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A Novel Model for Economic Integration of 'Refugee Doctors' in the UK: Opportunities and Costs of New Policy Initiatives

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Abstract

Policy initiatives and support programmes for refugee doctors are helpful mechanisms for facilitating their economic integration in the UK. The inclusion of refugees in the formal labour market of host countries is one of the durable solutions promoted by the UNHCR and implemented in novel models in the countries' domestic policies. The Introduction of the Medical Support Worker Scheme is the most recent support programme aiming to improve refugee doctors' economic integration during the unprecedented demand for medical workers during the COVID-19 pandemic. This article investigates the long-standing support programme before the pandemic as well as the most recent policy initiatives for refugee doctors' economic integration in the UK. The paper uses secondary data from literature and big datasets such as the Labour Data Survey and primary data from focus groups collected from the participants who are members of the Lincolnshire Refugee Doctors Project (LRDP). It performs a qualitative analysis of the perceptions of refugee doctors on their economic integration in the UK labour market. The data analysis shows mainly positive perceptions of the support programme and the guidance and training offered by the organisations like LRDP. The findings also suggest that there are existing impediments to the economic integration of refugee doctors deriving from structural and procedural obstacles as well as from the global health crisis. The paper addresses this issue and makes recommendations for policymakers in the UK to improve their rights and integration process.

Keywords: Economic integration; rights; refugee doctors; COVID-19 pandemic; democratic iterations

Introduction

The new types of migration drive the policymakers to develop new institutional structures (Jordan and Duvell, 2003) to make sense of new dynamics and define migrants with statuses that can be multi-layered. The legal status of migrants determines their position in the formal or informal labour market. The migration process also surfaces new vulnerabilities among the migrant populations, requiring global and national attention to formulate new protection

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mechanisms and integration programmes. 'Integration' is one of the 'durable solutions' promoted by the UNHCR, which calls for states to liberalise their labour policies to grant refugees with 'right to work' (UNHCR, 2017). In this article, the migrant group that is analysed brings to the surface the existing and new vulnerabilities and reinforces the drive for new policy approaches for the social protection of migrants through economic integration. As states are still the most viable entities that ensure safety, security, membership, rights, and social justice, international labour migration is predominantly regulated at the national level. Thus, the key responsibility and the role of the states are to create a safe space for workers in the labour market, safeguard their working rights, and prevent workers' exploitation regardless of their citizenship status.

The healthcare sector in the UK is over-reliant on a migrant workforce, including refugee doctors. The UK NHS is currently facing a recruitment and retention crisis of healthcare professionals (Butt et al., 2019) despite the NHS's long-term plan to increase staffing levels in the hospitals (Shah et al., 2021) and the COVID-19 pandemic exacerbated this growing problem (NHS Support Federation, n.d.). This issue necessitates the employment of overseas healthcare professionals to fill the gap in the health sector. Currently, 69 per cent of UK hospitals are actively recruiting doctors and nurses from abroad, and 1 in 3 General Medical Council (GMC) registered doctors are qualified overseas (ibid). There is a decline in full-time, fully qualified GPs in the UK, which has fallen by 1,800 since 2016 (Nuffield Trust, 2021); thus, refugee doctors fill the gap in the sector. British Medical Association (BMA) and GMC recognise the value of refugee doctors' contribution to the NHS and create new pathways to their economic integration. According to the BMA data, there are currently over 600 refugee doctors in the UK, and only a small number of them are actively working in the NHS (LRDP, n.d.).

The state and non-state institutions responsible for support programmes recognise the economic value of refugee doctors at low cost. For instance, training a doctor in the UK for up to seven years costs around £300,000, whereas re-qualifying a refugee doctor with support programmes under two years costs around £25,000 (Refugee Council, 2022b). By examining the early studies such as refugee doctors in Britain (Berlin et al., 1997; Department of Health, 2000; Ong and Gayen, 2003; Stewart, 2002, 2007; Hann et al., 2008;) and most recent literature (Pietka-Nykaza, 2014; Shah et al., 2020; Farooq, 2020; Mahase, 2021; Cohn et al., 2022) on the economic integration of refugees in healthcare, training, recruitment and retention of overseas doctors, the challenges and discrimination of overseas doctors, this article analyses the evolution of the status and rights of refugee doctors in the UK. Drawing on the perceptions and experiences of refugee doctors on the Medical Support Workers (MSW) Scheme, this article focuses on the impact of the support schemes on refugee doctors' lives and economic integration in the UK, the role of the state and non-state actors facilitating these schemes, and the influence of COVID 19 pandemic as a new global dynamic impacting the integration process. Thus, there is a gap in the existing literature on the impact of novel models for refugee doctors' economic integration through a moral lens incorporated into the economic lens. This paper adopts the moral lens of the UNHCR durable solutions for refugees in the analysis of the support programmes for refugee doctors' integration which is an integral part of these novel initiatives and usually is not spelled out.

A cosmopolitan moral perspective (Sonmez Efe, 2021) enables us to unpack economic integration initiatives through a moral lens. I deploy Benhabib's (2004) concept of democratic

iterations to analyse the evolution of these programmes, which are created as a result of moral and political dialogues with the inclusion of various actors through processes of interactions. This is described by Benhabib (ibid) as a 'messy process' incorporating multi-layered contexts which may entail unpredicted results that are not ideal but also may enable global distributive justice. Global justice is a dynamic process that is not only about international distribution but also incorporates local remedies to injustices, such as the economic integration of refugees in healthcare in the UK through innovative pathways.

This study makes significant contributions to the literature. First, it applies a theoretical framework for understanding both moral and practical remedies for the economic integration of refugees. Specifically, it highlights the heterogeneity in approaches for developing novel initiatives for refugee integration and emphasises the importance of how the role of state and non-state institutions/organisations as well as global external factors, affect the deliberation process for enacting innovative policies.

