

English in Displacement: Language Learning and Test Preparation Experiences of Refugees and Asylum Seekers

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Abstract

In an effort to better support adult and refugee English language learners, this paper aims to focus on understanding the needs and experiences of one specific group, that is, refugee and asylum seeker healthcare professionals (RASHPs), based in the United Kingdom. RASHPs tend to be highly educated and experienced learners. One of their main objectives is to acquire high levels of English language proficiency and possibly return to clinical practice in their new host country. The data for the study come from an online survey that was completed by 106 respondents, followed by interviews conducted with three nurses and nine doctors. Additionally, two language test preparation teachers were also interviewed. The findings show that RASHPs represent a very diverse group of learners, with a range of linguistic backgrounds, age groups, and proficiency levels. Results further reveal that RASHPs often face a range of situational, technological and psycho-social barriers that may prevent them from fully engaging with their English language and test preparation classes. The study concludes with a series of classroom and policy-level recommendations that could help ensure better outcomes for refugee and asylum seeker learners.

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INTRODUCTION

Adult English language learners (ELLs) represent a linguistically and culturally diverse group. This group may include university students studying in English, professionals acquiring English for international communication or business purposes, immigrants attempting to integrate into new communities, refugees seeking asylum, as well as individuals participating in English language programs for personal enrichment. Each subgroup within this diverse population brings unique needs, strengths, previous learning experiences, literacy levels, goals, and aspirations (Burns & Roberts, 2010). Although much has been written about best learning and teaching practices for adult ELLs, given the highly heterogenous and constantly changing makeup of this group of learners, it is fair to say that these practices will vary considerably from one individual to another, and from one context to another.

In an effort to better support adult ELLs and to contribute to the existing body of literature, this paper aims to focus on understanding the needs and experiences of one specific group, that is, refugee and asylum seeker healthcare professionals (RASHPs) wishing to practice in the United Kingdom. RASHPs tend to be highly educated and experienced learners, with high levels of literacy, strong study skills, and well-developed learning habits (Bandaranayake, 2013). Given that English is the dominant language in the United Kingdom, one of RASHPs' main objectives is to acquire high levels of English language proficiency and return to clinical practice in their new host country.

The level of language proficiency required for clinical practice and the means that are used to verify it may vary from country to country (Taylor & Pill, 2014). However, in most contexts applicants' proficiency levels are measured in relation to a threshold of performance established by the regulatory authorities, using internationally recognized English language tests (Chan & Taylor, 2020). Consequently, for many RASHPs English language learning and test preparation go hand in hand and are often approached holistically.

The two international tests that are currently accepted by nursing and medical regulators in the United Kingdom are the International English Language Testing System (IELTS) and the Occupational English Test (OET)¹. Both tests assess candidates' English language skills in reading, listening, writing, and speaking. IELTS was designed to assess candidates' readiness for university-entry purposes and

¹ In addition to standardized English language assessments, some applicants may also apply for an exception and demonstrate their language proficiency through an alternative route, for example, by having a higher education degree obtained in an English-speaking country or prior experience of working in the National Health Service in the United Kingdom, vouched for by a senior colleague.

therefore focuses largely on academic English skills. OET was designed specifically to test English language proficiency within the healthcare context, with the tasks designed to replicate the kinds of communicative demands that healthcare professionals encounter in their day-to-day work, such as consultations with patients, handovers, and communicating with other healthcare professionals.

Upon arrival in the United Kingdom, many RASHPs often begin their test preparation journey by improving their general language proficiency through publicly funded English language provision. Refugees and asylum seekers in the United Kingdom are entitled to free ESOL (English for Speakers of Other Languages) classes, typically offering an average of 5 hours per week, available through local community colleges. However, these classes are often limited in availability and have long waiting lists. Once enrolled, students may struggle to access enough hours to reach required proficiency levels due to high demand and lack of funding. (Refugee Action, 2019). Due to these constraints, many refugees and asylum seekers turn to various charitable organizations, some of which collaborate with private language schools and third-sector entities to provide comprehensive language and test preparation support (Agbaso & Roberts, 2023; Morrice, Tip, Collyer, & Brown, 2021).

In addition to English language skills, charities also assist refugees with other practical aspects of displacement, such as finding meaningful or alternative employment in the United Kingdom, assistance with housing, legal and immigration advice, as well as mental health and counseling services. In addition to dealing with various bureaucratic and administrative hurdles, refugees and asylum seekers often cope with deeply personal and distressing issues stemming from their experiences back home, which can result in post-traumatic stress disorder (PTSD), depression, anxiety, and overall poor mental health (Carswell, Blackburn, & Barker, 2011; Wood, Gerskowitch, Kayal, Ehntholt, & Blumberg, 2022).

Several charities, for example, RefuAid, Reache North West offer more specialized services aimed specifically at RASHPs to facilitate their transition into the healthcare workplace through a more holistic approach. These supports address the immediate and critical needs refugees and asylum seekers face as they establish livelihoods in their new host country and navigate complexities in seeking assistance from government agencies and local authorities, who are responsible for direct support within their catchment areas (Morrice et al., 2021). However, coherent national or local integration policies are often lacking, and the level of support varies between different local authorities and different parts of the United Kingdom (Agbaso & Roberts, 2023; Kesete, Thom, & Harvey, 2015, p. 27).

Given the central role that English language proficiency plays in meeting immediate functional needs and future aspirations of RASHPs, this paper focuses on both English language learning and test preparation experiences and challenges encountered by this specific group of adult ELLs in the United Kingdom. In doing so, the paper aims to highlight aspects of English language learning and test preparation that require further intervention and support, focusing on the immediate context of the classroom and wider policy issues.

LITERATURE REVIEW

Principles and Barriers of Language Learning in Adults

In order to understand language learning barriers specific to RASHPs, it is important to first revisit the key challenges experienced by all adult English language learners (ELLs). As Mathews-Aydinli specifies (2008, p. 199), adult learners are generally considered to range in age from 16 to 90-plus, in educational background from no formal schooling to PhD holders, and in first language literacy levels from advanced to pre-literate. Their corresponding needs range equally widely, from survival English skills to transitional classes to help them prepare for higher education or employment opportunities in English.

Despite the multitude of contexts, experiences and perspectives reflected in the literature on adult ELLs, there are several common themes that can be observed. One of the themes relates to the role played by external factors that force adult learners back into the ELT classroom, such as the need to find work, pass their citizenship language test, become self-reliant, access the healthcare system, assist family members with language support in a new host country or preserve their dignity and privacy by not having to rely on language interpreters (Kisiara, 2021). Unlike children and young adults who acquire English as part of school or university curriculum, often without explicitly choosing to do so, adult ELLs are extrinsically motivated, which is one of the key differentiating factors between these two groups of learners.

Another differentiating factor between adult and younger learners is the role of situational factors in facilitating or inhibiting adult ELLs' attempts to learn English. As Orem (2000: 441) notes, "[adults ELLs] lead very complex lives, which limits their access to classes." Situational barriers may include issues with childcare, erratic work schedules, balancing multiple jobs, or lack of employment and financial stability (Finn, 2011, p. 35). Although family commitments often pose a significant challenge for ELLs, several studies present a different perspective and acknowledge the critical role of the family in promoting learner

success, particularly among adult female ELLs with low literacy levels, where family support is crucial to ensure continuous access to education (Buttaro & King, 2001).

Another theme emerging from the literature relates to resources and pedagogical approaches that are most valued by adult learners. De Costa (2010, p. 536), for instance, emphasizes the importance of preparing adult ELLs to function successfully in a range of sociocultural contexts by bringing the outside into the classroom. Having students engage in activities that simulate reality (e.g., navigating the Internet in class) can further increase their engagement with their English language classes and assist with social advancement in their new host country.

Mathews-Aydinli (2008, p. 202) further notes that one of the recommendations emerging from the existing studies on ELLs is the need to balance newer pedagogical approaches with more traditional teaching methods that students are familiar with. In another study, Gault (2003) reports that adult ELLs showed a strong preference for features associated with a traditional classroom, such as grammar instruction, error correction, and use of summative assessment. The study concludes that teachers who relied only on natural or communicative approaches did not retain students as well as those who incorporated more traditional approaches to put students at ease, including the largely discarded grammar-translation method, despite the widely acknowledged superiority of the communicative language learning.

