

A Study of the English Language Learning Challenges that Inhibit Displaced Medical Professionals from Returning to Practice in the UK

Gabriel John Roberts Cert. TESOL, PGCE PCET, Dip. TESOL

Thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy

**Cardiff School of Education
Cardiff Metropolitan University**

9th of February 2015

Declaration

I declare that this work has not previously been accepted in substance for any degree and is not being concurrently submitted for any other degree. I further declare that this thesis is the result of my own independent work and investigation, except where otherwise stated, (a bibliography is appended). Finally, I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and abstract to be made available to outside organisations.

Gabriel John Roberts (Candidate)

Professor Janet Laugharne (Director of Studies)

Dr Siân Rhiannon Williams (Director of Research Degree Programmes)

Acknowledgements

I would most like to thank my excellent supervisory team, namely Prof. Janet Laugharne and Dr. Jill Llewellyn-Williams, for their support and patience. I am very grateful to the Cardiff School of Education for funding and supporting this project. I am also very grateful to the WARD group, particularly Leona Walsh and Patricia Moore for facilitating access to the group and sending out questionnaires. In the same, I am grateful to all of the staff at DPiA for providing me with a location and time to conduct the interviews. The views of the participants form the backbone of this study and I am extremely grateful to them for providing their insights, I wish them all the best in their endeavour to continue to work their chosen professions in their host country. I would also like to thank the team of expert witnesses whose knowledge and experience contributed greatly to the research.

Abstract

To join the General Medical Council (GMC) refugee doctors are required to pass professional and linguistic assessments. The first of these is the International English Language Testing System (IELTS) test and, according to British Medical Association statistics released in 2008, this is a major barrier to progress, impeding the progress of 45% of refugee doctors.

Drawing on my experiences of preparing refugee doctors for the IELTS test, I became interested in discovering what was holding them back. The students attending the daily classes were highly intelligent, motivated individuals who had a goal of integrating into their host country. Han (2004, pp.28-37) discusses the putative causes of stabilized language errors, which she describes as fossilization. However, the refugee doctors in my classes did not seem to fit into the traditional profile of a learner with these sorts of language errors.

My aim was to work with the clients from the Wales Asylum-seeking and Refugee Doctors (WARD) group and to ask them to reflect on the stabilized language errors by means of a questionnaire, interview and focus group. During this project, twenty-two participants were asked about their beliefs about their stabilized language errors and asked about their strategies to overcome them. In addition, four expert witnesses working in the field of language testing in medicine were invited to provide further perspectives on these challenges.

The research design foregrounded the participants' views on their stabilized language errors and the causal factors that may have led to them. Former clients of the WARD group were sent a questionnaire asking them to self-assess their stabilized language errors and identify the causal factors. At the same time, current clients of the WARD group who were training for the IELTS test were given a diagnostic language quiz. Subsequently, they were interviewed to find out their views on their weaker areas identified in the diagnostic language quiz. When the results were analysed, emergent findings were presented to the interviewees in a focus group, to give them further opportunity to comment on the possible reasons for their stabilized language errors.

The main findings were that many of the participants who had achieved the GMC language requirements felt that they still had some stabilized language errors. The participants that were given the diagnostic language quiz while still training for the IELTS test did not exhibit as many problem areas. The participants attributed the majority of their problems to 'input' and 'intake' (Kumaravadivelu, 2006) or within Han's (2004) six domains, 'knowledge representation' and 'knowledge processing'. Initially, none of the participants felt that Han's 'neuro-biological' and 'socio-affective' domains held them back. However, during the focus group, it appeared that the participants reconsidered their socio-affective problems but continued to reject the impact of any neuro-biological problems. Expert witnesses were called upon for their opinions and they corroborated many of the points made by the participant group. The findings identify how displaced medical healthcare professionals may be further supported in regaining their professional identities and to contributing fully to their host society.

Contents

| | |
|---|-----|
| Chapter 1. Introduction | 1 |
| 1.1 Background..... | 1 |
| 1.2 The Historical Context of the Study | 6 |
| 1.2.1 English Language Teaching to Displaced Professionals..... | 6 |
| 1.2.2 Overseas Doctors in the UK | 7 |
| 1.2.3 The WARD Group..... | 9 |
| 1.2.4 The IELTS Test..... | 10 |
| 1.3 Rationale..... | 12 |
| 1.4 Identification of the Problem | 14 |
| 1.5 Contribution to Knowledge and Understanding | 21 |
| 1.6 Thesis Structure..... | 22 |
| 1.7 Summary | 24 |
| Chapter 2. Literature Review..... | 26 |
| 2.1 Introduction | 26 |
| 2.2 The Condition of Contemporary Displaced Healthcare Professionals..... | 30 |
| 2.2.1 Integration..... | 34 |
| 2.2.2 Identity | 38 |
| 2.2.3 Prior Learning | 42 |
| 2.2.4 Language Training Provision for Displaced Medical Healthcare Professionals..... | 47 |
| 2.3 Fossilization and Stabilized Language Errors | 48 |
| 2.3.1 Fossilization in the Literature | 48 |
| 2.3.2 Han's (2004) Six Domains | 55 |
| 2.3.3 Target Language | 75 |
| 2.4 IELTS Skills | 76 |
| 2.4.1 The IELTS Training Dilemma | 79 |
| 2.4.2 IELTS in the Context of this Study..... | 82 |
| 2.5 Possible Language Groups within the Study and Predicted Problems | 84 |
| 2.6 Summary | 91 |
| Chapter 3. Research Design | 93 |
| 3.1 Introduction | 93 |
| 3.1.1 Developing the Research Questions | 93 |
| 3.2 Quantitative and Qualitative Research Methods | 95 |
| 3.3 Divergence and Convergence of Research Methods | 97 |
| 3.3.1 Questionnaires..... | 98 |
| 3.3.2 Interviews..... | 100 |
| 3.3.3 Focus Groups | 102 |
| 3.4 Ethics | 102 |
| 3.5 Rationale for the Selection of the Methods..... | 108 |
| 3.5.1 A Conceptual Framework of the SLEs Affecting Displaced Medical Healthcare Professionals. | 109 |
| 3.6 Reliability of the Methods..... | 115 |
| 3.6.1 Credibility, Transferability and Dependability..... | 119 |
| 3.6.2 Comparing and Corroborating Results | 120 |
| 3.7 Data Analysis..... | 121 |
| 3.8 Summary | 121 |
| Chapter 4. Phase One: Methods, Analysis and Findings | 124 |
| 4.1 Introduction | 124 |
| 4.2 Methods for Phase One..... | 126 |
| 4.2.1 Preparing for the Questionnaires..... | 126 |