Second, by incorporating the perceptions of refugee doctors, the concept of democratic iterations is placed to work in a strongly contextualised field, where the development of the concept is integrated into its social context (Cuthill, 2009). This contextualisation is crucial because involuntary migration is socially constructed, which builds on expert language and concepts, research practices (Feindt and Oels, 2005; Cronon, 1996), and policy approaches to their economic integration. While this paper studies the new economic integration initiatives for refugee doctors, it promotes a meaningful interaction between NHS institutions, NGOs, refugees, and policymakers. The paper builds on data from focus group discussions with refugee doctors and makes a methodological contribution to the most recent literature by including refugees' perspectives on a range of issues. These perspectives also enable the researchers to measure the effectiveness of the new support programmes in the UK. Thus, the paper offers evidence from the UK, a developed country that has a large proportion of international healthcare professionals (Sonmez Efe, 2022), including refugee doctors.

The next section outlines the theoretical approach adopted in this paper. It will continue with a section on the refugee doctors' status and rights in the UK and what this legal status means for their economic integration. The paper then outlines the existing research on the support programmes for refugee doctors' economic integration and maps out these Programmes across the UK. It will then present the methodology along with the theoretical framework for the data analysis. The paper provides key themes that emerged from the qualitative research analysis through the lens of the moral constructivist approach to the economic integration of refugees.

Theoretical Framework

The analysis of the new policy initiatives aiming at the economic integration of refugee doctors entails conceptualising the integration, which is a dynamic and multifaceted process. In this context, the creation and implementation of the policy process can be analysed with the inclusion of the perspectives of migrants and the host country's policymakers through a debate within a democratic platform. Thus, the analytical framework to examine the economic integration process of refugee doctors into the NHS ought to enable us to understand the dynamic relationships between internal conditions, external or global factors, and the active or passive participation of migrants in this process. Refugee doctors can be active or passive

recipients of these support programmes depending on which spectrum of the policymaking platform they are positioned within and how they are represented at these platforms.

The cosmopolitan global world system takes a position between the norms of international law and individual policymakers' actions which entails multiple iterations of the norms and legal structures (Benhabib, 2004). The transformation of transnational citizenship through rights by virtue of residency (ibid) and the creation of new types of migrant categories and integration processes are indicators of the cosmopolitan norms that are embedded in international and national legislation. In other words, cosmopolitan norms of universal hospitality prevail within states' integration policies which is an ongoing process through iterative self-creation in a democratic platform. The rights of migrants, whether refugees or workers, are defined and re-negotiated under the influence of contemporary internal or external conditions that are fluid. Democratic iterations are defined by Benhabib as:

"…*complex processes of public argument, deliberation, and exchange through which universalist rights claims and principles are contested and contextualised, invoked and revoked, posited and positioned, throughout legal and political institutions, as well as in the associated civil society. These can take place the 'strong' public bodies of legislatives, the judiciary, and the executive , as well as in the informal and 'weak' publics of civil society associations and the media*" (2004, p.179).

The term 'iteration' is introduced to the philosophy of language by Derrida (1982, 1991 in Benhabib, 2004) which is described as *"in the process of repeating a term or a concept we never simply produce a replica of the first original usage and its intended meaning; rather every replication is a form of variation. Every iteration transforms the meaning, adds to it, enriches it in ever-so-subtle-way"* (p.179). Iterations can take the form of re-appropriation of the original meaning but, at the same time, its preservation through continuous deployment. When framing the economic integration policies at the national level, policymakers design integration policies through deliberation processes through continuous consultation with the inclusion of various actors/stakeholders, which takes form in a democratic platform, re-iterate the new principles and incorporate them into legislation.

However, one cannot disregard the paradox of the excluded, who cannot be among the decision-makers in this process, which can be re-negotiated through democratic iterations that is fluid and in constant transformation. In this framework, this study is valuable in terms of including the refugee doctors' perspectives about the MSW Scheme who are currently passive recipients of the programmes, thus, are the excluded group in the policymaking process. Their perspectives, however, contribute to this iterative process by incorporating their accounts of experiences, beliefs, goals, hopes, and understandings of the integration process in the host country. This conceptualisation can be applied in analysing doctors with asylum seeker and refugee statuses, how they approach the economic integration process and their experiences and reactions to the conditions that impact their lives in the UK. In this context, it is imperative to contextualise these concepts by studying the key challenges that refugee doctors encounter, to elucidate the external and internal conditions that have implications on their choices, resources, re-entering into their medical profession, and ultimately their economic integration into the UK health sector. On these grounds, the data analysis section will include the key challenges to refugee doctors' economic integration during MSW Scheme.

Refugee Doctors' 'Right to Work' in the UK

The UK legislation recognises the UNHCR definition of a Refugee[2] (Refugee Convention, 1951). This legal status grants the right to seek asylum in a safe country who have well-grounded reasons for fleeing their home country for safety. An 'asylum seeker' is someone who waits for his/her case to be processed by the host country legislation to be granted a 'refugee' status. All refugees have once been asylum seekers, but not all asylum seekers can become refugees, as many cases can be denied based on the decision taken as a result of national assessments.

Asylum Seekers in the UK do not normally have the right to work in the UK labour market until granted a 'refugee status'; instead, they are provided with basic rights such as accommodation and support for their basic needs (Gov.uk, 2021). However, the UK government 'may' grant asylum seekers the right to work whose claim has not been decided for 12 months 'through no fault of their own' (ibid). This is important progress for the pathways to the economic integration of doctors on asylum seeker status. However, if these doctors' asylum claims are refused at any point, they will be expected to leave the country and thus will not be able to continue to work in the UK.

Doctors who are granted refugee status have more rights and are eligible for a pathway for indefinite leave to remain and UK citizenship. Refugees are initially granted 5 years of temporary residence after the acceptance of their asylum case. This is an internationally recognised comprehensive approach to the local integration of refugees whose displacement is long-standing (UNHCR, 2017). Thus, refugee status grants doctors the right to work in the UK and receive social welfare benefits to better their lives through economic integration (Gov.uk, n.d.,a). For instance, refugees can have free language courses if they are unemployed (ibid) and receive interest-free 'refugee integration loan' for housing and education (Gov.uk, n.d., b) which are both crucial for doctors for social and economic integration.