It is reasonable to assume that all the situational and neuro-biological barriers that affect adult ELLs equally apply to refugee and asylum seeker learners. The key differentiator between adult ELLs and adults ELLs who are refugees or asylum seekers is the prevalence of trauma among the latter group, which may in turn lead to the development of post-traumatic stress disorder and depression (Callaghan, Yemane, & Baynham, 2019). The degree of severity will of course vary from individual to individual, with some individuals relatively unscathed by their past experiences while others severely affected (Capstick, 2018, p. 56). Numerous studies have confirmed that the effects of trauma can interfere with many areas of functioning, including all aspects of education and motivation for learning a new language (Gordon, 2011; Iversen, Sveaass, & Morken, 2014), and should therefore be acknowledged and addressed in English language classrooms.

Test Preparation

One of the more commonly used definitions of test preparation is that of Messick, who refers to test preparation as any intervention

procedure specifically undertaken to improve test scores, whether by improving the skills measured by the test or by improving the skills for taking the test, or both (1982, p. 70). Test preparation activities can be varied and include attending specialized courses, doing practice tests and similar self-study activities, getting help from family and friends or practicing under timed conditions (Knoch, Huisman, Elder, Kong, & Mckenna, 2020, p. 551).

Most of the existing test preparation literature focuses on two major strands, which include the effects of test preparation on score gains and the effects of test preparation beyond the test, usually referred to as washback. In the English language assessment context, Liu (2014) looked at the relationship between test preparation activities and TOEFL iBT performance in a cohort of Chinese test takers. The study concluded that, compared to the often short-term and intense test-specific preparation strategies, general English learning strategies may take a longer time to show any effect on test scores. However, if practiced consistently and frequently, general English learning strategies may be significantly correlated with improved English abilities across multiple skill domains (Liu, 2014, p. 11). The findings of the study therefore suggest that test preparation should be approached from a broader perspective, rather than focusing on score gains alone.

The second strand of work focusing on test preparation deals specifically with washback, that is, the effects of test preparation on learning and teaching that go beyond the immediate context of the test (Clark & Yu, 2022; Green, 2007; Hughes, 2003). Although washback is highly context-dependent, the mediating factors outlined in Green (2007), such as the perceived importance of the test, the difficulty level of the test, and the resources available to test takers and teachers allow for prediction of washback in various contexts. These factors are particularly relevant to the test preparation context discussed in the current study, where test outcomes are closely linked to an official policy regulating RASHPs' access to employment, leading to language tests being perceived as high stakes by test takers.

In addition to Green (2007), the research is also guided by the impact by design model (Saville & Khalifa, 2016). The model advocates for an integrated view of the micro- and macro-contexts, which is of particular relevance to the present study. Consequently, the study aims to investigate the outcomes at the student and classroom level (micro-contexts) and situate them within the everyday realities of displacement and forced migration (macro-context). The model also makes an explicit link between test impact and actions to be taken in order to achieve the desired impact, which fits well with the overarching goal of the study to provide classroom and policy-level

recommendations with regard to RASHPs, as well as adult ELLs from refugee and immigrant backgrounds.

Healthcare Professionals' Experiences with English Language Assessment and Clinical Communication Challenges

The research aims to further build upon the existing body of literature dealing specifically with healthcare professionals' experiences with English language tests. Most English-speaking countries recognize IELTS and OET as proof of English proficiency, a decision influenced by various factors including test content, quality, and practical considerations (Taylor & Pill, 2014). In the context of OET, Maqueen, Pill, Elder, and Knoch's (2013) study revealed an overall strong congruence between the individual test tasks and actual communication in the workplace, based on the feedback from former candidates, clinical supervisors, and representatives of medical and nursing boards. In contrast, focusing exclusively on IELTS, Sedgwick, Garner, and Vicente-Macia (2016) suggest that nurses require a much wider competence in spoken English than is assessed in the IELTS speaking test.

Looking at the challenges post-registration, the issue of acculturation has been singled out in several studies. For example, Pilotto, Duncan, and Anderson-Wurf (2007) noted that overseas healthcare professionals working in Australia struggled with their understanding of the English language, particularly the use of idiom, linguistic nuances, and vernacular terms. Further difficulties were reported in terms of establishing rapport with patients and responding to their emotions, despite high English proficiency levels. Similar findings were reported by Dorgan, Lang, Floyd, and Kemp (2009) in the United States, where overseas healthcare professionals faced communication challenges due to unfamiliar dialects, shifting power dynamics, and varied expectations regarding rapport building. These challenges were linked directly to participants' previous educational backgrounds, where communication training "seemed to be an afterthought" (Dorgan et al., 2009, p. 1569).

Finally, the paper will expand upon the limited existing literature focusing on the English language learning journey and test preparation experiences of RASHPs. Roberts (2020) examined linguistic and psycholinguistic barriers faced by 22 refugee healthcare professionals in Wales, highlighting struggles with English use in social situations and socio-affective barriers related to displacement, deprofessionalization, family commitments, and the pursuit of lost professional status. At the time of the study, IELTS was the only English language test accepted for medical registration purposes in the United Kingdom,

with OET added as an option in 2018. As the author reports (2020, p. 12), participants felt that “IELTS was not a perfect fit for the purposes of the GMC” and it was hoped that the introduction of OET—a healthcare-specific language test—would help rectify this situation.

Carr (2021), conducted when both IELTS and OET were available, examines the suitability of the two tests by focusing on the views of 50 refugee doctors and nurses and their test preparation experiences at Reache North West². The study concluded that candidates perceived OET as more achievable and motivating than IELTS and resulted in higher pass rates (Carr, 2021, p. 100). Participants also confirmed their preference on being tested on topics that are related to healthcare and closely linked to their future career.

The present study further builds on the existing research by focusing on both RASHPs’ and test preparation teachers’ perspectives. Unlike the previous studies, this study was conducted when OET was fairly well-established both in the United Kingdom and other English-speaking countries and thus offers a more up-to-date analysis of RASHPs’ experiences with English language learning and testing.

METHODOLOGY

The following three research questions (RQ) are addressed in the paper:

- RQ1. What is the English language profile of RASHPs wishing to transition into healthcare employment in the United Kingdom?
- RQ2. What English language test do most RASHPs choose for their professional registration purposes and how do they prepare for their chosen English language test?
- RQ3. What are the common challenges that prevent RASHPs from engaging with English language learning and test preparation, and what can be done to mitigate them?

The research presented in this paper was conducted from an exploratory perspective and employed a sequential mixed-methods design. This involves collecting and analyzing quantitative and qualitative data in two consecutive phases within a single study (Ivankova, Creswell, & Stick, 2006). In this study, survey data were collected first, followed by online semi-structured interviews conducted with selected

² Reache North West is an organization that supports refugee health professionals to gain the necessary skills and qualifications to re-enter their profession and become safe and effective practitioners in the UK National Health Service. The organization provides English language classes and clinical teaching programmes (Carr, 2021).

RASHPs and test preparation teachers working with RASHPs. Prior to data collection, ethical clearance was obtained from Cambridge University Press and Assessment.

The mixed-methods approach was chosen for several reasons. In the first instance, it allowed to capture insights into the prevalence, frequency, and distribution of variables under investigation from a large number of RASHPs through the survey. These quantitative insights were explored further in the qualitative phase and informed the design of interview questions. To achieve triangulation of data, the interview questions mirrored the questions and themes in the survey. However, unlike the survey, most of the interview questions were designed as open-ended. Additionally, the inclusion of the qualitative component allowed to capture participants' subjective and deeply personal experiences, providing them with a platform to share their perspectives.

Participants

Participants for the study were recruited via two UK-based charitable organizations working with RASHPs, namely RefuAid and NHS Refugee Support Programme, operated in partnership with Liverpool John Moores University, RefuAid and Talent Beyond Boundaries. The organizations sent out information sheets and survey links to refugee and asylum seeker doctors and nurses registered in their database. This approach enabled the researchers to recruit participants from across the United Kingdom, ensuring that the sample was representative of the broader RASHP community, rather than being confined to a particular geographic area or associated with a specific educational institution. The decision to primarily focus on doctors and nurses was based on recommendations from charitable organizations, which highlighted that these are the two largest groups of RASHPs in the United Kingdom. Other healthcare professions, such as dentists and pharmacists, were noted to be relatively infrequent.

RefuAid representatives helped identify two institutions that support RASHPs with language learning and test preparation. Each institution nominated a teacher who agreed to be interviewed for the study. While one of these teachers instructs both RASHP and non-RASHP students, the other works exclusively with RASHPs. There is no information to suggest that the two teachers were directly involved in providing English language or test preparation classes to RASHPs taking part in this study. Overall, 106 responses were provided to the online survey³ (74 doctors,

³ Note that sample size varied for each question within the survey. Responses are reported as percentages of the total number participants for each question.