| | | |
|--|---|-----|
| 4.2.2 | Preparing for the Semi-Structured Interviews | 137 |
| 4.3 | The Collection of the Data for Phase One | 143 |
| 4.3.1 | Transcription of the interview data | 145 |
| 4.3.2 | Reporting the Data..... | 146 |
| 4.3.3 | Returning the Findings to the Participants..... | 147 |
| 4.4 | Methods of Analysis for Phase One | 148 |
| 4.4.1 | Methods of Analysis for the Questionnaire | 148 |
| 4.4.2 | Methods of Analysis for the Follow-up Open Answer Email Questions..... | 149 |
| 4.4.3 | Methods of Analysis for the Diagnostic Language Quiz | 149 |
| 4.4.4 | Methods of Analysis of the Semi-Structured Interviews | 150 |
| 4.5 | Participant Profiles..... | 151 |
| 4.5.1 | Additional Profile Data Collected in Questionnaires | 157 |
| 4.5.2 | Vignettes of Interviewees..... | 163 |
| 4.6 | Research Question One: What are Displaced Medical Healthcare Professionals' Perceptions on their Own Common SLEs? | 167 |
| 4.6.1 | Analysis of the data on SLEs | 168 |
| 4.6.2 | Findings for Research Question One | 174 |
| 4.7 | Research Question Two: In the Participants' Views, What is the Impact of Life Histories, Educational Histories and Other Experiences on SLEs? | 175 |
| 4.7.1 | Questionnaire Data on the Causal Factors under Each Domain..... | 176 |
| 4.7.2 | Interview Data on the Causal Factors under Each Domain..... | 180 |
| 4.7.3 | Analysis of the Data on Causal Factors of SLEs | 188 |
| 4.7.4 | Analysis of the Data on Impact of Life, Educational and Other Histories | 192 |
| 4.7.5 | Analysis of the Data on Strategies for Improving English Language Skills | 200 |
| 4.7.6 | Findings for Research Question Two | 204 |
| 4.9 | Summary | 206 |
| Chapter 5. Phase Two: Methods, Analysis and Findings | | 208 |
| 5.1 | Introduction | 208 |
| 5.2 | Methods for Phase Two..... | 209 |
| 5.2.1 | Preparing for the Focus Group | 210 |
| 5.2.2 | Preparing for the Expert Witness Interviews..... | 211 |
| 5.3 | Collection of the Data for Phase Two | 214 |
| 5.3.1 | Transcription of the focus group and expert witness interviews | 214 |
| 5.4 | Methods of Analysis for Phase Two | 215 |
| 5.4.1 | Methods of Analysis for the Focus Group Data | 215 |
| 5.4.2 | Methods of Analysis for the Expert Witness Interviews | 216 |
| 5.5 | Participant Profiles..... | 217 |
| 5.5.1 | Focus Group Vignettes | 217 |
| 5.5.2 | Expert Witness Profiles..... | 217 |
| 5.6 | Research Question Three: What Are the Participants' Responses to the Emerging Findings of the Study in Research Questions One and Two?..... | 220 |
| 5.6.1 | Analysis of Focus Group Data | 220 |
| 5.6.2 | Findings for Research Question Three..... | 230 |
| 5.7 | Research Question Four: What are the Views of Expert Witnesses on the Training and Language Skills of Displaced Medical Healthcare Professionals? | 231 |
| 5.7.1 | Analysis of Expert Witness Data and Findings | 231 |
| 5.7.2 | Findings for Research Question Four..... | 239 |
| 5.7.3 | Synthesis of the Findings from Phase Two | 240 |
| 5.8 | Summary | 243 |
| Chapter 6. Conclusions and Discussion..... | | 246 |
| 6.1 | Introduction | 246 |
| 6.1.1 | Limitations of the Study | 247 |
| 6.2 | Synthesis of the Key Findings | 252 |

| | | |
|------------------|---|-----|
| 6.3 | Discussion of the Key Findings..... | 255 |
| 6.4 | Recommendations..... | 259 |
| 6.5 | A Final Reflection..... | 261 |
| References | | 265 |
| Appendices..... | | 276 |
| | Appendix 1: Provision of Training Offered by the WARD Group | 276 |
| | Appendix 2: Han's Sample Empirical Studies of Fossilization | 279 |
| | Appendix 3: IELTS Band Descriptors for Productive Skills..... | 280 |
| | Appendix 4: The Safeguarding Vulnerable Groups Act (SVGA) 2006 Definition of a Vulnerable Adult | 285 |
| | Appendix 5: Letter to Participant Organizations | 286 |
| | Appendix 6: Email from NRES..... | 288 |
| | Appendix 7: Categorisation and Simplification of Han's Factors for the Questionnaire... | 290 |
| | Appendix 8: The Flesch Kincaid Readability Formula | 292 |
| | Appendix 9: The Questionnaire Script in Full | 293 |
| | Appendix 10: Language Quiz | 295 |
| | Appendix 11: Typology of SLEs According to Errors in the CLC at IELTS Level 7.0 or Above and L1 Group..... | 299 |
| | Appendix 12: Adaptation of Han's (2004) Putative Causal Factors of SLEs for Mapping Exercise During the Interviews. | 301 |
| | Appendix 13: Explanation of Putative Causal Factors | 302 |
| | Appendix 14: Transcript of Pilot Interviews..... | 303 |
| | Appendix 15: Transcription Conventions Adapted from Edley and Litosseliti (2010) and Mackey and Gass (2005)..... | 322 |
| | Appendix 16: Analysis of the Questionnaire Data | 323 |
| | Appendix 17: Questionnaire Results CSV | 345 |
| | Appendix 18: Response to Follow-up Email Questions | 352 |
| | Appendix 19: Constant Comparison of Interviews | 354 |
| | Appendix 20: Transcription Summary of Semi-Structured Interview | 361 |
| | Appendix 21: Full Thematic Analysis According to Putative Causal Factors..... | 368 |
| | Appendix 22: The Interview Schedules for the Expert Witness Interviews..... | 373 |
| | Appendix 23: Thematically Analysed Transcript of Focus Group | 375 |
| | Appendix 24: Constructionist Analysis of the Focus Group | 389 |
| | Appendix 25: Notes on Interviews with Expert Witnesses | 393 |
| | Appendix 26: Coding of the Notes from the Expert Witness Interviews | 400 |
| | Appendix 27: Details of the Intersecting Elements Discussed by the Expert Witnesses in the Venn Diagram | 401 |

Figures and Tables

Figures

| | |
|---|-----|
| Figure 1. Headlines regarding overseas doctors in the UK media | 2 |
| Figure 2. Progress towards employment for BMA registered refugee doctors (British Medical Association, 2008)..... | 15 |
| Figure 3. Number of asylum applicants UK (Blinder, 2014) | 40 |
| Figure 4. The contradiction in IELTS training | 80 |
| Figure 5. Conceptual framework for the study, drawing on Han's putative causal factors.. | 110 |
| Figure 6. An overview of the stages of the project | 114 |
| Figure 7. Overview of the research design..... | 122 |
| Figure 8. The mapping of the questionnaire..... | 130 |
| Figure 9. A description of the data that was reported upon from the data collected | 146 |
| Figure 10. Length of time serving as a doctor | 159 |
| Figure 11. Length of time that had elapsed since working as a doctor | 160 |
| Figure 12. Skills that the participants were most confident in using | 162 |
| Figure 13. Questionnaire respondents' reasons for selecting the 'environmental' domain .. | 176 |
| Figure 14. Questionnaire respondents' reasons for selecting the 'knowledge representation' domain..... | 177 |
| Figure 15. Questionnaire respondents' reasons for selecting the 'knowledge processing' domain..... | 178 |
| Figure 16. Questionnaire respondents' reasons for selecting the 'psychological' domain .. | 179 |
| Figure 17. Hexagon mapping exercise for Dr. Farid, Dr. Ghanem and Dr. Jasmine..... | 181 |
| Figure 18. Hexagon mapping exercise for Dr. Bader, Dr. Cadi and Dr. Irene..... | 182 |
| Figure 19. Hexagon mapping exercise for Dr. Ali, Dr. Dafi and Dr. Hadeel | 184 |
| Figure 20. Questionnaire respondents' analysis of the causal factors of their SLEs | 189 |
| Figure 21. Causal factors of SLEs as identified by interviewees..... | 190 |
| Figure 22. Comparison of causal factors between questionnaire and interviews | 191 |
| Figure 23. Expert witnesses and how their areas of expertise intersect in the context of the research | 219 |
| Figure 24. Areas of intersection between the expert witnesses' interviews | 233 |