Doctors qualified overseas can only practice medicine in the UK through registration to General Medical Council (GMC) which has four routes: sponsorship, membership in a royal college, passing the Professional and Linguistic Assessment Board (PLAB) tests, and requalification through the United Examining Board (Berlin et al., 1997). Overseas doctors need to prove their language competency through the IELTS test after taking an Objective Structured Clinical and Oral Exam (OSCOE) (ibid). Studies suggest that refugee doctors face more challenges than other overseas doctors such as extreme financial difficulties; PTSD due to loss, persecution, or uncertainty of their legal status; the cost of exam fees; the long waiting list for retaking the PLAB test; the complexity of the GMC registration; unhelpful feedback after failure; and discrimination (ibid; Stewart, 2002; ONG and Gayen, 2003), falling into the informal labour market, exploitation and skill wastage.

Economic integration as a concept is crucial for refugees in terms of reducing the uncertainties and temporariness of their legal status, preventing exploitation in the informal labour market, enabling life in dignity, and creating a sense of belonging to the host country by contributing to the economy and creating pathways for social integration and political integration. After

[2] "a person who is in fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it"

the legal recognition, economic integration is the second step for refugees to have the right to a decent life which is possible through decent work (Sonmez Efe, 2021). In the context of doctors with refugee status, states can enable them to have decent work by liberalising their labour law and implementing Economic and Social Rights (ibid) at the national level. The support work schemes for refugee doctors are pathways to their economic integration through legally recognising their medical professional skills in the formal labour market.

This article will use 'refugee doctors', 'doctors on asylum seeker status', and 'doctors with asylum seeker and refugee statuses' interchangeably depending on the usage within the literature and perceptions of these statuses by the medical professionals on these statuses.

Economic Integration Through Novel Models

The economic integration programmes that support refugee doctors for employment in the NHS have been implemented within policy schemes last two decades in the UK. These programmes aim to find practical ways to help refugee doctors re-establish their medical profession in the UK. Table 1 shows the policy initiatives between 2000 and 2007 most of which are still active. These initiatives focus on initial data collection about refugee doctors, limited support for GMC registration, and networking/information sharing among institutions.

Table 1. UK-wide policy initiatives to assist refugee doctors

Year/Duration	Policy Initiative	Description of Main Activities
2000–2005	Refugee Health Professionals Steering Group (Department of Health	Steering Group – distribution of £2 million for refugee health professionals
2000–present	Refugee Doctors' Database (BMA/Refugee Council) Refugee Doctor Liaison Group (RDLG)	Database of refugee doctors/ quarterly newsletter Communication and action group
2003–present	Refugee Doctor Programme Evaluation Network (RDPEN)	Evaluation/monitoring database
2005–present	ROSE website (NHS)	Online information portal
Ongoing	GMC registration for refugee doctors	Waive/reduction in fees for PLAB I & II exams
2006–Present	Building Bridges (NHS Employers)	Leadership/service provision
2007–Present	Reachout Network	Networking/collaboration/ information sharing

Source: Stewart, E. (2007), p.410

Table 1 illustrates the policy initiatives that aim to support refugee doctors (and other international health professionals), most of which are still facilitating their activities. For instance, GMC continues to support refugee doctors by waiving/reducing the fees for PLAB exams and collaborate with organisations that support them in preparation for the GMC registration process (GMC, 2022). Table 2 below illustrates the collation of the current programmes that aim to support refugee doctors, which indicates the UK's commitment to their economic integration. Refugee doctors usually prefer to stay in London because of the well-established refugee communities and support services (BMJ, 2000). As a result of an overburden of services in London, the Immigration and Asylum Act (1999) requires the distribution of asylum seekers and refugees in 'cluster areas' across the country where support services are available or further developed (BMJ, 2000, House of Commons, 2016) which is embedded in these programmes. For instance, a refugee doctors who received support from a programme in Midlands can only be placed in work in NHS in Midlands. In 2015, the number of local authorities that volunteered to participate in national dispersal arrangements was 99 (House of Commons, 2016). Although the local authorities voluntarily sign in these

arrangements, the central government reserves the power to ensure the local authorities cooperate with the Home Office for accommodation arrangements (ibid). The table below also reflects the government's policy on dispersal areas which aims to distribute asylum seekers evenly across the country. In line with the staff shortages in the NHS system, this paper suggests that the support programmes also aim at the placement and employment of these health professionals in different regions in the UK.

Table 2. the UK Support Programmes as Pathways to Refugee Doctors' Economic Integration

Sources: Bridges Programme (n.d.), BMA (2022), RAGU (n.d.), Refugee Council (2022a), Reache Northwest (n.d.), LRPD (n.d.),

Region	Support Programme	Main Activities
Scotland	Bridges Programme/Doctors Programme	-Assistance with Medical Portfolio -Advanced English classes delivered by the Glasgow Council for IELTS or OET preparation -Virtual classroom training-support and Training for IELTS and OET
UK	British Medical Association Refugee Doctor Initiative	-Free weekly subscription to the BMJ -A confidential, 24 hour phone counselling service for Refugee Doctors and for their families. -Use of the BMA library -Local BMA support and attendance of local BMA meetings -Support from the BMA international department
London	Refugee Assessment and Guidance Unit (RAGU)	-Provides specialist career advice and guidance and employability training for all refugee health professionals including doctors -Practical employability workshops focused on getting work in the health sector -Work placements in the NHS -Funding for some professional exams and training -Extensive advocacy with professional bodies
London	The Refugee Council-Building Bridging Programme for Refugee Health Professionals	-Prepare Refugee Doctors (RDs) for OET and PLABs -Improve RDs' language and communication skills -Prepare RDs' for working in the NHS -Familiarise RDs with UK medical procedures ad systems clinical attachments -Support RDs to obtain GMC registration and to understand recruitment processes
Northwest England (Salford)	Reache Northwest	-Support Refugee Health Care Professionals (RHCP) with training, English classes, pastoral care -Prepare RHCPs to OET and English practice in medical context -Provide medical examination preparation including PLAB and essential clinical knowledge -Prepare RHCPs to getting into work including work placements
Lincolnshire and North-East Lincolnshire	The Lincolnshire Refugee Doctors Project	-Help RDs to settle with family in Lincolnshire -Refreshing of skills, knowledge and confidence -Re-qualifying to UK and securing employment appropriate to professional qualifications -Prepare RDs to OET through English training courses
Wales	WARD (Wales Refugee and Asylum Seeker Doctors) Group	-Offers RDs weekly tuition to prepare them to IELTS, OET -Support RDs practically and financially to pass PLABs -Support RDs for entering employment process
Teesside and Tyneside	REPOD (Resettlement Programme for Refugee Doctors) within IPC (Investing in People & Culture)	-English classes to prepare RDs to IELTS and OET -Support RDs for clinical attachments -Prepare RDs for PLABs and GMC registration

WARD Group (n.d.), REPOD (2022).

