

Integrating refugee doctors into host health-care systems

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Refugee doctors face a number of barriers to practising medicine, despite the significant contributions that they can make.

Despite being highly motivated to practise medicine, refugee doctors¹ in the United States (US) and elsewhere often find themselves working in low-skilled jobs while waiting to get into residency programmes.² They may face difficulties in communication, providing documentation and verifying previous training. This may represent a missed opportunity not only for the refugee doctors themselves but for the host country's own health-care system, especially in countries or areas with doctor shortages and/or a high proportion of immigrant or refugee populations.

The authors of this article are themselves former refugees or asylum seekers, immigrants to the US and/or have immigrant

or refugee backgrounds. This issue is close to our hearts as medical professionals and we would like to explore how we can empower and assist refugee doctors to join the workforce, resuming their professional lives and identities and helping to fill gaps.

Lessons from other countries

Integrating refugee doctors into a host country's health-care system requires the involvement of different stakeholders including medical associations, regional and national health services, private organisations and universities. The UK, for example, recognised that overcoming barriers such as recognition of equivalency of qualifications and training, and employment

regulations, would require specific national and local policy changes to enable refugee doctors and dentists to practise in the UK.³ UK-wide policy initiatives included the creation of the Refugee Health Professionals Steering Group which supervised the development of programmes to help retrain refugee doctors to National Health Service standards, cover examination costs and relocate doctors to under-served areas. Many local programmes assisted refugee doctors to register with the General Medical Council and pass the Professional Linguistic Assessment Board exam. Although subsequent immigration laws have since made it more difficult for refugee doctors to enter the workforce rapidly and remain in the UK permanently, most of the refugee doctors participating in these projects have remained in the UK to practise.

In 2015, the Swedish government 'fast-tracked' refugee doctors into their health-care system by rapidly verifying their credentials and providing individual training, mentoring and Swedish language lessons. And in Turkey, Gaziantep University and the World Health Organization teamed up to train and employ 500 Syrian refugee doctors to help care for the Syrian refugee population, with local clinics providing opportunities for the doctors to familiarise themselves with the Turkish health system.⁴

The current situation in the US

To practice medicine in the US, refugee doctors must undergo a process that is very intensive in terms of time, labour and finances, involving certification, examination, residency periods and licensing. While advocates of this system point to the need to ensure the best and most consistent quality of care for patients, other experts argue that foreign-trained doctors have more advanced bedside clinical skills than domestically trained doctors, having generally practised medicine in settings with less technology. A recent study, for example, showed that older patients in US hospitals treated by International Medical Graduates (IMGs) were less likely to die within 30 days of treatment than those treated by US-trained graduates.⁵

A number of private, public and non-profit programmes have been established to support refugee doctors in the US:

The Welcome Back Initiative (WBI), founded in 2001, used the untapped pool of IMGs living in California to provide linguistically and culturally competent care to local populations.⁶ The WBI has since expanded to a national network of 11 centres in nine states, serving almost 15,000 individuals from 167 countries. These centres provide free services to refugee doctors, including orientation, career counselling, support in obtaining credentials and licences, assistance in exploring educational programmes, job and volunteer opportunities, and alternative career options. Success has been modest: 23% of participants obtained employment in the health sector for the first time, 21% passed licensing exams, and 87 doctors were accepted into training programmes.⁷

The Minnesota Department of Health's International Medical Graduate Assistance Program aims to increase access to primary care in rural and under-served areas by providing clinical readiness assessment of IMGs and funding non-profit organisations to provide career guidance, additional clinical experience and primary-care residency positions for IMGs willing to practise in under-served areas.

In 2014, Missouri was the first State to pass legislation creating a new category of licensed 'assistant doctors' who can provide primary care under the direct supervision of a doctor in a health-care shortage area for the first 30 days, and thereafter with indirect supervision from a doctor who practises within a 50-mile radius. Although there has been criticism of the law,⁸ as of May 2017 127 doctors had applied for the licence with 23 being issued a licence, 55 deemed ineligible, and the others under review.

Several US academic institutions, such as University of California San Diego and University of California Los Angeles, have created programmes to place multi-lingual, culturally competent family doctors in areas with large immigrant and refugee communities.

Recommendations

Despite the creativity and early successes of some of these US programmes, what almost all of them have in common is their small scale. Compared with other refugee-hosting countries, the US lags behind in making concerted efforts to recognise the training of refugee doctors and to find more streamlined ways of harnessing their knowledge, talents, language and lifesaving skills to benefit our communities. We propose:

- A task-force consisting of stakeholders from federal and State governmental, private and public organisations, medical boards and professional associations, as well as refugee doctors themselves, to collect basic statistics on the number of refugee doctors, their demographics and current specialisms and to study other countries' approaches, review certification requirements and explore the integration of refugee doctors into different clinical roles.
- Training incentives for residency programmes that are geographically or specialism-focused, based on local population needs; this may also include the restructuring of observerships (shadowing), internships and fellowships specifically tailored to refugee doctors.
- Easing re-training requirements as a temporary or permanent solution for some, alongside other measures to strengthen job opportunities that recruit refugee doctors in other roles initially (to gain exposure to the US system).
- A more centralised scholarship and needs-based grant or stipend system to help with the significant financial burden of re-certification and licensing exams.
- Robust, accessible programmes to provide supervision and guidance through the complex certification and licensing process in the US, as well as instruction on the US health-care system.
- Free, easily accessible toolkits including national and State-based resources, communication modules, test-taking strategies and information about the application process.

Finally and critically, refugee doctors themselves should help drive new initiatives. Professional development efforts may help identify leaders who would run IMG-support programmes, seek partnerships in strategic planning, and organise – and perhaps partner with – existing IMG advocacy organisations.

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1. In this article, we use 'refugee doctors' to include both refugee and asylum-seeker doctors.
2. A formal period of supervised training for medical school graduates, usually three to five years in length, during which a doctor specialises in a field of medicine.
3. Steward E (2007) 'Addressing the Challenges Facing Refugee Doctors in the UK', *Local Economy* Vol 22 (4) <http://journals.sagepub.com/doi/abs/10.1080/02690940701736868>
4. Özdemir V, Kickbusch I and Coşkun Y (2017) 'Rethinking the right to work for refugee Syrian healthcare professionals: a call for innovation in global governance', *British Medical Journal* 357 www.bmj.com/content/bmj/357/bmj.j2710.full.pdf
5. Tsugawa Y J, Anupam B J, Orav E J and Ashish K J (2017) 'Quality of care delivered by general internists in US hospitals who graduated from foreign versus US medical schools: observational study', *British Medical Journal* 356 www.bmj.com/content/356/bmj.j273
6. Fernández-Peña J R (2012) 'Integrating Immigrant Health Professionals into the US Health Care Workforce: A Report from the Field', *Journal of Immigrant and Minority Health* Vol 14 (3) <https://doi.org/10.1007/s10903-011-9496-z>
7. This figure relates to the 10,700 individuals in the programme in 2012.
8. For example, Freeman B D (2016) 'The Implications of Missouri's First-in-the-Nation Assistant Doctor Legislation', *Journal of Graduate Medical Education* Vol 8 (1) www.jgme.org/doi/10.4300/JGME-D-15-00341.1