Tables

| | |
|---|-----|
| Table 1. IELTS guidelines for acceptance onto academic courses (IELTS, 2009) | 28 |
| Table 2. The changing trends in refugee arrivals since the 1980s | 39 |
| Table 3. List of some of the proposed causal factors of fossilization, according to the literature (Long, 2005) | 51 |
| Table 4. Han's (2004) putative causes of fossilization | 56 |
| Table 5. Academic candidates: Reason for taking IELTS in 2010 (Overall Band score by %) (IELTS.org, 2010) | 83 |
| Table 6. Language groups from the Crawley and Crimes questionnaire and their skills | 83 |
| Table 7. L1 interference according to language groups likely to feature in the study (adapted from Swan and Smith, 2011) | 88 |
| Table 8. Research questions mapped to data capture events and the expected results | 112 |
| Table 9. Mapping research questions to the schedule | 141 |
| Table 10. Personal details of the questionnaire respondents | 152 |
| Table 11. Personal details of the interviewees | 153 |
| Table 12. Statistical data on the profiles of questionnaire respondents | 158 |
| Table 13. Length of time in an English L1 country | 161 |
| Table 14. The problem areas highlighted in the project | 169 |
| Table 15. Instances of problem areas selected by displaced medical healthcare professionals during interviews, organised according to their language groups | 172 |
| Table 16. A summary of factors that emerged during the semi-structured interviews | 186 |
| Table 17. A summary of the strategies used by respondents for improving their English skills | 200 |
| Table 18 Coding of the Focus Group Interview | 222 |
| Table 19. Areas of agreement, disagreement and unique statements from the findings of phase two. | 241 |

Abbreviations and Acronyms

BERA – The British Educational Research Association; the body responsible for providing guidelines on ethical research into UK education;

BMA – The British Medical Association; the trade union and professional association for doctors and medical students in the UK;

DPiA – Displaced People in Action; a refugee charity that hosts classes for refugee doctors;

ELT – English Language Teaching; a broad term that is, for the purpose of this study, intended to encompass all aspects of English Language Teaching;

GMC – The General Medical Council; the independent regulator for doctors in the UK;

IELTS – International English Language Testing System; the English language test that is used by the GMC;

NHS – National Health Service; the healthcare system in the United Kingdom;

NRES – National Research Ethics Service; the NHS division responsible for ensuring ethical compliance in medical research;

PMQ – Primary Medical Qualification; a medical qualification that is recognised by the GMC;

RHP - Refugee and asylum-seeking Health Professionals; an NHS group who support refugee healthcare professionals;

RP – Received Pronunciation; A form of English pronunciation considered by some to be a classical form;

SLE – Stabilized Language Errors; a term that describes tenacious or repeated problems with language learning;

WARD – The Wales Asylum-seeking and Refugee Doctor group; a charity housed within the Deanery of Cardiff University that aims to support clients aiming to work in the GMC

Word count: 79,151 (not including abstract, references and appendices)

Chapter 1. Introduction

1.1 Background

On the 28th of June 2010, Dr. Hamish Meldrum, the Chairman of the British Medical Association (BMA), opened the Annual Representative Meeting (ARM) with a speech in which he spoke about the use of locum doctors from overseas:

We must ensure that the doctors who treat our patients are competent to do so, that they have the necessary language skills, and that they are subject to the same regulation as UK doctors... ...The BMA will continue its work with the government, the GMC (General Medical Council) and others to make this happen.

(Tran, 2010)

This was a response to a tragedy that occurred in 2008. A locum doctor, Dr. Daniel Ubani, visited two patients, David Gray and Iris Edwards, who subsequently died after their treatment. An inquest into the Ubani incident (Dreaper, 2010) heard that, among other things such as unfamiliarity with the relevant medication and his own fatigue, Dr. Ubani's level of English was called into question.

There have been other examples of doctors from overseas who have struggled with linguistic and cultural misunderstandings with potentially dangerous results.

Incidents of this nature have been reported in the popular UK media over the years as can be seen in figure 1.

NHS Locums Need Checks and Training

BBC News: April 21st 1999;

FOREIGN
DOCTOR WITH
POOR ENGLISH
MISDIAGNOSES
TODDLERS
LEUKAEMIA AS
TRAPPED WIND
By DAILY MAIL REPORTER

The Daily Mail: 13th April 2010;

THE TELEGRAPH

Foreign Doctors Who Have Come Under Scrutiny

is Center for the
Arts, 27579
field Drive in 846, on
day, March 20 at 2 and 4
Tickets are \$38 for adults
\$19 for students for the
one performance and \$30

These are the 100 Most Influential teachers and students director of the school of Education, let the future more and entertain

The Telegraph: 8th February 2011.

Figure 1. Headlines regarding overseas doctors in the UK media

The level of training of these doctors has also been an enduring political issue. The Labour Party began recruiting overseas doctors in the late 1990s, via the Highly Skilled Migrant Programme and other similar channels, in order to meet the National Health Service (NHS) demands for more doctors and medical graduates. In 2006, a block on overseas doctors who were not already working in the NHS was proposed in favour of UK candidates. The House of Lords ruled this proposal as unlawful in April 2008 (BBC, 2008). In 2010, The Liberal Democrats called for criminal charges to be raised against NHS organisations if they failed to carry out sufficient checks on the competence and credentials of EU doctors (Meikle, 2010a). In 2011, Andrew Lansley, the UK Secretary of State for Health, discussed plans to centralise these

checks, even as the government was preparing to devolve many responsibilities in the NHS to GP Consortia.

Meikle (2010b) reported that European Union (EU) immigration laws did not allow the GMC to conduct the same checks that they ran on doctors who came from outside the EU. When non-EU qualified doctors wished to practise in the UK, they had to submit evidence of their level of English competence from two separate examinations, alongside their Primary Medical Qualification (PMQ). In the case of Dr. Ubani, it was reported that he was a doctor of Nigerian origin who had lived in Germany for over forty years and trained in that country (Connolly and Meikle, 2009). Nearly all of the doctors mentioned in the reports above came under EU laws, rather than under the rules set by the GMC protocol for non-EU doctors training for work in the UK. Passi (2011) reported that EU qualified doctors were statistically more likely to be struck off the medical register than non-EU qualified doctors, even though there were more inquiries into the latter group. In addition, Passi reported that the GMC had called for an improvement of training standards across Europe, in order to bring them in line with the GMC standards for non-EU doctors. According to Passi, the overarching difference between EU and non-EU doctors was language skills. However, it should be noted that most of the scandals involving non-British doctors have been linked to doctors who have bypassed the GMC requirements via the EU regulations. Until 2014, these doctors were not obliged to take International English Language Testing System (IELTS) and Professional and Linguistic Assessments Board (PLAB) tests so there is currently very little raw data that can be collected.

The employment of doctors from outside the UK was criticised as an attempt to force costs down, especially since the formation of the NHS and the subsequent artificial depression of doctors' wages (Legrain, 2007, p.110). It also had an adverse effect in countries where there were high levels of emigration to the UK, leading to the

phenomenon of 'brain drain'; the situation that occurs when highly skilled workers leave their country in large numbers.

Another reason for non-EU doctors finding themselves in the UK was asylum. The exact figures for refugee and asylum seeking doctors in the UK is uncertain as there is a discrepancy between the number who are actually registered with the GMC and those who are at an earlier stage in their application for leave to remain. The most recent publicly available BMA statistics, released in June 2008, (British Medical Association, 2008) showed that they had 1,199 non-EU refugee doctors registered on their database, with just under half of them attempting to achieve the BMA's IELTS requirements. Due to the limited refugee dispersal areas prior to 2008, the majority of the registered doctors on the BMA database lived in or around London.