30 nurses, and two midwives)⁴. Most participants were between 36 and 45 years old ($n = 45$, 48%) and came from 22 different countries. The two most common countries of origin for nurses were Lebanon ($n = 7$)⁵ and Iraq ($n = 6$), whereas most doctors came from being Sudan ($n = 156$) and Turkey ($n = 145$). There were more refugees ($n = 42$) than asylum seekers ($n = 20$) who took part in the study. The remaining participants had come to the United Kingdom as refugees or asylum seekers, but at the time of the study had either limited or unlimited leave to remain, were under humanitarian protection, had a visa, or were British citizens.

Out of the 74 doctors who took part in the survey, there were 33 male, 32 female, and one other gender participant⁶. The sample for nurses consisted of 25 female and five male participants, representative of the typical gender distribution patterns across the wider nursing workforce (Purnell, 2007). Further demographic information can be found in Figures A1–A10, Appendix A.

Of all survey participants, three nurses and nine doctors agreed to take part in semi-structured interviews. Semi-structured interviews were also conducted with two English language teachers working with RASHPs to explore their perspectives on the issues of test preparation and language learning.

Survey

In the first phase, primarily quantitative data were collected using a web-based survey. The survey comprised a mixture of closed questions (Likert scale, multiple choice, checkboxes) and open-ended questions. The goal of this phase was to gain an overview of the key challenges that RASHPs experience at each stage of their professional registration and employment journey. Survey domains included basic demographic information, immigration status, English language proficiency, English language tests and preparation, common employment and registration challenges, as well as previous clinical experiences and employment. Survey questions can be found in Appendix B.

The survey was informed by the insights gathered through the interviews conducted with charity representatives working with RASHPs, as well as the findings of existing studies focusing on adult learners, as

⁴ Given the anticipated small sample size, there was no separate survey designed for midwives. They answered the nurses' survey instead.

⁵ A relatively high proportion of nurses from Lebanon (25% of the sample) participated through the NHS Refugee Nurse Support Programme, led by the UK's Department of Health and Social Care for displaced people from Lebanon and Jordan.

⁶ Eight participants chose not to disclose their gender.

outlined in the literature review. The survey aimed to verify some of the assumptions based on the anecdotal evidence provided by charity representatives in relation to such issues as the most common difficulties experienced by RASHPs, the similarities and differences in the experiences of refugee and asylum seeker doctors and nurses, and challenges related specifically to English language learning and assessment.

The survey was peer-reviewed by researchers from the two institutions to ensure its content validity and relevance to the research objectives. To evaluate the survey's clarity and appropriateness, pilot testing was conducted with two RASHPs prior to its wide-scale administration. This pilot phase allowed researchers to seek feedback on the clarity of survey instructions, the appropriateness of response options, and the overall coherence of the instrument. Given that all participants in the present study are speakers of English as a second or additional language, this phase was particularly crucial in ensuring that the survey was comprehensible and tailored to the right level of language proficiency.

Semi-Structured Interviews

Participants who expressed an interest in taking part in semi-structured interviews ($n = 11$) were interviewed virtually using Microsoft Teams. The semi-structured interviews lasted for 30 minutes and focused on RASHPs' experiences with English language learning, English language tests and preparation, professional clinical examinations, clinical experiences, as well as their journey and experiences of clinical employment, as appropriate. Interview questions can be found in Appendix C. For the purposes of this paper, only data related to English language learning and test preparation are included.

A narrative inquiry approach was adopted in semi-structured interviews. Narrative inquiry is a form of qualitative research in which participants' stories themselves become the raw data (Bleakley, 2005). The qualitative data gathered via interviews enabled the elicitation of more personal, individual experiences and were used to complement and interpret the significance of the data gathered in the survey.

The interviews were recorded with consent from the participants. Interview responses were transcribed and anonymized by a professional transcription services company. Thereafter, the data were analyzed by the research team drawing upon the principles of thematic analysis (Braun & Clarke, 2006) using Nvivo. All transcriptions were double-coded by two researchers, and coding reliability was found to be acceptable at more than 80% of agreement.

RESULTS

RQ1. What is the English language profile of RASHPs wishing to transition into healthcare employment in the United Kingdom?

A total of 12 different first languages was recorded in the survey, which included Arabic ($n = 48$, 46%), Turkish ($n = 15$, 14%), Farsi/Persian ($n = 14$, 14%), and Spanish ($n = 4$, 4%).

Qualitative interview data revealed a very mixed picture of previous English language learning experience. Some interviewees began their English language learning journey upon arrival in the United Kingdom, having no previous knowledge of the language. Other interviewees had English classes in high school and reported having some proficiency, often with jagged profiles and greater confidence in some skills. On the other hand, some interviewees were highly fluent speakers of English who had completed their medical degrees in English or acquired fluency after living in the United Kingdom for many years. The variance in previous experience of learning English is demonstrated in the interview excerpts below:

First, when I came here, I didn't speak any English, because in my country we speak French

(Interview 2, Doctor) ⁷.

I didn't need lots of support with the language because I've already studied in English. So my university was in English, so all the subjects that I studied, all my medical knowledge was in English

(Interview 3, Doctor).

Related to this, there was a range of perceived English proficiency levels reported in the survey. Overall, most participants who rated their perceived English proficiency indicated a score between 6 to 8 out of 10 ($n = 71$, 84%), with an average score of 6.9. Though similar across both doctors and nurses, there may be indication that nurses seem to show a lower level of self-perceived English language proficiency compared to doctors, with slightly more nurses rating their English language proficiency at 5 or below out of 10 compared to doctors (18% vs 10%, respectively).

The data reported above were corroborated by English language teachers, who noted that "there's probably more success with [English

⁷ Open-ended survey responses and interview quotes have been copied verbatim to preserve authenticity. In some instances, minor edits have been made for readability.

language tests] for doctors rather than nurses,” adding that it usually takes more attempts for the nurses to be successful compared to doctors. The difference between the two groups was attributed to prior academic experience, with doctors having a much higher awareness of study skills due to the more academic nature of their professional training, which gives them an advantage when it comes to test preparation and English language tests.

RQ2. What English language test do most RASHPs choose for their professional registration purposes and how do they prepare for their chosen English language test?

English Language Tests. As mentioned in the introduction, when applying for professional registration, internationally qualified doctors and nurses (including RASHPs) must submit proof of English language proficiency at the required level. The two tests currently accepted in the United Kingdom are OET and IELTS⁸.

Of the 93 respondents, 78 participants (84%) indicated that they were preparing for or had passed OET compared to 10 participants (11%) choosing to take IELTS. The relevance of OET to RASHPs’ professional training and future aspirations in the healthcare sector was strongly emphasized in the qualitative interviews, as exemplified below:

Well OET, at least it’s more specific for [the] medical field, so the exam is not that difficult because they are using the medical terminology, the topics mainly about medicine, pharmacy and about public health, so things related to healthcare, which are more relevant to what we are doing

(Interview 3, Doctor).

Some interviewees had initially attempted IELTS but had switched to OET when they had learned that OET was available as an alternative option. For example:

Previously, I attempted twice IELTS which I thought is really hard, and was not relevant to my major ... OET was really more relevant to our major, and to my profession

(Interview 9, Doctor).

⁸ For IELTS, nurses must achieve a 7.0 score in the reading, listening and speaking sections, 6.5 in writing and 7.0 overall. For OET, nurses must achieve a grade C+ in the writing section, and a grade B in the reading, listening and speaking sections. Doctors are required to achieve an IELTS 7.0 score in all four skills and 7.5 overall, or an OET grade B in all four skills.

Since OET was the most commonly chosen test among this group of research participants, test preparation practices reported below are in relation to OET only. A detailed breakdown can be found in Table 1; participants were able to report more than one method.

As the table demonstrates, RASHPs typically prepare for the test either on their own, using OET preparation materials (35%), or by attending structured OET preparation classes (33%). Other forms of preparation included studying with other RASHPs or attending classes run by volunteer groups, for example:

Another volunteer group in [City], some British people, British doctors arranged that organisation. We meet every Tuesday for almost two hours, or 1.5 hours, and they teach each week one medical topic

(Interview 4, Doctor).