These programmes predominantly aim to support refugee doctors in preparing for the GMC registration through OET, IELTS, and PLAB I and PLAB II exams. After GMC registration, refugee doctors can start working in the NHS through starting from Clinical Attachments

(CAs) or the Medical Support Worker (MSW) Scheme. CAs (unpaid observerships) are recommended for refugee doctors as an effective first step to prepare them for employment or re-employment (Advisory Group on Medical and Dental Education and Staffing, 2000) who usually had not been in practice for a few years (Cheeroth and Berlin, 2001; Ong and Gayen, 2003). The CAs enable the refugee doctors an individual sit in with a consultant, join ward rounds, and have an opportunity to attend educational meetings, which are great learning opportunities (Ong and Gayen, 2003). As a result of the slow pace of the employment process, to make the CAs more effective, 'the Pan-London Clinical Attachment Scheme' is developed where there is a learning process and exposure of refugee doctors to more than one speciality and sitting (ibid). The core curriculum of the learning programme consists of routine clinical items, primary care experience; Advance Life Support and Intermediate Life Support course; and educational and personal skills (ibid and Sullivan et al. 2002). However, the eligibility for this scheme is limited to refugee doctors who passed the PLAB and the IELTS or are exempt from these tests.

The programmes (see Table 2) are funded by the NHS and supported by organisations and hospitals through collaborations. For instance, Building Bridges Programme (BBP) is a multi-agency collaborative programme that involves RAGU based at London Metropolitan University, The British Refugee Council, Whipps Cross University Hospital, and other hospitals based in London (Butt et al. 2019). The most recent data suggests that the BBP supported 477 refugee doctors from 2009 to 2021; 147 of those found jobs in the NHS, and 189 of them were employed in other healthcare roles (Refugee Council, 2022b). BBP also offers the 'Clinical Apprenticeship Scheme' (CAPS) supported by Health Education England (HEE) and administered via the Professional Support Unit (PSU) (Shah et al., 2021). CAPS are only offered in London, which enables refugee doctors (who passed PLAB) to have a supernumerary placement for six months at Foundation Year Level 2, which allows them to access educational resources and cultural and communication awareness courses (ibid). 45 of 48 refugee doctors who completed CAPS have been retained in the NHS between 2009 and 2020, which is a positive result (ibid).

The COVID-19 pandemic accelerated the implementation of these temporary integration programmes, which compelled policymakers to develop novel models. The Medical Support Worker (MSW) Scheme was introduced in NHS England to overcome the staff shortages during the pandemic and created a new role to support doctors who do not yet have GMC registration and who passed IELTS or OET (BMA, 2021, NHS England, n.d.). The MSW role is suitable for doctors who have medical qualifications in the UK or overseas, have been out of practice for over a year, and have no GMC registration, which is an ideal role for overseas medical graduates or refugee doctors (NHS England, n.d.). MSWs can undertake essential routine clinical tasks under the supervision of the relevant consultant, GP, or GP nurse (BMA, 2021). The MSW Scheme allowed graduating doctors, refugees, and overseas doctors to work in NHS as Support Workers (NHS England, 2022) who otherwise could not use their skills while waiting and preparing for their GMC registration. As a result of the COVID-19 pandemic pressures, the NHS England announced £15m of national funding to trusts for the short-term recruitment of up to 1,000 doctors as MSWs on a fixed term until March 2022 (NHS England, 2020), which is recently extended for another year until the end of April 2023 (NHS England, n.d.). The trusts have provided funding to cover the full salary of the MSWs, and £250 training costs (ibid). There are over 400 doctors who have been recruited as MSWs in NHS England who do not have GMC registration due to retirement or

having overseas qualifications (Mahase, 2021). MSW Scheme was created to overcome the unprecedented challenges during the pandemic as a temporary solution; furthermore, the Scheme gave hope to refugee doctors to step into the NHS system while waiting for the GMC registration process, which may take years. This Scheme will prevent refugee doctors from remaining out of medical practice for a long time and overcome skill wastage as they will develop work experience in the NHS system, leading to regaining their confidence as qualified doctors.

Methods

This article draws on focus group data from a COVID-19 impact study[3] conducted with migrant workers in the UK in April 2022 (Sonmez Efe, 2022a). While the study involved quantitative methods, such as a survey, this article draws exclusively on focus group data to rely on recent data to elucidate the current integration processes through the illustration and analysis of the doctors' perspectives on refugee and asylum seeker statuses. People's narratives can include subjective and objective experiences in a given context. The task here is not only working out what 'an individual' makes sense of a specific issue but also how individuals discuss the issue collectively as members of a group. This method gives the researcher to 'develop an understanding about why people feel the way they do', and the process of 'arguing' challenges the participants to 'probe each other's reasons for holding a certain view' (Bryman, 2012: 503).