The June 2008 statistics from the BMA showed that Wales was host to just 2% of the recorded UK figure, or 24 asylum seeking or refugee doctors. According to the Wales Deanery website (Wales Deanery, 2010), the Wales Asylum-seeking and Refugee Doctors (WARD) group had identified 115 doctors, showing an increased number than that of the 2008 BMA statistics. Although the main focus is on supporting refugee doctors, the WARD group have also supported a small number of other displaced medical healthcare professionals in attempting to pass the IELTS test. Similarly, the main focus of this study is on refugee doctors but concessions are made for other displaced medical healthcare professionals who are attempting to meet the professional requirements of the relevant regulatory bodies.

The GMC guidelines (General Medical Council, 2014a) state that any doctors who wish to register with them have to provide evidence of their PMQ. In most cases, if the applicant was not from a European Economic Area (EEA) country, or their PMQ was from a university that was situated outside the EEA, they needed to take a PLAB exam (General Medical Council, 2014b). Before the 18th of June 2014, the GMC

(2014c) also stated that applicants had to have a minimum score of 7.0 in each skill in the IELTS test, as a minimum requirement. Since then, they have added the requirement of an overall score of 7.5.

With regard to other displaced medical healthcare professionals, the IELTS requirements for displaced pharmacists are slightly lower. According to the General Pharmaceutical Council (GPhC):

Where legislation permits the GPhC to ask for an English language test prior to registration, the GPhC, in the interests of public and patient safety, asks applicants to show that they have a score of at least seven in the academic level of the International English Language Testing System (IELTS).

(General Pharmaceutical Council, 2014)

At the time of writing, due to EEA laws, the GPhC could not ask for evidence of English language competency from EEA applicants. Similarly, the General Dental Council ask non-EEA applicants for an overall score of at least 7.0 with no skills subsets lower than 7.0 (British Council, 2014).

On a personal note, I worked on behalf of the WARD group from 2006 to 2008; training refugee doctors and other displaced medical healthcare professionals to pass the IELTS test. I developed the IELTS course as an on-going part-time course covering the four skills of reading, writing, speaking and listening each week. The course featured daily workshops, training in strategies for the test, as well as test practice. It was during this time that I became interested in investigating the reasons why some of my students who were motivated, intelligent and surrounded by an English speaking society, were failing to progress in their English language abilities.

The aim of my thesis is to try to understand the possible linguistic, pedagogical and cultural factors that may affect this specific group. The IELTS test seemed to be the biggest hurdle for the majority of the clients of the WARD group, which, according to the BMA June 2008 report, is reflected in the wider population.

The outcome of the GMC's necessarily stringent policies on training and testing immigrant doctors is that the NHS has competent members of its workforce who come from outside the EU. In my experience, a failure to overcome their persistent language errors and meet the GMC's linguistic requirements has held back experienced professionals who could contribute greatly to their host society.

1.2 The Historical Context of the Study

The study aims to examine the English language learning challenges that confront displaced medical healthcare professionals when attempting to pass the IELTS test as a GMC requirement. Accordingly, this section will contextualise four areas: the history of provision of English language lessons for displaced professionals, integration of overseas doctors into the health system in the UK, the development of the WARD group, and the development of the IELTS test.

1.2.1 English Language Teaching to Displaced Professionals

History tells us that in the most populated city, in one of the world's most developed countries, civilians were attacked by religious extremists resulting in the tragic loss of thousands of lives. Many believed that political differences and the desire for power had long since overtaken the religious schism that had initially been the driving force of this attack. This view was supported by the fact that the architect of the attack was brought up as part of an influential family in a country, described as the cradle of contemporary religion, as well as one of the wealthiest nations in the world.

In the years that followed, this 'religious' war raged on many fronts and large populations were displaced or forced into migration from their countries of origin. Many families were separated, moving to unfamiliar cultures in order to take refuge. They found themselves alone, without the basic tools of communication. Britain had been sympathetic in its immigration policies and in London in particular, there were thousands of refugees, many of them highly skilled professionals in their own

countries. These people were unable to find work due to the language barrier. Worse, some of the native English speaking population began to resent having to share what scarce work there was with these 'outsiders' and there was growing racial tension.

Although this situation is familiar to us in the 21st century, it is a problem that is much older. The year described above is 1572 and the St. Bartholomew's Day Massacre had just taken place in Paris.

According to Howatt (2009), during the Reformation in Northern Europe and, in particular, after the St. Bartholomew Massacre in Paris in 1572, England was host to a large influx of French Huguenot and other Protestant refugees. While the majority at this time were craftsmen, Howatt (2009) observes that Queen Elizabeth welcomed many people from the middle classes, who had professional roles. Although many immigrants were able to survive with a basic grasp of spoken English, a lack of fluency prevented their full integration into society. The need for language and cultural education was clear and the beginnings of English as a Foreign Language (EFL) to refugee groups emerged from the aftermath of these religious massacres. Integration and the utilization of the skills of migrant workers had become a political agenda that has remained with us to the present day.

1.2.2 Overseas Doctors in the UK

Visram (2002) describes the beginnings of immigration from India in the early 17th century, when many of the Indians living in England at the time would have been servants and were required to learn English for their work. English language ability and racial intolerance presented barriers to integration for these groups for many years. One such immigrant, Sake Dean Mahomed, sought political refuge in Britain in 1784. When he eventually established his Indian Vapour Baths and Shampooing Establishment in 1815, he was met with distrust and scepticism yet he persevered

and eventually made a success of his healing practice. Mahomed's offspring followed in his footsteps and contributed to healthcare in the UK (Visram, 2002).

Eligibility to work in the UK for overseas and displaced doctors has always been controversial. In the late 19th and early 20th centuries, before the formation of the NHS in 1948, there was a burgeoning number of Indian doctors leaving the troubled Raj behind and working in the UK. During this time, Sir Lyon Playfair (Great Britain. Parliament. House of Commons, 1886) had proposed in a debate on the Medical Act Amendment Bill that medical practitioners from colonies with reciprocal arrangements in respect of qualifications could join the GMC register. Visram (2002) notes that in the lower socio-economic areas of Cardiff there was a strong base of Indian doctors at that time and this tradition continued well after the NHS was founded. Since the end of the Second World War, throughout the 1960s and 1970s, the NHS continued to open its doors to immigrants from South Asia (Legrain, 2007). The 'pull factor', which is described by Finlay, Crutcher and Drummond (2011) as the motivation for immigration, has increasingly become economic, rather than political asylum. In respect of immigrant doctors from Europe, there was controversy about Belgian immigrant healthcare workers after the First World War (Jacobs, 1915). In 1947, the Medical Practitioners and Pharmacists Bill (HL Deb 11 November 1947) was passed which allowed foreign doctors who had taken refuge in the UK during WWII to register with GMC permanently. This bill was hotly debated and some doctors felt that it was passed as a tactic to ensure support for the formation of the NHS from refugee doctors (Leitch and Scott-Easton, 1947).

Over the last 25 years, the NHS has been accused of using its monopoly to force doctors' wages down (Legraine, 2007) and, as a result, discouraging the uptake of medical studies in the UK. This has resulted in a severe shortage of healthcare professionals. Perkins (2011) reported that, in Wales, the situation was at crisis point with a shortage of 400 doctors. As a response to this, the NHS continued to employ

locum doctors from the European Economic Community (EEC), as well as many from overseas.