The crucial role of volunteers was also brought up by English language teachers, not only in helping students practice their speaking skills, but also building their test confidence and helping overcome disappointment, as exemplified in the quote below:

We do spend some time trying to help them with their confidence, and that's something that the two RefuDoc⁹ volunteers talk about as well, how to keep yourself going, how to bounce back from disappointment, also how to deal with exam stress and things like that.

TABLE 1

Breakdown of Responses from Doctors and Nurses on their OET Preparation. Participants Could Select More than One Answer

	Total	Total %	Nurse	Nurse %	Doctor	Doctor %
By studying on my own using OET preparation materials	49	35	10	35	39	36
By attending OET test preparation classes	46	33	11	38	35	32
By attending general English preparation classes	24	17	3	10	21	19
By studying on my own using general English preparation materials	18	13	5	17	13	12
In other ways	2	1	0	0	2	2
Total	139		29		110	

⁹ RefuDoc is an informal name for a group of initiatives designed to support refugee-background doctors at the University of Leicester, some of which involve qualified refugee-background healthcare professionals volunteering to support current students.

Test preparation teachers further reported that unlike other students, RASHPs tend to be “more tolerant and supportive toward each other,” both within and outside the class. It was noted that refugee students are more likely to form self-study groups to add in extra practice between classes, which was attributed to RASHPs being more isolated and therefore more willing to engage with other members of the class.

Engagement and Motivation. Engagement and motivation have long been identified as key affective factors that correlate with academic learning and achievement. Motivation can be defined as an individual’s inclination, energy, direction, and drive toward learning and achievement (Collie & Martin, 2019: 2), whereas engagement is a multi-faceted construct that consists of several dimensions, namely behavioral (attendance, participation, preparation for class), academic (time on task, homework completion), and cognitive (value, relevance, goal setting) (Appleton, Christenson, Kim, & Reschly, 2006).

Preparation teachers reported very high levels of engagement in class and motivation to pass the English language tests in RASHP students. When talking about engagement in class, one of the teachers felt that “engagement and enthusiasm to participate and learn is very, very high,” adding that “students will do the absolute best they can to attend. And when they can’t attend, then they’ll still be engaged in the sessions, and have very high levels, in general, high levels of self-study.”

Another teacher also noted that the refugee students are “more highly motivated and have a higher intrinsic motivation than perhaps some of the other groups we work with.” They further added that refugee and asylum seeker students demonstrated significant willingness to engage in extra self-study activities to achieve their goals. Previous language test failure was identified as a key barrier to motivation, as explained by one of the teachers:

They are motivated, although some of them are a little bit – some feel like they lack confidence and can feel a bit demoralised especially if they’ve tried the exam before and they’ve failed.

Finally, contrary to what is reported in the literature on adult language learning, the teachers felt that refugee student groups “tend to be quite open, perhaps more than other groups, open to learning and open to new strategies and new techniques than perhaps some of the other groups that we work with.” This observation further demonstrates that RASHPs are highly driven and motivated to succeed in their English language tests and willing to trial new approaches in order to achieve their goals.

RQ3. What are the common barriers and challenges that prevent RASHPs from engaging with English language learning and test preparation, and what can be done to mitigate these challenges?

Situational Barriers. The barriers that emerged from the survey and qualitative interviews included situational, technological, and psycho-social factors that prevent RASHPs from fully engaging with English language learning and test preparation. Each of these categories is discussed below.

As stated in the introduction, for many RASHPs test preparation begins with getting access to an English language class, which in itself can pose significant hurdles. Participants reported instances where they were unable to access the course either due to living outside catchment areas of support or the unavailability of courses, as exemplified in the quote below:

They straightforwardly first ask “where is your location?”. Once you tell them that, “I’m living in Bristol,” “unfortunately, we won’t be able to help you.” Even with the virtual classes, what offers they can do, just nothing. So that was really unfair, for me, that everything was in London

(Interview 5, Doctor).

Both RASHPs and English language teachers also acknowledged challenges posed by childcare and family commitments, lack of flexibility at work, or inadequate living arrangements. Many RASHPs reported being unable to attend English language classes or study on their own because they had to look after their children or take care of family members, as they are often the only English speaker in their family. This is illustrated by the following comment:

I have 3 kids. I attend online English courses, but I can’t find much time to study English by myself

(Survey, Doctor).

When it comes to work commitments, the situation differs significantly between asylum seekers and refugees, as the former are not allowed to undertake any paid employment while their application is being reviewed. On the other hand, most refugees attempt to find meaningful employment during their registration journey, particularly nurses, many of whom reported being employed as healthcare support workers ($n = 14$ out of 30).

Both RASHPs and test preparation teachers recognized the importance of healthcare-related employment in facilitating progress with

their English, especially their speaking skills. These perspectives are exemplified in the quotes below:

I work in mental health [as a support worker]. Working in mental health allows you to communicate with the patients more, to interact with the patients more

(Interview 10, Nurse).

There tends to be a difference in strengths, weaknesses and progress, depending on if students are working. [. . .] So we sometimes get students in refugee groups who can talk about or appear quite isolated, so if they're not working [. . .], they're not exposed to the language in the healthcare setting or language in general, that can then impact on the progress that they can make [. . .]

(Test preparation teacher).

While there are clear benefits that can be attributed to undertaking employment while preparing for English language tests, test preparation teachers also acknowledged attendance challenges, noting that students sometimes drop out because their shift patterns change or because they are unable to get the support from their employer. However, they went on to emphasize that this was a barrier to attendance, rather than engagement, as many students made significant efforts to catch up with the class recordings or submit their assignments even if they could no longer attend test preparation classes.

Technological Barriers. Both test preparation teachers that were interviewed noted that all classes were provided online. The rationale for this decision was to allow as many healthcare professionals as possible to benefit from the classes, as they tend to be based in different parts of the country or even abroad. Another reason for conducting the classes fully online was to allow participants an opportunity to combine English classes with their work or family commitments. While there are certainly many advantages to online classes, there are also challenges, which in the case of RASHPs are exacerbated by their situational circumstances.

One of the key barriers identified in the study is access to stable broadband and lack of an environment conducive to learning, which arises because of RASHPs' difficult personal circumstances and inadequate living arrangements. As one of the teachers explained:

Depending on where [RASHPs] are living, and how stable the living situation is, can then impact how easy it is for them to connect, and how easy it is for them to participate in the classes.

They further added that some students had to keep their cameras off because of broadband issues, which in turn creates difficulties with engaging fully with class content and interacting with fellow attendees.

These issues were also highlighted by RASHPs themselves, as exemplified in the quote below:

Currently, we are in a hotel, it's been nine months, we are still in a hotel. There is some progress on our journey, but still, everything is stuck because of the accommodation issue. Once you have your accommodation, you can plan properly

(Interview 6, Doctor).

Another common technological barrier is having access to the right hardware. Preparation providers recommend using a laptop or a computer to attend online classes, which many RASHPs simply do not have and cannot afford. One of the teachers provided the following overview of the typical scenario that they deal with in their class:

[...] quite often, people don't have a functioning laptop, and they're trying to access the class on an iPad or a phone, and they need to not only be able to join the Zoom lessons, but we use Google Classroom as well as a repository for materials, and quite often, it just doesn't have the functionality to be able to use that mechanism properly.

This challenge was also highlighted by some of the RASHPs, as exemplified below:

I was joining online classes from my phone [...] and every time I was struggling [...]. Try this ID, try that ID. So I was, I mean, in a two- or three-hour class, you're struggling [to connect] for half an hour

(Interview 10, Doctor).

Some attempts at helping RASHPs overcome technological barriers were reported, such as providing them with pre-paid SIM cards or second-hand hardware. However, these initiatives applied to a very small number of individuals and were not available more widely.

Psycho-Social Barriers. The last set of barriers encompass a broad range of issues that fall under the psycho-social category. Psycho-social barriers include the internal and personal barriers that stem from individual's beliefs, attitudes, values, hang-ups, and inhibitions and can include such factors as learning and test anxiety, low self-esteem, and mental health issues.

Learning anxiety was noted by both teachers interviewed, though less so by the students themselves. According to the teachers, different learning backgrounds and past learning experiences have to be taken

into consideration and addressed in class when students first join the test preparation course. It was also noted that giving students “time and space to discuss these different experiences, ideas, anxieties” was important in order to improve engagement with the course and reduce anxiety.