As the aim was to explain the realities and experiences of the participant's economic integration process, the sample is purposefully kept small. The sampling followed a non-random purposeful selection procedure that identified participants from healthcare professionals from migrant backgrounds as part of the recruitment procedure of the Erasmus+ Project[4]. I selected participants from the Lincolnshire refugee doctors Project (LRDP) online platforms by negotiating with the senior officials from the Project. I attended the LRDP online language classes and informed the doctors on the course about the research project and the purpose of the focus group discussions. Six participants from refugee and asylum seeker statuses from the LRDP were recruited, and Table 3 below illustrates the sample group:

[3] Bridging Youth and Young Professionals in a Migrational Context via Digitalisation (YOUNGMIG) (2021-2023). Report: Employment and Young Migrants in the UK. *Erasmus+ Programme of the European Union*. Youngmig.org

[4] Bridging Youth and Young Professionals in a Migrational Context via Digitalisation (YOUNGMIG) (2021-2023). Report: Employment and Young Migrants in the UK. *Erasmus+ Programme of the European Union*. Youngmig.org

Table 3. Refugee Doctors who participated in focus group discussions.

Participants (Codes)	Gender	Age	Country of Origin	Mother tongue	Legal status	Education (lastly finished degree)	Employment status
FG1-P1	Female	26	Syria	Arabic	Student-graduate visa	MSc Medicine-UK	Medical Support Worker
FG1-P2	Male	25	Syria	Arabic	Refugee	Bachelor of Medicine and Surgery (MBBS)-Syria	Unemployed
FG2-P3	Male	30	China	Chinese	Asylum Seeker	Doctor of Medicine-Turkey	Unemployed
FG2-P4	Male	39	Turkey	Turkish	Asylum Seeker	Doctor of Medicine	Unemployed
FG2-P5	Male	28	Syria	Arabic	Refugee	MBBS-Egypt	Unemployed
FG2-P6	Male	41	Syria	Arabic	Refugee	MSc in Cardiovascular Medicine	Medical Support Worker

These participants were divided into two focus groups[5]. Ranging from 25 to 41 age groups, the participants obtained their medical qualifications from their home countries. Five participants were male and one female; four had lived in the UK for more than two years, and two had been here for over one year. Two participants work as Medical Support Workers (MSW) at NHS, and the remaining four are preparing for exams to be registered with the GMC. Their English skills vary from intermediate to advanced levels, and all could speak fluent English during the focus group discussions.

The semi-structured focus group discussions aimed at an in-depth portrayal of participants' experiences and perspectives of their economic integration processes in medical practice in the UK, what they make of these new support and training programmes, the key frustrations they experience in the process and the impact of the COVID-19 pandemic. The focus group discussions took place online, on MS Teams, lasted 60-80 minutes, and were conducted in English. The ethical approval was obtained from the University of Lincoln ethics committee. The participants were offered anonymity through a consent form. Thematic data analysis involved manual coding of the data from the transcripts and identifying emergent themes, focusing on participants' experiences and perspectives of the support programmes and their interpretations of their individual economic integration experiences to identify both commonalities and divergence in the narratives.

The key limitation of the methodology would be sample size, which may prevent the researcher from generalising the data findings. Nonetheless, a small sample group can also be advantageous in constructing detailed data by engaging participants' experiences and observations about the research questions under exploration. The aim here has not been a generalisation of data; instead, to shed light on the challenges refugee doctors face for economic integration and to illustrate their voices to the audience engaged with this subject. By doing so, this research aims to fill the gap in the literature where there is limited study analysing refugee doctors' economic integration in the UK.

[5] Focus Groups are coded as FG1 (participants are coded as FG1-P1, FG1-P2) and FG2 (participants are coded as FG2-P3, FG2-P4, FG2-P5, FG2-P6).

Economic Integration of Refugee Doctors: a dynamic iterative process

Based on the refugees' lived experiences as healthcare workers, I draw upon Benhabib (2004) to elucidate the transformations and the continuations of the legal and political understandings and meanings of economic integration through the processes of 're-appropriation' and 're-interpretation' of norms and principles. The practical usage of 'jurisgenerative politics' (ibid) will enable us to make sense of the actors involved in the iterative process.

Perceptions of the Legal Status of a 'Refugee' and Right to Work in the UK

Participants' experiences of the legal system mainly focused on their 'legal statuses' as considered a green card that opens doors for the 'right to work' in the health sector. 'Refugee status' straddles between natural rights granted based on common humanity and positive rights bestowed through national membership routes (citizenship). Participants had an understanding of the practical meaning of their status and were aware that it is crucial in determining their employment status, accommodation type, region for living, and accessing public services. A doctor who was recently granted refugee status (FG1-P2) found it frustrating when he was on asylum seeker status, which he described as a barrier to the 'right to work' and 'freedom of movement' within the country. Asylum seekers cannot work until twelve months of residence in the UK (it was two years previously), which means being out of medical practice. This is an important issue for doctors in terms of the risk of the erosion of their medical skills.

In addition, asylum seekers and refugees fall under the national dispersal arrangements (House of Commons, 2016), and the lack of freedom of movement in the UK is described as highly stressful for participants with these statuses. A participant describes the random accommodation decisions as, "*That's usually how things are done…spend some time in one accommodation, and then you'll disperse another one"* (FG1-P2). This situation of instability prevents long-term employability and adds another layer to their temporariness in the context of employment. While all participants were conscious of the amount of stress that they go through as a result of their legal status, the way they expressed their feelings was 'submissive' and 'passive', which positioned them as 'weak publics' (Benhabib, 2004) of temporary members of the society. They become 'passive recipients' of rights in the host country (Sonmez Efe, 2021), whose fundamental rights are addressed and resolved by actors representing refugees on democratic legal platforms. The participants collectively discussed their experience of the psychological effects of not being able to work and practice their medical profession due to the instability caused by their legal status.