This strategy was not without its own controversies, with debates surrounding 'brain drain' in developing countries (Finlay, Crutcher and Drummond, 2011), the ethical dilemma of dissuading potential 'home' medical practitioners through artificially low wages (Legrain, 2007) and reports from the media questioning the cultural and linguistic suitability of non-British doctors treating patients (Dreaper, 2010; The Daily Mail, 2010; The Telegraph, 2011). In order to allay accusations made toward the developed world for taking away doctors who were needed in the third world, a logical option seemed to be to rely upon the untapped resource of highly skilled refugees and asylum seekers. Legrain (2007) conceded that it is almost impossible to answer the matter of British citizens having little interest in studying to be medical workers. Although access to university places is increasingly more challenging, the option is available for those who wish to study medicine in the future. The GMC has strict standards in language and cultural understanding, which non-EEU doctors have to meet (ROSE, 2011a). The BMA offers a great deal of support to such doctors in the form of the BMA Refugee Doctor Initiative.

1.2.3 The WARD Group

In 2002, the WARD project came under the governance of the Wales Deanery (Wales Deanery, 2010). Initial funding of £73,600 was awarded to the project, which set out to address the educational and training needs of refugee and asylum-seeking doctors in Wales.

Their aim is to offer these doctors the chance to validate their qualifications and work within the NHS. Many were redistributed from London or had recently arrived in Wales from countries such as Afghanistan, Iran, Iraq and Sudan.

The WARD group offers a range of support, including: communication skills workshops, CV writing and interview skills sessions, IELTS classes and PLAB training (see appendix 1 for details on the exam training). Training materials and tutors for this support are made available through their Drop-In centre in Cardiff (Wales Deanery, 2010). Assistance in booking for the tests is also made available there.

Beyond IELTS and PLAB training and support, the WARD group help their registered members who have passed the required exams to PLAB 2 with finding work in supernumerary placements. These are six-month placements, as described by Walsh, Davies and Gallen (2010), which enable displaced medical professionals to find work in the competitive environment at Foundation Grade 1 level, which forms the first year of a two-year supervised training programme for all junior doctors. They provide practical experience for people who may have had a gap in their career and cannot supply references, due to their life experiences. These posts have been created specifically for refugee doctors in Wales and aim to meet NHS workforce requirements, as well as the Welsh Government's targets in strategic workforce planning. The exact number of supernumerary posts was not specified in the report but it stated that 74 of their clients were in employment.

1.2.4 The IELTS Test

According to Howatt (2009), The IELTS came about from the early English for Specific Purposes movement of the 1970s. In particular, the joint project between the University of Birmingham and the University of Malaysia from 1974 to 1978, called the University of Malaysia English for Special Purposes Project (UMESPP) began to develop English for Academic Purposes (EAP) as a subject, which led to the testing of EAP. The British Council's English Language Testing Service (ELTS) in conjunction with the University of Cambridge Local Examinations Syndicate (UCLES) developed such a test based on John Munby's book 'Communicative

Syllabus Design' (1980). This new 'ELTS' test would be able to assess learners' language skills in academic subjects that they wished to study in UK universities. It was intended that this test would focus less on grammar than its predecessor, the English Proficiency Test Battery (EPTB), or its American counterpart, the Test of English as a Foreign Language (TOEFL).

Munby's (1980) reductionist syllabus revolved around building the test more communicatively using the works of his contemporaries as a platform to base his theories upon. Munby set out to equip learners with communicative competences. He hoped to achieve this by meeting their communicative needs and combining them with more traditional language skills, thus addressing the EAP agenda.

According to the official IELTS literature (Taylor, 2007; IELTS, 2014), the ELTS covered these six modules until 1989:

- Life Sciences
- Social Studies
- Physical Sciences
- Technology
- Medicine
- General Academic

On top of the five core subjects and the last more general module, there was a general test, much like there is today. There was a specific medical module, which was later combined with Life Sciences in the 1989 review. The review came from a scheme to simplify the ELTS and increase the international presence of the test, giving rise to the name IELTS. The University of Edinburgh oversaw a collaborative project with the International Development Program of Australian Universities and Colleges (IDP) and UCLES. The revision of the test introduced two non-specialised modules i.e. Listening and Speaking alongside three specialised Reading and Writing modules: Module A – Physical Science and Technology; Module B – Life and Medical Sciences; Module C – Business Studies and Social Sciences.

In the second review in 1995, the Life and Medical Sciences was removed from the current test format altogether, in favour of the over-arching General Academic module. This was done based on the findings of Clapham (1996) who wished to ensure that tests were not biased against certain disciplines.

It is interesting to note that the GMC have gradually increased their minimum IELTS requirements for refugee doctors. This may be to do with the trend that Green (2007) describes when he suggests that the successes of test-specific training courses might lead to doubts about the reliability of test scores in adequately describing a cross-section of a person's language skills.

1.3 Rationale

The BMA statistics from the BMA/Refugee Council database for refugee doctors (British Medical Association, 2008) indicated that 66% of the doctors in the UK who were registered on their database were working towards some form of linguistic examination: the IELTS exam and both components of the PLAB exam. This figure appeared to be disproportionately high when one considered that many of these refugee doctors would have received some training for their PMQs in the English language. From my two years' experience of teaching English and IELTS techniques to refugee doctors and other displaced medical healthcare professionals on behalf of the WARD group, I knew that these students had been exposed to the English language for some time, had very high levels of motivation, many opportunities to practise the language and a keen interest in integration into British society. Yet in spite of all of this potential for success, the majority were struggling to pass the aforementioned language exams.

One reason could be that the students had reached a plateau in their language learning. In his influential work entitled 'Interlanguage', Selinker (1972) introduced the term 'fossilization' to Second Language Acquisition (SLA) studies in order to

describe the premature consolidation of an interlanguage, before fluency was achieved. The term interlanguage itself refers to the grammatical set of internal rules that exist when a learner of a second language (L2) is developing their understanding of the target language, based on their knowledge of their first language (L1). In his work, Selinker gave a bipartite definition of fossilization. Firstly, he identified 'fossilization in interlanguage', which describes any interference in the ability to create and develop an interlanguage. This dealt with the cognitive processes of recognising rules, subsystems, similarities, and differences between the L1 and L2, as well as using these observations as a framework to build language learning. He also wrote about 'fossilization in linguistic content' referring to the parts of speech and grammatical forms that are unique to the target language. These would not be features that are recognised in interlanguage and thus are likely to be learnt through rote learning. These forms may not be instantly accessible to learners and may often become embedded as errors, in favour of overall communication of meaning. Seigel (2005) describes some of the critiques of the interlanguage hypothesis, stating that one of the major criticisms is that learners may not have either the level of access to 'fluent' target language forms or the desire to produce the target language to such a degree. It must be remembered that the intended focus of this study was to examine the language state of people who were studying to achieve an IELTS score that would allow them to join the GMC and therefore, an assumption may be made that they were training to achieve sufficiently fluent forms to do so.

In the years that followed this, the phenomenon has been given various terms including 'virtual halt', 'linguistic monstrosities', 'plateaux', 'rigor mortis', 'stopping short', 'fossilized variation', 'permanent optionality', 'siesta' and 'end state' (Han, 2004, pp.13-4). There is a certain tone of finality to many of these terms that could work counter intuitively to motivational strategies, which intend to overcome this

hiatus in language acquisition. Qian and Xiao (2010) identified attitudes and motivation as being contributing factors to what they referred to as ‘temporary fossilization’. In using terms with such negative connotations as those listed above, it would appear that the task of reactivating the language acquisition process might be made more difficult. In this thesis, I seek to identify and understand the phenomena using the term ‘Stabilized Language Errors’ (SLEs). According to Long (2005), the term ‘stabilization’ was accepted by Selinker in his later work with Han, as being a more moderate term, less suggestive of permanence. Stabilization was defined by Long as being a precursor to the final stage of fossilization, where it may still fluctuate away from being an engrained and unchanging feature of an individual’s interlanguage.