In addition to learning anxiety, test anxiety was also evoked by the teachers and RASHPs themselves. In most instances, anxiety was caused by previous failed attempts of passing language tests. As one of the teachers explains:

Sometimes we can get students who have done IELTS a lot of times, and so they get quite a lot of, I think, test fatigue and very negative feelings toward tests in general, and frustration. So sometimes students will come to class with that frustration that they have already, around English language testing.

For many RASHPs, switching from IELTS to OET was akin to a fresh start on their professional registration journey. However, some candidates, particularly nurses, will require more than one attempt to achieve the required scores on OET, which often leads to low self-esteem and frustration. As one of the RASHPs explains:

It’s really hurtful. It’s stressful. Each OET, it’s lots—has been lots of pressure for me, to be honest. Emotionally, physically

(Interview 8, Nurse).

As noted in the quote above, test anxiety is predominately caused by the high stakes associated with passing a language proficiency test. For many RASHPs, the alternative is to lose an opportunity to go back to practicing medicine or nursing in their host country and seek employment opportunities unrelated to their professional training, which is not the choice they want to be forced to make.

Related to the points raised above, is the low self-esteem that many RASHPs struggle with, not only as a result of previous failed test attempts, but also as a result of suffering multiple losses in their personal lives. As one of the RASHPs explains:

To be honest, in this last year, I felt very bad about myself. You know, in Yemen, I had my job, I had my family, I had my social life, here I lost almost all

(Interview 4, Doctor).

Loss of a professional status as a doctor or a nurse was something that many respondents evoked in the interviews and struggled to accept. Many of them emphasized the contrast between their previous status of high regard and their current status of a refugee or asylum

seeker, or the contrast between their previous professional status and the low-grade employment they were in at the moment, for example:

I don't mind working as a healthcare support worker. Normally I was a professor in Turkey. Yeah, for years, I worked as a professor

(Interview 7, Doctor).

Conversely, many RASHPs emphasized their strong desire to regain their previous social status and expressed their fears around losing their clinical skills as a result of a long journey toward clinical registration. These feelings and barriers are potentially starkly different from the experiences of non-refugee OET candidates, who are pursuing better career opportunities abroad but can continue practicing in their countries of origin in the meantime.

Finally, the effects of previous traumatic experiences as well as the multiple challenges of trying to make a living in a new host country were acknowledged by several RASHPs, who spoke of "mental trauma" and "losing their spirit." As one respondent summarized:

I think 99 percent of [refugees and asylum seekers] might need psychological support [...] because they came with nothing. They left their home country, they bought only one handbag with nothing, so they started from zero. [...] I saw how difficult it was, not only for women, also for men. They were going all going through bad mental health issues

(Interview 2, Doctor).

While RASHPs were clear about the need for additional mental health support, as one of the test preparation teachers acknowledged, teachers do not normally know how to deal with trauma in the language classroom. There was a range of approaches and practices reported in the qualitative interview data. One of the teachers was fully aware of trauma-informed ELT practices and was actively applying them in their classes. These practices included avoiding triggering topics (e.g., family, childhood or previous life experiences), building trust, creating safe space, "focusing on the people rather than the content," giving students choices and a sense of agency.

Although the other test preparation teacher applied some of these practices (e.g., giving students time and space to discuss their anxieties and inhibitions), they did not explicitly refer to them as trauma-informed practices and appeared to be mainly guided by intuition rather than formal training. The teacher acknowledged that students' previous traumatic experiences were "in the background" but not focused on overtly or discussed in detail. The difference in approaches is likely to stem from the fact that the former preparation

provider was focusing exclusively on working with RASHPs, whereas the latter worked with mixed classes, where refugee and asylum seeker students were integrated with other students, that is, overseas health-care professionals hoping to secure employment in the United Kingdom.

DISCUSSION AND CONCLUSIONS

The present study focused on the English language learning and test preparation experiences and challenges of RASHPs who are hoping to return to medical practice in the United Kingdom, with the aim of identifying areas for improvement and further support. While some of the findings and recommendations are relevant only to this specific group of learners, a lot of them may apply to the wider context of adult language learning.

As reported in RQ1, RASHPs represent a very diverse group of learners, with a range of linguistic backgrounds, age groups and previous English language learning experiences. The results of the study suggest that doctors tend to have higher levels of English language proficiency compared to nurses. This difference can be linked to the length and scope of their clinical training, with doctors required to acquire such study skills as self-efficacy, self-reflection, as well as critical and creative thinking, all of which can be transferred to other learning contexts (Bandaranayake, 2013, p. 244).

The results for RQ2 revealed that RASHPs are more likely to choose a healthcare-specific English language test for medical registration purposes (84% would choose OET and 11% would choose IELTS). These preferences align with the results reported in previous studies. Carr (2021:89) notes that “[RASHP] candidates overwhelmingly prefer the OET, rating it more achievable, more relevant and more motivational than the IELTS.” Elsewhere, Roberts (2020: 12) reports that introducing OET as an alternative to IELTS resulted in “less negativity toward [language] assessments” (ibid).

Although candidates taking OET for professional registration purposes tend to achieve higher pass rates compared to those taking IELTS (Goldstone, McCarthy, Byrne, & Keen, 2023), qualitative interviews suggest that some RASHPs still attempt to pass IELTS first. A number of participants reported switching to OET following one or more unsuccessful IELTS attempts, emphasizing that OET was better aligned to their previous professional experience and therefore easier to pass.

Analyzing these findings through Green (2007), the strong preference for OET can be seen as an instance of positive washback. OET’s

focus on healthcare-specific language skills directly supports the professional needs of RASHPs, making the test more relevant and motivating. This relevance likely enhances candidates' learning experience and increases their engagement, thereby improving their performance and success rates. RASHPs' preference for OET is therefore not merely subjective but is linked to the test's ability to create a beneficial learning environment aligned with RASHPs' professional aspirations, a core principle of Green's washback model.

RQ3 directly relates to the impact by design model, which highlights the need to address both micro- (individual and classroom level) and macro- (system-level) factors when evaluating learning and test preparation outcomes. The findings of the study demonstrate that RASHPs face a number of situational, technological, and psycho-social challenges on their English language learning and test preparation journey. The key situational barrier reported by participants is lack of access to English language and test preparation classes as a result of living outside of designated catchment areas. With the classes conducted mainly online, participants felt that restrictions by catchment area were unfair and unnecessary.

Technology limitations emerged as another major barrier to engagement. The interviews revealed that lack of broadband and access to laptops are often closely linked to RASHPs' unstable living situation. At the time of the study, there appeared to be no concrete initiatives in place by the local authorities, refugee charities, or educational institutions offering language programs to assist RASHPs with overcoming technological barriers.

While situational and technological barriers are largely caused by external factors, psycho-social barriers arise from internal beliefs, attitudes, and inhibitions. In addition to test and learning anxiety, RASHPs' feelings of low self-esteem were further exacerbated by previous language test failures, which were compounded by experiences of deprofessionalization and displacement. These conclusions align with similar findings documented in earlier studies (Carr, 2021; Roberts, 2020).

Finally, some RASHPs disclosed that previous traumatic experiences as well as multiple challenges associated with making a living in a new host country can have a very negative impact on their mental health, with some interviewees reporting symptoms of depression and PTSD, which can interfere with their attendance, engagement, and ability to concentrate in class. As reported by one of the teachers interviewed, trauma-informed ELT practices can help English language teachers create a safe and supportive learning environment. However, the extent to which these practices are known and actively applied in ELT classrooms supporting refugee students in the United Kingdom and

elsewhere remains unclear. Evidence suggests that many teachers are eager to learn more about this approach. For instance, Agbaso and Roberts (2023, p. 102) found that out of 62 teachers surveyed in Wales, 60 expressed interest in receiving training on trauma-informed approaches to better support their students. This strong interest likely reflects broader sentiments among teachers working with refugee learners.

Trauma-informed pedagogy, while important, is unlikely to be sufficient on its own to adequately support RASHPs and vulnerable ELLs dealing with mental health and other complex issues. However, as Wood et al. (2022) rightly point out, “recovery and wellbeing for resettled refugees [...] depends upon an interaction of variables at a wider systemic level, that go beyond the direct remit of mental health services.” For many, especially those recently arrived, the ESOL classroom represents the first environment where they can begin to rebuild their lives and take control of the future. On one hand, the English classroom can serve as a safe space for currently vulnerable individuals, offering them the support they need to move forward. On the other hand, it also functions as a space for skill development, enabling RASHPs to build resilience and confidence as they begin to pursue their professional aspirations.

