgery, and paediatrics and psychiatry, as 2-month blocks; obstetrics and gynaecology, medicine and clinical pharmacology as weekly tutorials; public health as two blocks of eight tutorials. The doctors attended the weekly grand round and other relevant open educational activities.

‘Mock’ papers, orals and clinicals were offered 1–2 months before each UEB examination; passing these was a prerequisite to taking the examination itself.

The United Examining Board examination

The UEB process allowed four attempts at the examination. Fifty-one of the 70 passed first time (Table 3). The mean time taken to re-qualify was 9.6 months (range 1–32 months; refugees mean 9.4 months, non-refugees 9.8 months). Four possible predictors for early success (defined as passing within

Fig 1. Number of years since doctors last practised (at start of course). Years not practising (means): ‘Outside UK’ + ‘In UK’ = Total. *One refugee excluded as she was not entitled to practise (final year medical student). **No data on length of time not practising for the doctor who failed to re-qualify.



12 months of starting the course) were examined: age ($p = 0.58$), gender ($p = 0.62$), English as language of original medical course ($p = 0.54$), and total number of years out of clinical practice ($p = 0.85$). There were no statistical differences between the groups.

Pre-registration house officer posts

Sixty-eight of the 69 who re-qualified undertook PRHO posts. This was regarded by the course tutors and the doctors themselves as an important prerequisite to pursuing higher medical training in the UK, and explains why even those who passed the PLAB test during the course opted to do PRHO posts. Of the 15 who were successful in the PLAB test, the only one who chose not to do PRHO posts had had a career break of under 2 years.

Career progress

Contact was maintained with the doctors through the Medical School's Alumnus association, through their peers, or by obtaining their addresses from the GMC. We remained in contact with all 69 who passed, and have information from 2004 for all of them.

The doctors re-qualified between 1996 and 2003. They are, therefore, at different stages of their careers. Thirty-three are pursuing a career in general practice, and 11 are at specialist registrar level or above in hospital practice (Table 4). The career intentions of the 21 at PRHO and SHO level are not yet clear.

Discussion

These data are the first detailed follow-up information on a cohort of refugee doctors in the UK. Both the refugee and non-refugee groups have made good progress. Their performance seems little different from that expected of a group of MBBS graduates. It is clear that the refugee group do need a secure route to integration into the NHS, preferably in a UK medical school alongside home students, as in most cases early return to their country of origin is very unlikely. The 'non-refugees' were a disparate group but in many respects similar to the refugees. We believe that these doctors chose to apply for our course – despite the cost – because they realised that their clinical and other skills had suffered as a consequence of not practising. This gap in practice is clearly not good for the doctors' continuing medical education and runs counter to the principles of clinical governance for UK doctors in training. Such a fallow period away from medicine in a doctor working in the NHS would lead to significant loss of skills. For someone from a different culture and whose first language is not English, the difficulties must be much more daunting, and the potential for unacceptable clinical risk a real one.

Many overseas doctors are attracted to the UK by the educational and career opportunities available, and they are well served by the PLAB test. In 2004, for example, 6,392 overseas doctors passed PLAB, and became eligible to join the UK workforce.⁴ For refugees, on the other hand, migration has often been a hasty flight from oppression rather than a planned move for

educational reasons. As shown in this paper, there is likely to be a significant break in practice because of the sudden geographical dislocation and family/financial difficulties. Those trained in a language other than English will need to learn English and achieve the necessary IELTS score. The difficulties have been well described.⁵ The inevitable loss of clinical skills means that the PLAB test is unsuitable for many refugee doctors.¹ Among the 2004 applicants for the 5-year undergraduate medical course at St George's Hospital Medical School, there were two refugee doctors. The fact that there are individuals desperate enough to be prepared to contemplate repeating a full undergraduate medical course emphasises the need for an alternative to the PLAB test.

In recent years, there have been attempts to assess the numbers of refugee doctors in the UK. The BMA/Refugee Council Refugee Doctors database – set up in 2001 – has shown that the numbers are large, and that many are doing non-medical work, as taxi-drivers, managers of fast-food outlets, etc; others work in hospital settings as nurses, phlebotomists or other non-medical healthcare personnel, or as summarisers of case-notes for GP practices. Surprisingly, only 77 of the 1,047 doctors currently on the BMA/Refugee Council database are known to be employed as doctors in the NHS.²

Table 5 summarises the special characteristics of migrating refugee doctors. The fundamental distinction is whether or not the act of migration was a move for primarily educational reasons or a hasty necessity. Those who have had time to plan their

Table 3. Total number of attempts at the United Examining Board examination.

Attempts	All	Refugee group
1	51 (14)	21 (4)
2	13 (6)	5 (3)
3	3	1
4	3*	0
Total	70 (20)	27 (7)

Figures in brackets indicate doctors whose primary medical course used non-Roman script. *One doctor in this group failed to pass after four attempts.

Table 4. Career progress of total cohort.

Hospital practice		General practice		Career break
PRHO	1 (1)	SHO	7 (5)	1
SHO	20 (8)	Registrar	12 (3)	3** (1)
Specialist registrar	7 (2)			0
Staff grade	3 (1)			0
Consultant	1*	Principal	14 (7)	0
Total	32 (12)		33 (15)	4 (1)

*1 overseas, **2 overseas. Refugee totals in brackets. PRHO = pre-registration house officer; SHO = senior house officer.

move, despite the various difficulties encountered on arriving in the UK, will be much better able to prepare for the PLAB test and apply for posts; refugees are not usually in this category.