My research aimed to identify various possible causal factors that contribute to SLEs as applicable to medical healthcare professionals attempting to pass the IELTS test. I sought to develop an understanding of:

1. The perceptions that displaced medical healthcare professionals have of their own SLEs;
2. The various possible causal factors of SLEs exhibited by displaced medical healthcare professionals;
3. The impact of their life histories, educational histories and other experiences on their SLEs.

1.4 Identification of the Problem

The BMA (2008) statistics in figure 2, on registered refugee and asylum-seeking doctors, highlight two main barriers to their progress towards employment.

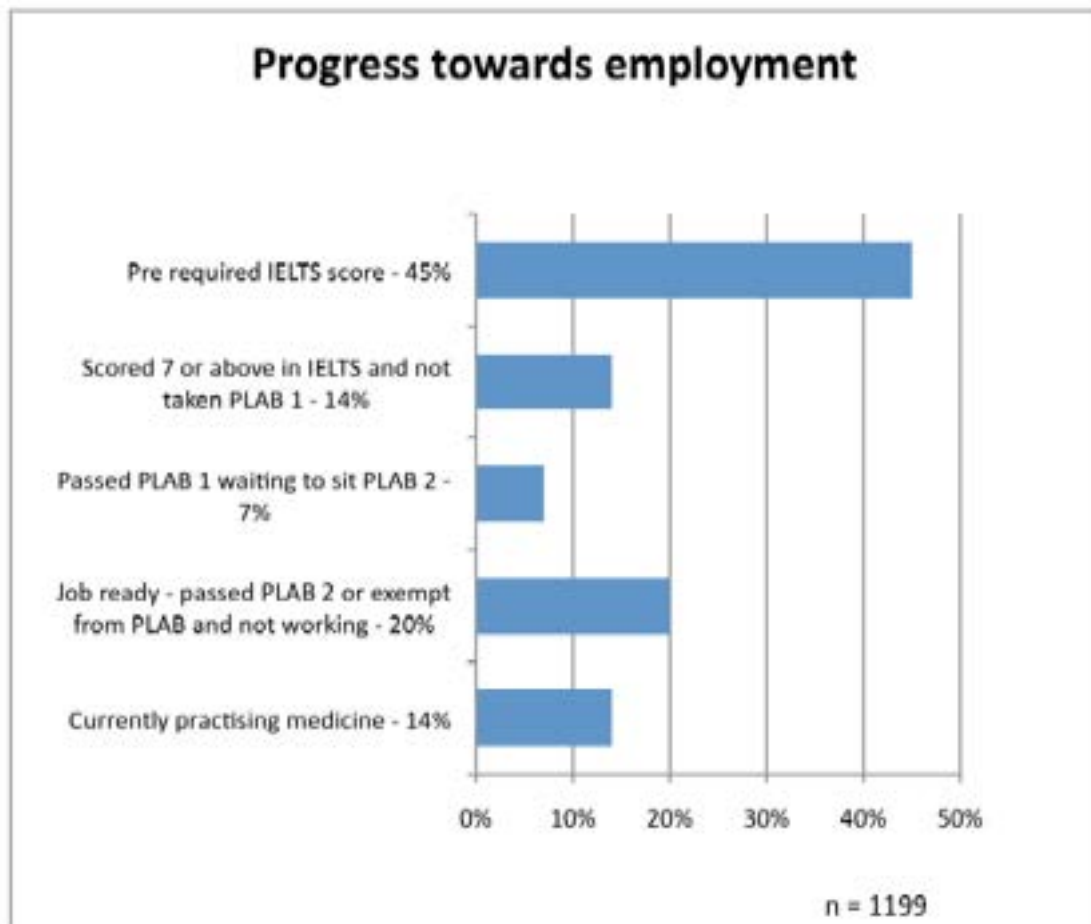


Figure 2. Progress towards employment for BMA registered refugee doctors (British Medical Association, 2008)

As can be seen above, the primary barrier was the achievement of IELTS requirement. The secondary obstacle appeared to be finding work once they were appropriately qualified. This suggests that a lack of mastery of the English language and employability are the main factors that count against them rebuilding their lives and contributing as fully as possible to their host society.

The report by the BMA (2008) further categorised the 1,199 registered doctors by country of origin. Of these doctors, 315 came from Iraq. The World Health Organisation's (WHO) AVICENNA Directories (World Health Organisation, 2011), provided a publicly accessible database of schools, colleges, and universities for education of academic professions in health, stated that all seven extant faculties

and colleges of medicine in Iraq used English as the primary language of instruction. This was further supported by anecdotal evidence from Dr. Tarik¹, an Iraqi refugee in the UK, currently on a training post to be a GP, who said that:

All the studies are in English; only Forensic Medicine is in Arabic language. We study this subject in the year 4 of our 6 years study. The study of Forensic Medicine is in Arabic Language because it is directly related to the legal system and we should use a proper language that judges and solicitors can understand away from any Jargon or English terminologies.

Dr. Tarik added that even after they had graduated and were working in hospitals, they wrote their ward rounds in English. He said that this use of English mostly consisted of medical terminology. In Dr. Tarik's case, general English language instruction was taught prior to university entry. The quality of English language instruction that an individual had received prior to entry to their PMQ is difficult to quantify, as it is likely to vary on a case-by-case basis.

The NHS's Refugee and asylum-seeking Health Professionals (RHP) programme, otherwise known as ROSE, provided eight case studies (2011a) of refugee doctors struggling to succeed in the UK. Two of the subjects were from Eritrea, where English is one of four major languages alongside Tigrinya, Tigre and Arabic. The barriers to progress, as described by these individuals, were connected to a lack of support in their day-to-day lives while they were training. They cited the pressure from the UK Jobcentres to take any work, as a cause of distraction from their studies. Although other work provides an opportunity to interact with English speakers, they did not feel that their language skills were progressing. This was reflected in nearly all of the case studies that were provided by ROSE. These case studies on doctors from Iraq, Sudan, Syria and Ukraine all indicated that their English language skills were too low to meet the IELTS requirements. All of the doctors in these case studies came from countries where the Medical faculties had English medium

¹ Name changed for confidentiality

training courses and additionally the majority had opportunities to practise their language skills while they had been residents in the UK.

Han (2004, p.12) recounted the story of the eminent Chinese physicist, Professor Chien-Shiung Wu, who lived and worked in the US for 56 years in the second half of the 20th century. Professor Wu talked about her lifetime's work at a symposium in Geneva on her 80th birthday. In spite of having lived in an English speaking country for two thirds of her life, she was reported to exhibit the same difficulties with the English Language as she had when she first arrived in the US in 1942.

This case is by no means unusual and can be tied into the debate on Chomsky's (1959) theories on the Language Acquisition Device (LAD), where he argued that language learners in early life have a greatly improved chance of achieving fluency in a target language. Globally, there are countless adults who possess second language skills, but many of them do not possess a degree of fluency that is akin to L1 English speakers. Qian and Xiao (2010) stated that 95% of adults do not reach their target language goals. In the case of Qian and Xiao's study, this was to be proficient in academic English.

Factors that contribute to this early cessation of acquisition, as listed by Qian and Xiao (2010, pp.180-3) were 'age', 'intelligence and aptitude', 'cognitive style' and 'personality'. These observations were made from within the learning environment at the time that learning was taking place.

The debate on the age of the learner contributing to SLEs is convincing on both sides. Among other contrasting theories, Interaction Hypothesis (Gass, 2003) attempts to explain the reasons why some adults are successful in achieving fluency, primarily through negotiation of meaning. This theory moves away from the idea that learners past a certain age cannot progress their language skills beyond a certain

point. The maturity of the learner is what allows Interaction Hypothesis to succeed insofar as it relies on self-discipline, reflection and self-realisation.