Existing studies and the results of the present study confirm that there are numerous entities involved in providing support for RASHPs at the macro-level, ranging from government bodies and local authorities to refugee charities and educational institutions. While this diversity of support is commendable, it can also lead to fragmented efforts, with different entities not fully aligned with each other. Moreover, funding remains a persistent challenge for many organizations assisting refugees.

Despite these challenges, it is important to continue highlighting areas for improvement to ensure a more cohesive and effective support system for RASHPs and other vulnerable learners. Following the Impact by Design model, addressing macro-level barriers through intentional design and targeted interventions can foster a more equitable and supportive learning environment, leading to enhanced educational outcomes for RASHPs.

RECOMMENDATIONS

The findings of the study point to a number of recommendations, both at the policy and classroom levels, with regards RASHPs, as well as learners from refugee and vulnerable backgrounds. Key policy-level

recommendations and the entities best-placed to implement them are outlined below:

- Expand the availability of online English language and test preparation classes without imposing geographical restrictions. This recommendation is aimed at government bodies (e.g., Department of Health and Social Care), refugee charities and educational institutions offering remote English language programs for refugees.
- Facilitate access to second-hand laptops, computers, and data SIM cards to ensure better and more equitable outcomes for RASHPs, as well as refugee learners in general. This recommendation is aimed at local authorities, refugee charities, and educational institutions working with refugees.
- Design pathways with refugee learners in mind taking into account the complexity of their learning and test preparation needs to include options for absolute beginners and more advanced students, with different levels of duration and focus (e.g., English for Specific Purposes and general English), including both online and face-to-face options. This recommendation is aimed at local authorities, educational institutions working with refugees, NHS trusts assisting RASHPs with their transition into employment in the United Kingdom, refugee charities and curriculum designers.

At classroom level, key recommendations include:

- Embed trauma-informed English language teaching practices in contexts with refugee and vulnerable adult learners. This recommendation is aimed primarily at teachers working directly with refugee learners. See Palanac, 2019 and Agbaso & Roberts, 2023 for specific examples of these practices.

LIMITATIONS OF THE STUDY

Finally, it is important to acknowledge the limitations of the study and outline areas for further investigation. The key limitations of the study are related to its sample. Firstly, the sample is largely biased toward doctors. The limited participation of RASHPs with nursing background limits the conclusions and quantitative and qualitative comparisons which can be drawn regarding the experiences of nurses of refugee and asylum seeker status. Secondly, the majority of study participants were in the process of meeting their English language

proficiency requirements. This prevented meaningful analysis of the experiences of RASHPs who are now employed in their desired healthcare roles.

Although tracking RASHPs who have benefited from various support programs and entered employment can be challenging (Butt et al., 2019), their perspectives would nonetheless offer a valuable point of reference in terms of the long-term washback of preparing for a healthcare-specific test such as the OET and their ability to cope with the communicative demands of an English-speaking healthcare workplace.

It should also be noted that many RASHPs never make it back into the English classroom, nor attempt to return to nursing or medical practice following displacement. Unfortunately, their perspectives are not represented in this research, which is another limitation that needs to be acknowledged.

AUTHOR CONTRIBUTIONS

Conceptualization of the study: Brigita Séguis and Ross Goldstone. Literature review: Brigita Séguis. Methodology: Brigita Séguis and Ross Goldstone. Development of data collection instruments: Brigita Séguis, Ross Goldstone, and Heidi Miu. Data collection: Brigita Séguis and Heidi Miu. Analysis: Brigita Séguis and Heidi Miu. Writing: Brigita Séguis. Review: Brigita Séguis. Editing: Brigita Séguis.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest to disclose.

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APPENDIX A

SURVEY DEMOGRAPHIC DATA. NURSES

Survey demographic data. Nurses.

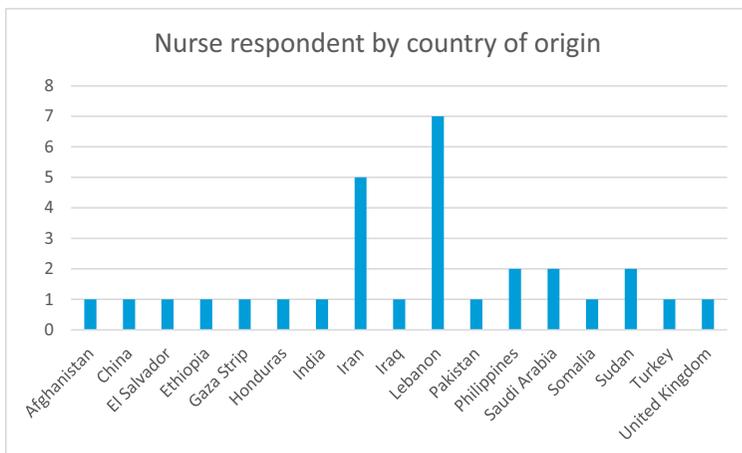


FIGURE A1. Nurse respondents by country of origin.

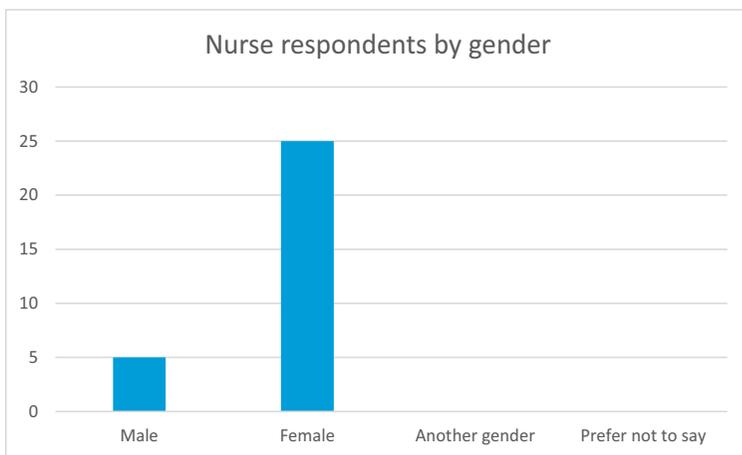


FIGURE A2. Nurse respondents by gender.

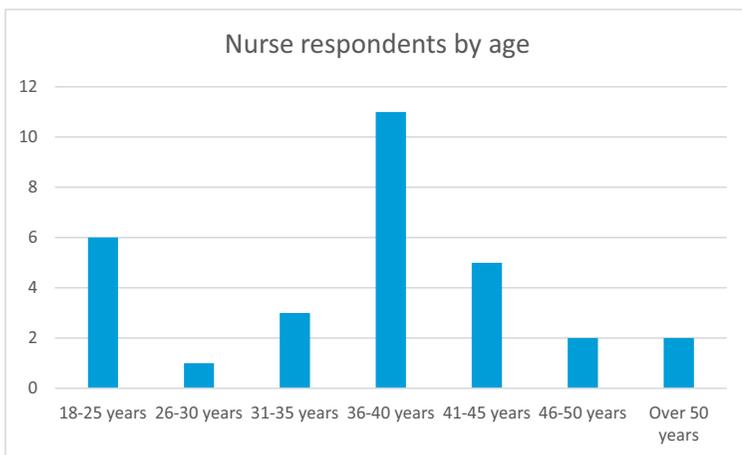


FIGURE A3. Nurse respondents by age.



FIGURE A4. Number of years of professional experience, nurses.

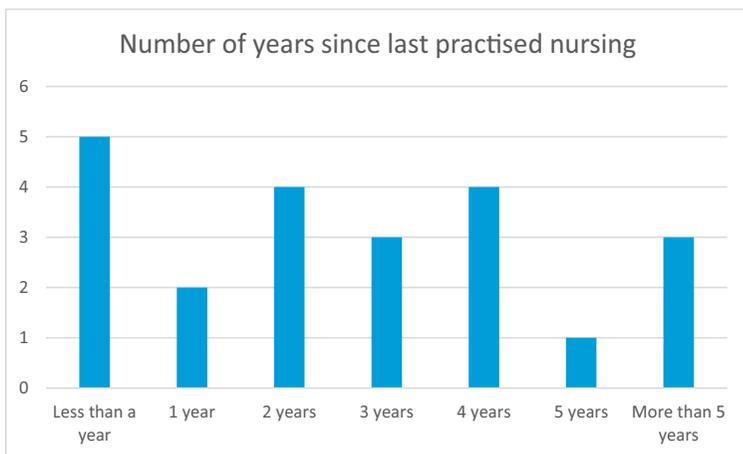


FIGURE A5. Number of years since last practised nursing.