It is a complex process to embed the 'refugee status' within state jurisdiction as the law needs to consider the moral obligations for assisting them with fundamental rights. Moreover, this temporary solution ought to evolve into 'durable solutions' (UNHCR), which means the pathways to the economic integration of refugees in the labour market. The UK legislation incorporates both temporary and durable solutions; for the former, refugees are granted basic rights through the state benefit system, and for the latter, there is a legal pathway for asylum seekers' (after one year) and refugees' employment in the labour market. However, due to legal and bureaucratic barriers preventing refugee doctors from practising their profession, their economic integration needs to be re-negotiated. All participants expressed their passion for working in the healthcare sector, but they mentioned their legal status pushes them to rely

on state benefits which they do not want: *"…now I want to start working very bad so…"* (FG1-P2). The participants describe the 'waiting time' for processing legal status as the major legal hurdle. This issue can also push them to work in the informal sector: *"…before the pandemic…it was already 1 year… waiting for the Home Office's decision…so I had to work illegally for a few months at that time at a coffee shop…I worked with much lower salaries than a normal citizen."* (FG2-P3). The problem of the lack of knowledge of their rights contributes to their vulnerability in the labour market, as irregular migrants are considered to be a readily exploitable workforce. During the focus group discussion, two participants had a conversation about their knowledge of their rights. One participant (FG2-P3) did not know that he had the right to work after one year after his residence, and the other participant (FG2-P5) informed him about his right to work. This conversation illustrates some participants' lack of knowledge of their rights. This might be due to being a member of the 'weak publics' of society and passive recipients of rights because of their vulnerable legal status that impacts their confidence to seek help.

Moreover, the complexity of the system and various local approaches to accommodate refugees cause ambiguity in determining the legal status in the UK, which further entails a lack of knowledge of rights. One participant illustrates this: "*Each person has the right to know what options they have...it's written on their websites, but it's not very clear…*" (FG2-P4). The participant stressed the fragmentation of the advice the refugees' legal representatives gave, which he suggested should be centralised through short-term mentoring by the Home Office upon their arrival. A clear knowledge of rights will enable refugee doctors to make sense of the legal pathways to practising their profession and legally joining the labour market with employment rights.

The participants' perceptions of their legal status show a consciousness of their status in determining 'what they can and cannot do' in the host country. It is a frustrating process of making sense of one's status that has an impact on his/her psychological and economic well-being. The multiple iterations of the norms and legal structures (Benhabib, 2004) in the context of 'refugee status' indicate a transformation of transnational membership through rights by virtue of residency in a state's jurisdiction and rights by virtue of morality within international law. My findings re-iterate this two-tiered system in the context of the 'right to work'. On the one hand, refugee doctors consider their legal status a disadvantage for employment because they have to depend on the benefits system under the moral stance that grants refugees basic rights.

On the other hand, they express their need for the support provided by the government for their economic integration and decent work. The former perspective illustrates that 'refugee status' continues to be deployed within the moral ground described by the refugee doctors as disempowering them without decent work. The latter view considers refugee doctors as a vulnerable group to be protected per international law. However, when refugee doctors' legal status is re-iterated in the context of durable solutions, their dependence on the state benefits is a temporary stage which transitions to their economic integration into the labour market. The status of 'refugee' gives these doctors a sense of temporariness, which can pose a hurdle for their economic integration process as this is usually considered a process for long-term or permanent migrants.

Key Procedural Hurdles for Refugee Doctors' Economic Integration

The legal procedures determining the economic rights of refugees have been taking shape over time. Jurisgenerative politics enables us to make sense of an 'authoritative original in a new and different context' and 'the iterative acts. Democratic people then consider themselves bound by certain guiding norms and principles and re-appropriate and re-interpret these contexts and acts, thus showing themselves to be not only the subject but also author of the law' (Benhabib, 2004:180-181). Identifying the challenges for economic integration in this research enables the refugee doctors to voice their experiences, thus, including their perceptions in iterative acts.

In this study, 'time' emerged as one of the key hurdles for doctors with asylum seeker and refugee statuses in the context of 'determination of legal status'; 'for GMC registration'; 'to gain the right to work'; 'requalification process'; 'delays in the system', and 'COVID-19 pandemic'. Most participants considered 'waiting times' as a key obstacle to their economic integration in the UK and experienced delays in processing their legal status. The additional waiting time for the professional and language exams (IELTS, OET, PLABs) for GMC registration contributes to these delays as almost all doctors said they had to stay out of practice for a few years: *"The frustrating part is the waiting times for the exams. It's a PLAB 1 and 2."* (FG1-P1). Thus, procedural issues and strict regulations are described to be hurdles for doctors to practice their profession in the NHS:

> *"…you can't pick and work immediately after having status… even before being granted, you can apply for permission to work, but it would take like 5 months or four months for the Home Office to reply and provide you with".* (FG1-P2)

The participant further expressed the issue of 'explaining the gaps in the employment history' which further illustrates waiting times for exams as being an issue:

> *"…you have to explain those gaps so that GMC so they asked about those gaps. They think that your skills fade away with time. But I don't think this is the case…If someone is skilled, he will do the job, but he has to go through the PLABs and this will provide him with the basic knowledge to work".* (FG1-P2)

Few participants stated that they already have medical knowledge through their medical degrees. Thus, what they need is to understand the UK health system.

The younger participants who have recently graduated feel different from the older participants who are specialised doctors and have more experience in their medical field. The former group acknowledges that the native professionals are advantaged because of their familiarity with the system. Thus, the younger participants view clinical attachments and Medical Support Workers (MSW) placements as positive, allowing them to learn about the UK health system. However, the older participants view this process as a disadvantage which a participant expresses:

> *"…my specialty is cardiology…but here you can't be registered as a cardiologist… you can only be registered as a GP General practitioner after that… Starting a position called registrar…If you're lucky, you can find the registrar work, if you are a specialist. But if not, you can start as an FY2."* (FG2-P5).

This statement indicates the deskilling of an experienced doctor because of the long re-qualifying process in the NHS system, which means he needs to re-start from a junior doctor position to regain his medical speciality position in the UK. Another participant mentioned the slight differences in educational approaches to medical degrees and added that in the UK, medical students are encouraged to do research during their education which places them in a preferable position in the job market in the UK (FG1-P2). As a result, refugee doctors need to devote time to increasing their understanding of the culture of practice in the UK healthcare system. Pietka-Nykaza (2015) calls this a 'compromise strategy' where refugees make realistic judgments to balance their professional aspirations with what the UK system can offer them. In this context, refugee doctors recognise the need to re-negotiate their skills to cope with the procedural hurdles and prove professional competence, even if it entails professional roles below their skills.