Qian and Xiao (2010) quoted Stern (1983, p.386) as calling intelligence 'a general academic and reasoning ability'. The group of learners being discussed within my research, refugee doctors and other displaced medical healthcare professionals, exhibited clear signs of intelligence and aptitude and had already achieved academic success in their PMQs. To cite 'intelligence and aptitude' as a causal factor of stabilization, could, in this case, be erroneous.

The theory of experiential learning has been developed over the years (Honey and Mumford, 1982; Gardener, 1983; Kolb, 1984) and, along with the Interaction Hypothesis, will be further discussed in the literature review chapter. Experiential learning relates to a student's style of learning. Although differences in cognitive styles have become an accepted part of educational psychology, these cognitive styles are generally seen as a reason for learning successes, rather than the cause of a cessation of learning. SLEs in refugee doctors and other displaced medical healthcare professionals may have been fortified by the delivery of their English language lessons. It may be that the form of instruction did not appeal to their individual cognitive style.

In the ROSE (2011) case studies, every interviewee exhibited a very positive attitude to their progression and a great deal of motivation to succeed. The majority of refugees and asylum seekers have a positive attitude toward their host country (Legrain, 2007) and aim to integrate into the culture, while maintaining their own sense of identity.

Whether 'personality' is a causal factor of SLEs among refugee doctors and other displaced medical healthcare professionals is a complex issue to examine.

Extroverted learners are often considered to be more successful in language

acquisition than introverted learners, as they are more likely to interact with target language users. It must be remembered that Qian and Xiao's (2010) theory is classroom based and people who live in the UK as refugees and asylum seekers are in frequent contact with English speakers.

It seems that the many and complex factors of SLEs as described above are less likely when examining a group such as refugee doctors and displaced medical healthcare professionals in the UK, who have done much of their learning prior to arrival in the UK. In order to get a fuller picture, the present study set out to conduct a study of this group's prior learning and experiences. Beliefs about their own prior learning, their learning styles, their attitudes toward the target culture and their reasons for a plateau in learning were examined through interviews, focus groups and collecting the views of expert witnesses who are involved in processing displaced medical healthcare professionals.

Like Dr. Tarik above, many of these refugee doctors and other displaced medical healthcare professionals would have learnt language and skills, simultaneously immersing learners in the target language. Critics of immersion learning claim that this method can lead to rote learning with only a superficial knowledge of the subject matter (Gajo, 2001; Ramsden, 2003; Hanshim, 2009). Proponents of immersion learning, in particular the Content and Language Integrated Learning (CLIL) approach (Mehisto, Marsh and Frigols, 2008; Lasagabaster and Sierra 2009; Macbeath, 2009; Coyle, Hood and Marsh, 2010) maintain that both subject knowledge and language skills can be developed simultaneously, with no detrimental effects on either part. With a great deal of medical terminology being derived from Latin, it is difficult to measure the success of the extent of immersion style training that a doctor would receive in terms of English language learning during their PMQs.

Han (2004, p.29) lists 50 possible causes of SLEs, which she categorises into 'environmental factors', 'knowledge representation', 'knowledge processing', 'psychological factors', 'neuro-biological factors' and 'socio-affective factors'. A discussion of these domains in the scope of refugee doctors and other displaced medical healthcare professionals is imperative in beginning to understand the causes of their SLEs. An examination of displaced medical healthcare professionals and their learning experiences would provide much needed information on this largely under-examined group. In looking for themes in the language learning experiences of displaced medical healthcare professionals, a pattern that rationalises the SLEs that they struggle with may be found.

'Environmental' factors account for the circumstances surrounding a language learner. Han's (2004) second domain 'knowledge representation' describes the influence of L1, as well as ability to access and use Universal Grammar (UG) i.e. Chomsky's developed theory of the LAD. At its basis is interlanguage and it leads all the way to native-like fluency.

In a study of a group such as displaced medical healthcare professionals, it would be difficult to draw comparisons between the interlanguage of one individual to another. One L1 group may find that they have similar features in their interlanguage, whereas a person from a different linguistic background may, according to Schacter's (1996) suggestion, and to a lesser extent Corder (1978), have a completely differently sculpted set of interlanguage principles. However, there may be similarities in the root languages from which the participants' first languages derive, such as Indo-Iranian or Afro-Asiatic languages.

Han (2004) defines the way a person digests information as 'knowledge processing'. This focuses on automatization, attention to form and noticing structure, top-down understanding and processing and analysing constraints of the target language.

From my professional experience of over sixteen years in English Language Teaching (ELT), one of the aims of second language learning is to be able to access linguistic knowledge intuitively. 'Psychological' factors describe students' willingness, or a lack thereof to take risks in language production. If a student is extroverted, it is potentially more likely that they will not avoid certain challenging structures in the target language. Often this might result in the production of an incorrect form but it also offers an opportunity for learning new ways via reformulation.

Han's (2004) next domain, 'neuro-biological factors', features heavily in the literature on SLEs, usually as a discussion on UG. These factors focus on changes in the brain connected to deterioration, usually brought about through ageing or lacking the capability to learn in a physical sense. Finally, the 'socio-affective' category is probably the most commonly occurring factor. There is a large amount of discussion around the attitudes towards the culture of a second language and their impact on language learning. While some of this may be tied into motivation, there are other factors at play too such as a desire to retain identity or culture shock. Han's research has formed the backbone of this study. It will be further examined in chapter two.

1.5 Contribution to Knowledge and Understanding

The question of SLEs has been the subject of research for over thirty years, in one form or another (Han, 2004). For some, particularly those whose errors seem to be caused through neuro-biological factors, these problems seem insurmountable. In the case of distinguished professionals who are users of English as a second language, such as the aforementioned Professor Chien-Shiung Wu, this may never become a barrier to their career. On the other hand, linguistic progression is vital to the highly skilled, but less socially powerful, refugee doctors that are on the GMC register.

Having worked with groups of displaced medical healthcare professionals who were trying to pass the IELTS test before going on to take the PLAB tests, I have witnessed the frustration caused by repeatedly failing to pass IELTS. In my experience, they are highly trained, intelligent and motivated individuals whose principle aim is to integrate into UK culture. The level of study that many doctors have to engage in prior to displacement evidences this. For example, in studying for their Primary Medical Qualifications, trainee doctors in Baghdad such as Dr. Tarik must learn formal Arabic, as well as English, alongside their medical training. Kader (2004, p.42) states that 'I can guarantee that doctors in my country are very hard-working student and have a very high IQ. They are very serious-minded people who work extremely hard.' These errors are not a mere inconvenience; rather they prevent doctors from continuing their careers and contributing to their host country, at a time when doctors are in short supply.

The findings highlight the causal factors of SLEs that the sample group identified as being problematic as well as uncovering those that did not seem immediately apparent. The findings also highlight the impact on motivation that was caused by the inequity of the former GMC policies between doctors from the EEU and those who were not. The project also provided a platform for an often-overlooked group to share their perspectives on the challenges and suitability of the IELTS test as an entry requirement to medical practice. As such, the findings contribute to knowledge in acknowledging the English language learning challenges that face displaced medical healthcare professionals, so that these challenges may be addressed in the training and support provided for these individuals.

1.6 Thesis Structure

The aim of my research is to make a contribution to the progress of displaced medical healthcare professionals struggling to meet BMA requirements, which in turn, might allow them to begin working within the NHS. The literature review chapter will examine the challenges that face displaced medical healthcare professionals, including the language training that is available to them. It will also examine research on Stabilised Language Errors and how they may affect displaced medical healthcare professionals who are training for the IELTS test in order to return to practice. In chapter three, titled 'Research Design', I will detail the development of the research questions and examine the methodological considerations that will inform how the project will aim to answer them. The research questions to be investigated are:

1. What are displaced medical healthcare professionals' perceptions of their own common SLEs?
2. In the participants' views, what is the impact of life histories, educational histories and other experiences on SLEs?
3. What are the participants' responses to the emerging findings of the study in research questions one and two?
4. What are the views of expert witnesses on the training and language skills of displaced medical healthcare professionals?