SURVEY DEMOGRAPHIC DATA. DOCTORS

Survey demographic data. Doctors.

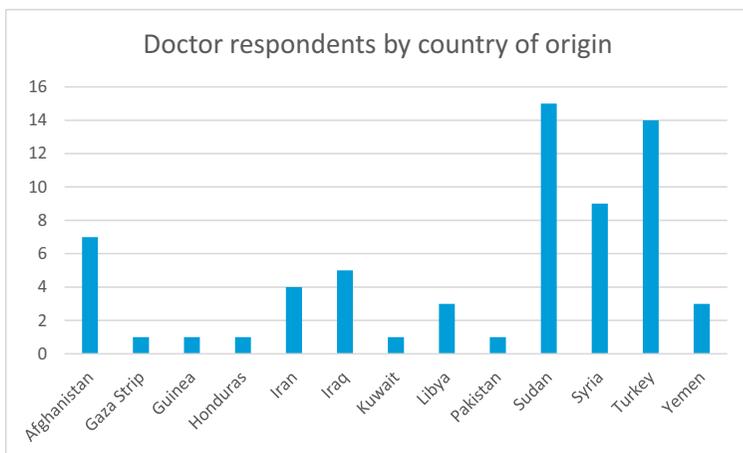


FIGURE A6. Doctor respondents by country of origin.

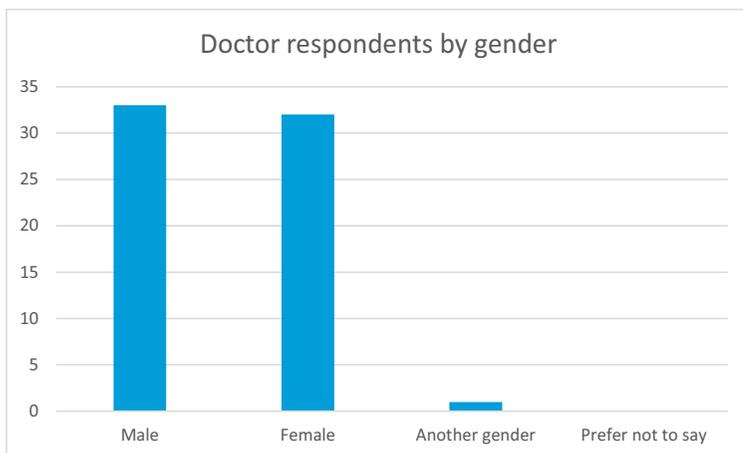


FIGURE A7. Doctor respondents by gender.

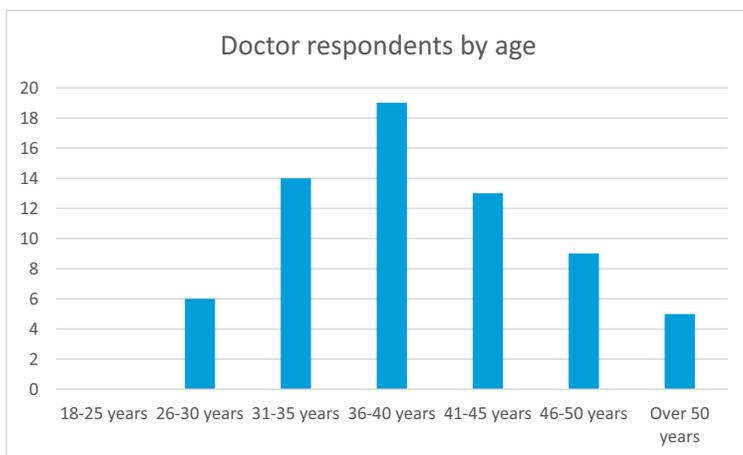


FIGURE A8. Doctor respondents by age.



FIGURE A9. Number of years of professional experience, doctors.

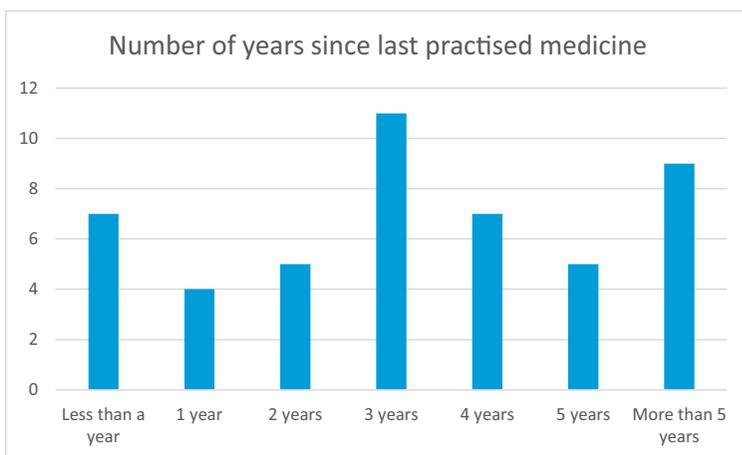


FIGURE A10. Number of years since last practiced medicine.

APPENDIX B

RASHP ONLINE SURVEY

The nurses' and doctors' surveys were identical. A screenshot of the survey is included below.

Refugee & Asylum Seeker Healthcare Professionals' Transitions Into & Experiences of Working in the NHS Online Survey Questions	
*1. I agree to participate in the research.	<input checked="" type="radio"/> Continue <input type="radio"/> Close
*2. What is your healthcare profession?	<input checked="" type="radio"/> Nurse <input type="radio"/> Midwife <input type="radio"/> Doctor [Skip to Q4] <input type="radio"/> Other, Please specify [End Survey]
*3. Are you part of the NHSE/I programme operated in partnership with Liverpool John Moores University, RefuAid and Talent Beyond Boundaries?	<input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> I don't know
*4. Which country do you come from?	Drop Down List
*5. In which country did you gain your health-related qualification?	Drop Down List
*6. What is your first language?	Drop Down List
*7. How many years of professional experience do you have?	<input checked="" type="radio"/> Less than a year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> 5 years <input type="radio"/> More than 5 years
*8. What is your gender?	<input checked="" type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Another gender <input type="radio"/> Prefer not to say
*9. What is your age?	<input type="radio"/> 18-25 years <input type="radio"/> 26-30 years <input type="radio"/> 31-35 years <input checked="" type="radio"/> 36-40 years <input type="radio"/> 41-45 years <input type="radio"/> 46-50 years <input type="radio"/> Over 50 years
*10. What is your current immigration status?	<input checked="" type="radio"/> Asylum seeker <input type="radio"/> Refugee <input type="radio"/> Humanitarian protection <input type="radio"/> Limited leave to remain <input type="radio"/> Unlimited leave to remain <input type="radio"/> Visa (Any type) <input type="radio"/> British citizen <input type="radio"/> Prefer not to say <input type="radio"/> Other (Please specify)
11. What is your current job/occupation? (can be any type of job you currently do)	Open Text
*12. Which of the following best describes your current status?	<input checked="" type="radio"/> I am currently preparing for my English language examination <input type="radio"/> I am currently preparing for NMC professional examinations [Option below Skip to Q16] <input type="radio"/> I have met all NMC registration requirements and I am awaiting confirmation of my registration <input type="radio"/> I am now registered with NMC and I am looking for a job related to my healthcare profession in the NHS <input type="radio"/> I am currently employed in the NHS
*13. Do you have access to the educational qualification certificates required to work in your profession in the UK?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know
*14. How long has passed since you last worked as a nurse or midwife / doctor?	<input checked="" type="radio"/> Less than a year <input type="radio"/> 1 year <input type="radio"/> 2 years <input type="radio"/> 3 years <input type="radio"/> 4 years <input type="radio"/> 5 years <input type="radio"/> More than 5 years
*15. How would you rate your overall English language proficiency on a scale of 0-10?	1-10 sliding bar No Knowledge of English to Native Speaker Proficiency
*16. Which English language examination are you preparing for/did you take?	<input checked="" type="radio"/> OET <input type="radio"/> IELTS [Skip to Q17] <input type="radio"/> I don't know [Skip to Q17]
*16a. Why did you choose OET? More than one option can be selected.	<input type="checkbox"/> I think that it is easier to achieve the required results on the OET for professional registration purposes.