Other procedural issues raised by a participant are related to the PLAB tests, the high cost of the PLAB tests, and the fairness of the examination process. The PLAB I costs £247, and PLAB II costs £906 (GMC, 2022b). Refugee doctors are offered support for the fees, they can have a fee waiver on their first two attempts of PLAB I, and they can pay a half fee for the two PLAB II attempts (GMC, 2022). However, most doctors who took the exams said that they had few attempts, and it has been very costly:

> *"…the test itself is very very costly. It cost like 900 pounds… I have to attend The Academy Is to prepare for this exam. So I was traveling to Liverpool to attend the Academy there so I can prepare for my exam which is also very costly."* (FG2-P4).

This participant is now receiving support from LRDP for free online training for preparation for the PLABs, and he passed the exams on his third attempt; however, at a high cost.

On the other hand, studies suggest racial discrimination against Asian graduates from British Medical Schools (Esmail and Everington 1993; 1997), which may lead the researchers to claim even greater discrimination against overseas doctors (Berlin et al., 1997). The participant expressed his experience with the PLAB tests that he took three times, where he criticised the fairness of the tests:

> *"…the PLAB 2 test is not fair at all and... you are judged by one examiner and there's one simulator…don't think that they are fair with their judgment… it's a very subjective exam…Some people study very hard, and they don't pass. Some people don't study at all, and they pass… I don't know how they measured it… when something is dependent on a human judgment there will always be some kind of discrimination because you don't know how they are judging you… You only have 4 four chances to do this exam".* (FG2-P4)

Another participant also suggested the lack of clear feedback on the reason for failing the exam, which raises the problem of transparency in providing the examinees with feedback. The participants agreed that the COVID-19 pandemic has exacerbated these delays and even caused the cancellation of exams during the pandemic:

> *"…they canceled the PLAB 1 exam for the first six months of this year due to COVID. Because there were not enough health care workers to participate in the exams, so that makes you like delays your registration six months is like if you even pass the exam on the first try."* (FG1-P1)

> *"I came to London, England at the time of the pandemic…and then it has been more than one year…due to the pandemic, my interview time and the decision time is extended"* (FG2-P3)

Another participant described the impact of the pandemic on his Clinical Attachment application:

> *"…restrictions for this pandemic. I tried many times to apply for clinical attachment, so it's just being the hospital…They told you. Now there's a restriction because of covid and we are not allowing so many people to be in the hospital. So I've tried many times to do so, but I couldn't do it.* (FG2-P4)

His unsuccessful attempts at CA also illustrate his lack of knowledge of the MSW Scheme introduced during COVID-19. This is when the NHS hospitals desperately needed support staff to help during the pandemic, which shows that either he was unaware of the MSW Scheme or did not apply for it.

The COVID-19 pandemic had an unprecedented impact on employment and the labour market in the UK, and some sectors are affected more, such as the health sector (Sonmez Efe, 2022a). The pandemic deteriorated the issue of the recruitment and retention of healthcare professionals in the NHS, which is currently debated by policymakers within the Health and Social Care Committee at the House of Commons (2022). The issues around the recruitment of 'refugee doctors' in the NHS is a part of the debate as an evidence paper (Sonmez Efe, 2022b) illustrates the challenges this group faces due to various reasons discussed in this paper. As discussed above, refugee doctors are usually 'weak publics' of society due to their disadvantaged legal status in the host country and lack of voices in policymaking. Thus, the evidence paper is important for the inclusion of their voices in the policymaking process, which can contribute to the re-negotiation of their status for creating practical pathways to their economic integration. Thus, participants' narratives in this study are part of the debate.

Novel Models Promote Economic Integration of Refugee Doctors in the UK

The policymakers responded to the current issue of staff shortages and the pressures of the pandemic on the hospitals with new temporary models, as discussed above. The participants expressed their positive views on this new recruitment initiative, Medical Support Worker (MSW) Scheme introduced in 2020, which is considered an opportunity for refugee doctors to have this role before GMC registration:

> *"…I feel… I think after covid we got more opportunities. For example…the medical support worker, came after COVID because they really needed the help of international doctors who did not finish their registration yet. So that was helpful for us…"* (FG1-P1).

Two participants were working as MSWs, and others were preparing for the professional language exams to be placed in NHS in this role. Mainly young participants saw the MSW as an essential step forward for economic integration in the health sector. Although the older and more experienced doctors emphasised advanced programmes such as FYI, they also see the value of this Scheme to enter the health system and understand it better. This Scheme also acknowledges the overrepresentation of migrant workers in the health sector (Fernandez-Reino, and Rienzo, 2021), who are vital cogs of the NHS.

All participants in the focus group discussions were members of the LRDP. The LRDP is an NGO supporting doctors with asylum seekers and refugee statuses with training courses. These courses increase doctors' confidence, prepare them for their professional exams, recruit them in Lincolnshire, and enable them to practice medicine in the NHS, which means full economic integration (LRDP, n.d.). The latter is carried out through the support of the refugee doctors with community engagement activities, such as events and mentoring. The total number of doctors who have joined the LRDP programme since 2019 is 44, and the current number of members is 34. The home office settles asylum seekers in specific locations around the UK; thus, the LRDP has accepted doctors from Birmingham, Liverpool, Manchester, Belfast, the North East of England, Nottingham, Bradford, Lincoln, London, and Scotland. Most doctors are joined from Midlands as LRDP supports refugee doctors with training and work placements in Lincolnshire. The doctors from other regions apply to the LRDP programme because it offers something that their local programme does not or because they like the idea of moving to Lincolnshire.

The focus group participants were from various cities in Midlands and London, and the role of digitalisation of training courses during the pandemic is stated to be a positive development for doctors joining outside of the midlands. For instance, one of the focus group participants (FG2-P2) recently moved from London to Lincoln and had an MSW placement at Lincoln Trust after joining the LRDP online training courses. However, if the doctors from other regions prefer to move to Lincolnshire, their relocation is not funded by the BMA because of the National Dispersal Arrangements. This illustrates the two-tiered legal arrangements for these doctors because of their refugee status. While dispersal arrangements recognise them as temporary members, the new pathways to their employment in the NHS embed the UNHCR's durable solution (economic integration) in the domestic law.