Special provision has been made to help refugee doctors pass the PLAB test but despite this there are clearly problems. Recognising that many were having difficulty in passing the test, the Department of Health invested £1 million to help these pre-PLAB doctors.⁶ The funding was used in the following areas: language skills, CV writing, exam technique, and clinical observerships or attachments, with a view to giving the doctors some experience of the NHS. Unfortunately, there are no data on outcome. The Department of Health report, *Integrating refugee health professionals into the NHS*, published in 2002, found that follow-up of refugee doctors can be difficult:⁶ doctors rarely kept in touch and did not identify themselves as refugees. As stated in the report, 'some refugees have had to flee authorities in their home countries so are understandably reluctant to keep in touch with authorities here'. It is not surprising, therefore, that despite providing funds for a variety of small-scale initiatives to assist refugee doctors, there are few Government data on outcome. However, available evidence suggests that success has been limited. Currently, 207 of the 1,047

on the BMA/Refugee Council database² have passed PLAB and are 'job ready', ie successful in PLAB – but unable to find a post.

These problems led the Department of Health to direct £0.5 million to supporting refugee doctors post-PLAB. To be eligible, doctors had to have passed PLAB but remained jobless for 12 months. These 'job-ready' doctors were then provided with a supernumerary post at SHO level by their deanery. Implementation has been the responsibility of the London Deanery which undertook the work with a first group of 20 doctors through its PRIME (Placing Refugee Doctors in Employment) project. As yet, it is too early to assess how successful it has been, in terms of both the doctors' career progress and value for money for the UK.⁷

Our data show that refugee doctors – by re-qualifying through the UEB – can achieve secure entry into the workforce and make good progress. This information on successful long-term outcome is in contrast to the limited published data on the results of initiatives designed to assist refugee doctors through the PLAB test route.

The fee for our course (£14,100) was small in comparison with the total estimated cost of producing a doctor in the UK (£250,000). It could be argued that financial support in the form

of Government loans or grants for refugee doctors would be cost effective, by increasing the numbers of practising doctors – who would contribute to the economy in the form of higher taxes – and very much in the UK's interests. Unfortunately, there has been no government support in the past for refugee doctors wishing to take the UEB route to qualification. Our 70 overseas doctors had to find the necessary funds to undertake the course, and for many this was a heavy financial burden. Indeed, three doctors accepted for the course at interview did not proceed for financial reasons. Forty-three of the overseas doctors enrolling for our course were not refugees. However, many of them had similar background, country of origin, language of medical education and number of years not practising as the refugees, with similar outcomes as regards UEB examination results and NHS career path.

There is clearly an almost insuperable problem for some overseas doctors – especially refugees – wishing to register for medical practice in the UK. On the forma-

Table 5. Characteristics of migrating doctors and examination most appropriate for registration.

	Majority of overseas doctors (Planned educational migration)	Refugees/asylum seekers (Hurried migration)
<i>Before migration</i>		
Time to ensure adequate English?	Yes	No
Time to take the language assessment (IELTS) test?	Probably	No
Opportunity to take a UK medical exam, eg PLAB Part 1, before migration?	Quite possibly	No
Family, financial and social difficulties?	No	Often
Opportunity for career in own country?	Yes	No
Break in clinical practice >2 years?	No	Sometimes
<i>After migration</i>		
Family, financial and social difficulties?	Unlikely	Likely
Language difficulty?	Not usually	Often
Likely to pass PLAB within short time?	Yes	No
Need for non-medical work?	Unlikely	Likely
Break in clinical practice before registration >2 years?	Unlikely	Very likely
Most suitable initial post?	SHO	PRHO
Most suitable type of GMC registration?	Limited	Provisional
Medical career inevitably in UK?	Sometimes	Nearly always
Appropriate examination	PLAB	UEB
<i>Economic considerations</i>		
Likelihood of paying tax	Early	Much later
Need for assistance from social security	No	Likely

IELTS = International English Language Testing System; PLAB = Professional and Linguistic Assessments Board; PRHO = pre-registration house officer; SHO = senior house officer; UEB = United Examining Board.

tion of the UEB in 1992, the GMC stipulated that the examination must be preceded by a course of instruction at a UK medical school and that before applying to take it the doctors must be signed up by a suitable individual in the medical school.

Over the period 1993–2003, 271 potential UEB candidates were attached to medical schools and assessed by the UEB process – 70 (34.8%) to St George's and 201 to other medical schools. Overall, 209 (77.1%) of the 271 taking the UEB examination re-qualified. Of the 70 attached to St George's, 69 (98.6%) re-qualified, 51 (72.9%) at their first attempt. Of the 201 attached elsewhere, 140 (69.9%) re-qualified, 35.8% at their first attempt. The purpose of this paper is not to compare success rates of different medical schools – this was a retrospective not a prospective analysis, and the doctors were selected by interview not randomised. The St George's course was able to achieve a high success rate by creating a formal course structure with designated tutors and, importantly, sufficient doctors on the course to sustain a minimum critical mass. On average, the other medical schools involved took around nine doctors each, in groups of 1–2, so the training arrangements would of necessity have been on a more individual basis.

The course was suspended on financial grounds in 2002. In 2004, in collaboration with the London Deanery, St George's entered into a financially secure risk-sharing agreement with the South West London Strategic Health Authority. The new course started in June 2005 with a group of seven refugee doctors.

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