School of Postgraduate Medical and Dental Education

How to:

Meet the Educational Needs of Refugee Doctors

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Increasing numbers of refugee doctors have entered the UK in recent years. Besides having to pass Professional Linguistics Assessment Board (PLAB) exams, many of them experience professional, educational and personal challenges when integrating with the prevailing cultures and professional practice of medicine and coming to terms with life in the UK. Those responsible for education and training need to be aware of the difficulties facing overseas and immigrant doctors and to develop strategies to support them in this transition.

Special challenges

There are clearly some specific challenges facing those educational supervisors who are responsible for training refugee doctors. These can be categorised in several different areas;

Professional

Clinical

Refugee doctors and international medical graduates (IMGs) often bring to the UK concepts of disease morbidity and illness, investigative models and therapeutic practices that are unfamiliar here. For example, their understandings of the incidence, definition and treatment protocols of Alzheimer's disease vary widely, indeed in some countries it is not recognised as a disease at all. Mentors or educational supervisors need to recognise the potential for difference, and actively seek to clarify it by questioning and discussion.

Work Environment

Many refugee doctors are unaccustomed to the style of professional relationship that doctors have with colleagues, particularly with nurses and support staff in the UK. Team members such as nurses are accorded a higher status than in the professional cultures of their countries of origin. Refugee doctors have to learn how to interact positively with support staff, dealing with them as colleagues and team members rather than subordinates.

Relationships with Patients

Overseas and refugee doctors face challenges in managing the consultation and practising the required consultation style. The UK emphasis on positive regard for patients and communication skills which are sensitive to the patient's concerns suggests that patients are seen as partners in the treatment process. This contrasts with cultures – notably in Asia, Africa and the Middle East – in which doctors are treated as unquestionable authority figures and patients expect to be firmly directed and readily defer to doctors' perceived greater wisdom. These pre-conceptions inform some overseas doctors' perceptions of how doctors should behave towards patients, how they should meet patients' expectations and live up to their role in local society. They do not sit well with the modest equality that underpins relationships with patients in the UK.

Educational

Learning Style

Research on the influence of culture on learning has shown that refugee doctors from countries in Europe and beyond have been accustomed learn in a traditional didactic style, with little freedom for debate and critical analysis. The habit of relying on their teachers for answers and direction make it hard for them to identify their learning needs and plan to meet those needs through self-directed learning. Refugee and overseas doctors have frequently reported the trauma of being unfamiliar with the system of learning, teaching and, particularly, assessment in the UK.

Methods of Assessment

IMGs' experience of assessment has largely involved regurgitation of knowledge from set texts rather than the application of knowledge to practice. This may help to explain their (earlier) reported failures to pass PLAB. The latter also contains exam questions on aspects of UK medical practice that are unfamiliar to doctors from abroad. The PLAB results reinforce the fact that methods of treatment and protocols differ across countries[2] and that candidates need a long period of practice in the UK. Exam failure may lead refugee doctors to lose confidence in their own abilities and to distrust the support system. Low morale and lack of trust appear to be detrimental to the progress of refugee doctors.

Personal

Social adaptation

On arriving in the UK, refugee doctors soon become aware of a requirement to adjust to social demands and expectations and to assimilate into the host culture. Social and financial hurdles intensify time pressures and the general stress of change. The social transition may be such as to include radical change in professional, personal and educational roles.

Personal Transition

Diffidence, anger, shock and a reluctance to change are common responses of refugee doctors to the transition that faces them. They may resist the expectation that they unlearn their professional practices, preferring to cling to familiar structures which served them well in the past and provided a comfortable position. In this destabilised state, motivation and self-belief are weakened and, if unchecked, could lead to a vicious cycle of failure.

Special challenges

A facilitative and supportive environment can lead refugee doctors to confront reality, recognise opportunities and generally re-orientate[8]. Clinical educators and mentors need to appreciate that colleagues from overseas may have experiences and backgrounds very different from their own. Refugee doctors may have to unlearn approaches that are widely practised in their countries of origin. The tenets of adult learning principles may have to be adapted if they are to overcome challenges to their professional or personal self-concept. Research on mentoring suggests specific strategies to assist refugee doctors through a turbulent transition. Experience of a hospital support unit suggests that the strategies need to be wide and varied.

Preparation

Those preparing to teach and supervise refugee doctors need to understand how the behaviour of their learners is informed by their previous experiences of learning and teaching. Sensitive discussion of those experiences and of how they differ from those in the UK will assist mentors in overcoming learner resistance or apathy and clarifying what is expected. Refugee doctors will require guidance in how to learn if they are to become independent learners.

Planning

Mentors and their refugee colleagues should conduct at the outset a joint review and plan relevant expectations and goals for learning. Appropriate information, career advice and help in planning will benefit these learners. Refugee doctors' trust in the support system, perhaps eroded by unrealistic encouragement and inconsistent advice, can be restored by realistic guidance, always taking into account the fierce competition for training places.

Practice

Mentors should assist refugee doctors in exploring the practice environment, alerting learners to options available to them, such as opportunities to observe clinical sessions, receive mentor feedback, view video demonstrations and role model a trainers' practice. Directive teaching may sometimes be necessary in the form of protocols provided at the end of tutorials.

Content

Clinical topics that are familiar to UK doctors may have a different meaning or little meaning for refugee doctors. Communication skills teaching and models of managing the consultation are rarely available in developing countries. Resources such as magnetic resonance imaging (MRI) and radioisotope scans are also scarce in some countries, making it impossible for their doctors to learn their practical use, indications and contra-indications.

Support

Refugee doctors need to know how to access and use the mentor support needed to rebuild their confidence and motivation to learn. IMGs frequently complain of lack of a support network in the UK, not realising that they are expected to become self-directed and seek opportunities for themselves. They sometimes expect the mentor to act as a patron and ensure job opportunities. Mentors need to be alert to such misconceptions and clarify expectations at an early stage. Regular, honest and constructive feedback on clinical performance, behaviour and attitudes is particularly important for doctors undergoing this transition.

Conclusions

Refugee doctors have an enormous contribution to make to the medical profession and health services in the UK. Their professional and career development will be stifled if they fail to integrate into the prevailing social and professional culture. Support systems based in sensitive and skilful mentoring will make for a smoother transition in key areas such as clinical knowledge, relationships with staff and patients, learning styles and methods of assessment, and generally will assist refugee doctors in coping with social adaptation and personal change.

Further Reading

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