	<input type="checkbox"/> I think that the OET results are valued more for employment purposes. <input type="checkbox"/> I think that the OET results are better evidence of my ability to use English in a health-related work place. <input type="checkbox"/> I have not achieved the required score in IELTS Academic and switched to OET. <input type="checkbox"/> I think that OET is more relevant for employment purposes in the healthcare sector. <input type="checkbox"/> Other. Please specify.
*16b. How did you prepare/are you preparing for OET? More than one option can be selected.	<input type="checkbox"/> By attending OET test preparation classes <input type="checkbox"/> By attending general English preparation classes <input type="checkbox"/> By studying on my own using OET preparation materials <input type="checkbox"/> By studying on my own using general English preparation materials <input type="checkbox"/> In other ways <input type="checkbox"/> In other ways. Please specify
*17. What are the main challenges that you faced/are currently facing on your NHS registration and employment journey? More than one option can be selected.	<input type="checkbox"/> Lack of English language proficiency <input type="checkbox"/> Difficulty meeting GMC/NMC accreditation requirements <input type="checkbox"/> Difficulty passing GMC/NMC professional examinations <input type="checkbox"/> Lack of prior NHS experience <input type="checkbox"/> Racism and prejudice <input type="checkbox"/> Lack of information and access to resources <input type="checkbox"/> Financial constraints <input type="checkbox"/> Family commitments <input type="checkbox"/> Lack of NHS employment opportunities <input type="checkbox"/> Difficulty passing NHS job interviews <input type="checkbox"/> Other (Please specify)
18. Please briefly explain your choices to the previous question in the box below.	Open Text
*19. Are you currently working in the NHS in your desired role?	<input checked="" type="radio"/> Yes <input type="radio"/> No [Skip to Q26]
*20. How long did it take you to find employment in the NHS?	<input checked="" type="radio"/> 0-6 months <input type="radio"/> 7-12 months <input type="radio"/> 1-2 years <input type="radio"/> 2-3 years <input type="radio"/> More than 3 years
*21. How would you describe your experience of looking for employment in the NHS?	Open Text
*22. What was the biggest challenge that you faced when looking for employment in the NHS?	Open Text
*23. Do you have access to a mentoring or buddying scheme in your role within the NHS?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know
*24. Do you receive frequent and tailored careers advice and guidance in your role within the NHS?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know
*25. To what extent do you agree with the following statements: - I am happy working in the NHS. - I feel confident in my ability to communicate with patients in English. - I feel well-supported in my current role. - I did not face any cultural or linguistic challenges when I first joined the NHS. - I easily fit in at my NHS workplace.	Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree N/A
	[Skip to Q32]
*26. Are you currently applying for employment in the NHS?	<input checked="" type="radio"/> Yes <input type="radio"/> No [Skip to Q32]

*27. To date, how many NHS jobs have you applied for?	<input checked="" type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> More than 5
*28. Do you have prior work experience in the NHS? This can include clinical attachments and placements (e.g. working as a healthcare assistant).	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know
*29. Have you received interview preparation training to help you prepare when looking for NHS employment opportunities?	<input checked="" type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know
29a. If yes, please specify who provided this training.	Open Text
*30. To what extent do you agree with the following statements: - I worry that my clinical skills will reduce because of the time it will take me to find work in the NHS - I have access to a sufficient level of knowledge and guidance on how to enter the NHS in my chosen profession. - I understand how the NHS works. - I feel confident in my ability to communicate with patients in English.	Strongly disagree Disagree Neither agree nor disagree Agree Strongly agree N/A
*31. What do you think is the biggest barrier to you working in the NHS?	Open Text
32. Would you like to take part in a focus group or interview to further discuss your experience? You will be offered a £50 Amazon voucher in exchange for your participation. If yes, please follow this link to submit your contact details:	Hyperlink to submit contact details.
END OF SURVEY	

APPENDIX C

RASHP INTERVIEW SCHEDULE

Introduction

Thank you for agreeing to participate in our research.

This interview is to investigate the challenges which refugees and asylum seeker healthcare professionals face when entering and working in the NHS in England.

We would like to use this as an opportunity to reflect on your own experiences in your journey and the successes and challenges you may have faced.

If you are in any way uncomfortable, please do tell me and we can stop this interview at any time. You have the right to withdraw from the interview at any time if you wish to without any adverse consequences.

For data analysis purposes, we would like to record the interview. However, your data will be anonymized at the transcription stage and

the recording deleted (*Explain anonymisation*). This means that any personal information will be removed from the interview transcript to ensure that no one will be able to identify you. Could you confirm whether you are happy to progress with the interview today?

Do you have any questions before we start?

Individual and healthcare background

1. Before we talk about your experiences around entering the NHS workforce, could you introduce yourself, your professional background and your current situation/status?

Transition into the NHS (Registration and pre-employment)

English Language. *Lead in:* We would like to focus on your experiences with the English language requirements for NMC/GMC registration.

- 2 Can you tell me about your experience of English language learning to date (e.g., no. of years learnt and no. of examinations taken)?

Prompt: What worked well for you in regards to English language preparation (e.g., strategies, approaches, and types of learning and preparation)?

- 2.1 What has been the main challenges you have faced (e.g., cost, time, technology)?
- 2.2 What support do you think would have benefited you with English language learning and test preparation?

Registration and Professional Examinations. *Lead in:* We are also interested in understanding your experiences of trying to register with your professional body and undertaking the required professional examinations (e.g., the OSCE and PLAB examination).

- 3 Can each of you tell me about your registration journey and experiences so far?

Prompt: Your healthcare professional qualifications, finding and/or undertaking clinical/professional examinations, placements or training, applying for NHS roles.

- 3.1 *If you have taken the examinations, what has been your experience of preparing for and undertaking these?*

Prompt: How did you prepare for this examination?

Prompt: What challenges did you encounter when preparing for the examination?

3.2 *If not taken*, what challenges do you think you may encounter when you go to take the examinations?

Prompt: What support do you think will help in your preparations?

4 What additional support would be beneficial during the registration and pre-employment processes?

Prompt: financial constraints, family commitments, work experience and/or placements, job seeking and interview support, access to information.

Future aspirations

6 Can you tell me a bit about your goals for the future as a health-care professional?

Prompt: *If plan to return to the NHS*: What are your thoughts about working again in clinical practice and joining the NHS? (Confidence in your own clinical skills, working with multidisciplinary teams, and communicating with patients).

Prompt: *If do not plan to the NHS*: What are your employment plans for the future?

7 If you could suggest one area which could help/have helped you in returning to clinical practice in the United Kingdom, what would that be?

Finish

Thank you for taking part in this focus group/interview today. It has been very interesting to hear about your experiences and stories. Do you have any questions about anything we have spoken about today or the research project?

INTERVIEW SCHEDULE WITH ENGLISH LANGUAGE PROVIDERS

Intro and Welcome

- Aim: To explore English language learning in Refugee and Asylum Seeker Healthcare professionals (RASHPs) which is one of the biggest challenges faced by RASHPs to register and enter the NHS workforce. We are looking to understand the challenges they face when preparing for their English language proficiency examinations, in language learning, as well as in access to support.

English Language (EL) Provision

- How long has the organization been working with RASHPs in EL support?
- Do you deliver both virtual and face-to-face courses?
 - If yes, how well do you feel either/both are received by RASHPs?
 - Prompts: focus and group work, access to technology, learning gains
 - If no, were you able to continue EL support during the COVID-19 pandemic?
- What is the structure of the EL support for RASHPs like?
 - Prompts: Mixed classes, OET specific, weekly/monthly/intensive, quota, geographical location
- Can you give general overview of the RASHPs that access the provided EL support?
 - Prompts: Gender? Profession? Age? Entry level proficiency? Average duration? Number of repeat examinations?

RASHPs and English language learning

- How do RASHPs engage with their English language / examination preparation classes?
 - What do you think are the main reasons for RASHPs not being able to complete EL training courses?

- What do you think are common challenges for RASHP to pass their English proficiency examination?
 - What are common strengths or weaknesses in EL proficiency?
 - Non-EL related factors—for example examinations, family, financial commitments, and mental health
- Do you work with other non-native English speakers of not RAS status? if yes:
 - Are they any different to RASHPs?
 - How does their engagement and motivation differ?

Accessing support

- How do RASHPs find out about the support provided at the organization?
 - Prompts: Find themselves, word of mouth, referral via other organizations
- What do you think are, in general, challenges for RASHPs to access EL support such as yourselves?

Other

- As a whole, how do you think EL support could be improved to better support RASHPs?
- Do you have any other thoughts about RASHPs and English language learning as a part of their requirements to register with governing bodies, and obtain employment in the NHS?