The analysis of the participants' interaction with one another during the focus group discussions illustrated their experience in the LRDP through receiving the support of mentoring for professional progression, language training classes for GMC registration, and job placements including MSW which are important aspects of their 'economic integration'. A participant stated that:

> *"it's a completely different healthcare system and you really feel at first if you just…go into system without getting the amount of preparation needed… Because you would feel completely like, I'm doing everything wrong… maybe I'm not good enough. So the training we do at first I thought it's really a bit frustrating, but then it's like I feel it's really helpful now because you really get familiar, familiarise yourself with the system more and learn more about the system. So that makes you more confident".* (FG1-P1)

A study suggests that starting a new job in a new country itself is a challenge (Valero-Sanchez, 2017). Refugee doctors need to learn new medicolegal frameworks, skills, guidelines, and training systems and work on relationships with other professionals (Ibid). The MSW seems to be contributing to this process: *"…the LRDP, which helped me a lot to progress… after joining LRDP during the pandemic, I could get a suitable job as a healthcare assistant…"* (FG2-P6).

Since its foundation in 2019, the LRDP has supported six doctors to register the GMC, five of those are now working in NHS, and one doctor has a job offer but is an Asylum Seeker, thus, does not have the right to work yet. The programme also helped eleven doctors pass the OET test, fourteen pass PLAB 1, and four pass PLAB II. In total, twenty-two LRDP

members have been able to access work for local trusts as MSWs, which means they are financially independent and gaining skills and knowledge of the NHS system, which prepares them to work in the NHS as registered doctors.

The LRDP is one of the organisations (see Table 2) that provide support for refugee doctors' economic integration, which as a durable solution, transforms the meaning of 'refugee status' and re-appropriates the temporariness of people with this status in the host country through work placements. Moreover, besides supporting refugee doctors for their economic integration, these Support Programmes (including LRDP) also act as an 'active voice' for these doctors who are otherwise passive recipients of rights. This is evident from participants' experience with the LRDP, who stated the positive impact of mentoring and training courses where they can freely express their feelings which become a part of the policymaking debates (e.g., House of Commons Evidence Paper, 2022).

Conclusion and Recommendations

This article provides insight into the realities of economic integration processes experienced by refugee doctors. In doing so, it adds to the body of scholarship that highlights the legal and practical hurdles that delay or prevents the employment of refugee doctors in the healthcare sector in the UK (Esmail and Everington, 1993, 1997; Berlin et al., 1997; Pietka-Nykaza, 2015; Valero Sanchez, 2017; Author, 2022a). Participants' narratives indicate that there is both transformation and continuation of the meaning of the legal status of a 'refugee' in each iterative process (Benhabib, 2004). This article identifies the two-tiered legal arrangements for refugee doctors' legal status and rights in the UK, which conjoins the universal moral entitlements into the national membership rights. Through focusing on refugee doctors' voices, the article unpacks how the advantages and disadvantages of their legal status shape their economic integration in the host country.

While acknowledging vulnerabilities and disadvantages in the UK labour market due to their legal status, the research participants saw themselves as valuable assets of the workforce in the NHS. They showed their willingness to transform their weak position through employment. This article provides insight into how doctors with asylum seekers and refugee statuses challenge their disadvantaged position in the labour market. They show resilience by not relying only on state benefits, participating in support programmes, and working hard for legal and economic integration. While participants' narratives reaffirm the prevailing challenges preventing them from entering the labour market that causes skill wastage, the new innovative models for economic integration, such as the MSW Scheme, give hope for more practical pathways to their economic integration. Participants who passed their professional exams and were placed in employment showed more confidence in their expressions of their status and belief in breaking the barriers between their legal status and practising medicine.

By examining the economic integration processes of refugee doctors, my analysis draws attention to the overlapping and interconnected forms of status, rights, and integration that are debated at the international and national levels but practised and implemented at the national level. Benhabib calls the debating process' democratic iterations' and describes it as a 'messy process' incorporating multi-layered contexts which may entail justice or unpredicted results. Findings support Benhabib's (2004) concept of 'democratic iterations' which actually happened and is still happening in the context of the economic integration of refugee doctors that incorporates moral judgments and legal systems that are multi-layered. The participants

describe Support Programmes and the MSW scheme introduced during the COVID-19 pandemic as pathways to practising medicine in the UK, transforming the temporariness of their refugee status to a long-term or permanent one. These programmes enable UNHCR's durable solutions by embedding the 'right to work' principle for refugees in domestic law, typically bestowed through legal membership, namely citizenship or other types of legal residence. This illustrates the inevitable re-appropriation of refugee status in the context of economic integration; thus, contextualisation of the moral concept helps us connect the concepts and real-life practices. NGOs like LRDP provide support for refugee doctors' economic integration and act as a platform for their voices to be heard within policy debate. Although refugee doctors continue to be the 'weak publics' of society with existing vulnerabilities and challenges due to their legal status, these support programmes improve their skills in the profession and knowledge of their rights, help build confidence and transform them into being active agents with the conscious act of integration.

Thus, the paper concludes its analysis by offering the following policy recommendations:

- the legal and practical hurdles for refugee doctors' economic integration in the UK needs to be recognised and included in the policy agenda in the UK,
- the experiences of the refugee doctors in their integration process need to be further analysed nationwide to get a bigger picture of this issue.
- there should be a dataset collected centrally within GMC with the inclusion of primary data from the NGOs that incorporates Support Programmes for Health Professionals in the UK.
- more financial support needs to be provided to refugee doctors during their economic integration process. For instance, GMC can offer further financial support for their preparation for the GMC registration exams.
- the government needs to expand its financial support for NGOs training and preparing refugee doctors for practising their profession in the NHS.

Ethical Approval Statement

The ethical approval application is made to the University of Lincoln through LEAS system and the data collection methods and other ethics details are approved in July 2021 (ref no: 2021_6942).

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