The sample in the research was based on feasibility and convenience; as such participants were selected via the WARD group. It was a study that aimed to examine participants' responses to the situation that they found themselves in, where they were struggling to overcome barriers to their progress towards employment. The research took a bipartite approach, examining linguistic aspects of the SLEs themselves as well as the impact of individual factors that may contribute to SLEs.

From the previous discussion on the identification of the problem, it is evident that there has been much research conducted on L2 learners whose language does not progress beyond a certain point. It is less clear which of the aspects, as described by Han (2004), would apply to this particular group. In order to develop an

understanding of the ways that displaced medical healthcare professionals understood and were seeking to overcome their SLEs, an in-depth approach to their learning experiences, both prior and current, was taken through a process of questionnaire, interview and focus group. This will be reported in Chapter 4. The approach aimed to account for the potential volatility of the sample. The data collection covered the participants' beliefs regarding SLEs: what they were and why they exhibited them. This provided information on the SLEs that were identified and how they fit into Han's (2004) taxonomy.

In order to complement, by confirmation or contradiction, the views of the displaced healthcare professionals, expert witness interviews were carried out. These expert witnesses were selected from professional networks through their role in the processing of displaced healthcare professionals. The views of the focus group and the expert witnesses are reported in Chapter 5.

In Chapter 6, I will draw conclusions from the findings of the study, aim to highlight the challenges that confront displaced medical healthcare professionals and provide some recommendations. These challenges are not only from external factors such as increasing requirements made by the governing bodies of their professions, but also from internal factors such as harsh self-assessments of their language skills and the effects of their circumstances on their wellbeing.

The study focused on displaced healthcare professionals, aiming to gather the perspectives of the clients of the WARD group and to provide them with a voice in the on-going discussions on training displaced medical healthcare professionals. However, the findings could be applicable to other groups of refugee professionals attempting to gain English language qualifications, such as people qualified to work in the wider sphere of healthcare or educators.

1.7 Summary

In looking at the background of this project, I have identified a tension between the need for doctors in the NHS and the need for overseas doctors to be competent in both language skills and medical knowledge. I have identified the difficulties that refugee doctors and other displaced medical healthcare professionals face in attempting to pass the IELTS test, the first stage of joining the GMC and the biggest challenge to displaced medical healthcare professionals. I have also identified the putative causal factors that contribute to SLEs that, in turn, hold language learners back.

In looking at the research design, I set out to answer the research questions, which, as I will demonstrate in the methodology, were specifically designed to foreground the voices of the potential participant group. Alongside asking for their view on their own SLEs, the project intended to gauge their reactions to the situation that they found themselves in, socially and linguistically.

The next chapter will contextualise the study via a review of the literature in four main sections: the condition of contemporary displaced medical healthcare professionals, an examination of the literature on fossilization and SLEs, a review of IELTS in the context of this study and the language families of the expected sample.

Chapter 2. Literature Review

2.1 Introduction

In this chapter, an audit of the literature on the goals and prior learning experiences of displaced medical healthcare professionals is conducted. The linguistic aspects of the study are underpinned by discussing the current literature on fossilization studies. Then, the IELTS test, as applicable to this study, will be reviewed. To end the chapter, I will discuss the characteristics of the first languages of the majority of asylum-seekers and refugees in the UK, as well as the inherent challenges that learners from these linguistic backgrounds face in learning English.

As many ELT professionals will testify, migration has become a normal part of modern life. Whether the driving factors are economic, academic or social, leaving the hometown behind has become commonplace for many people worldwide. Often this represents an exciting new chapter that can have a major impact on one's life story.

Forced migration, on the other hand, is a much less positive experience. People who are displaced due to famine, conflict or natural disaster are often reluctant to relocate and rarely prepared to do so. In fleeing danger, many are lucky to escape with their lives and a few personal effects and, once they find refuge, they have to begin rebuilding their lives. Travel documents and qualification certificates are misplaced, access to accounts can be lost and with them, identities can begin to disappear. While there are charitable organizations such as the Red Cross that can assist forced migrants, the responsibility for reconstructing one's life rests ultimately with the individual.

In working with displaced medical healthcare professionals for the charity DPiA, which is associated with the WARD group, I was involved in trying to help refugee

doctors and other displaced medical healthcare professionals return to their professions. My input was to deliver International IELTS exam strategy classes, which would assist them in their first step in registering with the GMC.

At the time of writing, the IELTS test is one of the most widely taken English language tests in the world. In their brochure, the IELTS group (IELTS, 2009) stated that it has been used for immigration purposes in the UK, Canada and Australia, accepted by thousands of universities in English first-language (L1) countries and used by training and professional bodies in Law and Medicine. The score results range from 1.0, representing a non-user of English, to 9.0, which describes an expert user. Each skill is given its own grade and an overall score is awarded based on an average of the four skills: reading, writing, speaking and listening. The grade scale allows for partial 0.5 marks to be awarded. The General Test is used for the purpose of immigration to English L1 countries. The Academic Test is more commonly taken when professional qualifications are a goal of the test-taker. Below is a table that lays out guidelines for acceptance onto academic courses:

Table 1. IELTS guidelines for acceptance onto academic courses (IELTS, 2009)

| Band | Linguistically demanding academic courses e.g. Medicine, Law, Linguistics, Journalism | Linguistically less demanding academic courses e.g. Agriculture, Pure Mathematics, Technology, IT and Telecommunications | Linguistically demanding training courses e.g. Air Traffic Control, Engineering, Pure/Applied Sciences, Industrial Safety | Linguistically less demanding training courses e.g. Catering, Fire Services |
|-------------|---|--|---|---|
| 7.5 – 9.0 | Acceptable | Acceptable | Acceptable | Acceptable |
| 7.0 | Probably acceptable | Acceptable | Acceptable | Acceptable |
| 6.5 | English study needed | Probably acceptable | Acceptable | Acceptable |
| 6.0 | English study needed | English study needed | Probably acceptable | Acceptable |
| 5.5 | English study needed | English study needed | English study needed | Probably acceptable |

Table 1 indicates that a score of 7.0 or above is the suggested minimum requirement for acceptance onto medical courses. This benchmark has been adopted by the GMC. IELTS (2009) also acknowledges the phenomenon of language loss. This is when an individual's linguistic competence deteriorates over time when they are not exposed to on-going linguistic input. It is for this reason that IELTS recommends that any IELTS test certificate is considered valid for two years only after the test is taken.

If an applicant to the GMC register satisfies the minimum requirements to enter the PLAB test, they need to take the test within two years of successfully achieving their IELTS score, unless they have evidence of further study in Higher Education on a course that is delivered and assessed entirely in English (General Medical Council, 2014c).

The PLAB test was developed in order to ensure that International Medical Graduates (IMGs) are able to practise medicine safely in the UK (General Medical Council, 2014d). The questions reflect the level of a Foundation Year 1 qualification. It is administered in two parts, the first following the format of a written exam. In the exam, there are 200 computer-marked questions, which are roughly divided into around 25-30% single best answer and the rest being extended matching questions. The questions cover four areas, which are Diagnosis, Investigations, Management and Context of clinical practice. Within two years of passing PLAB 1, candidates have a maximum of four attempts to pass PLAB 2.

The GMC (2011e) advised that the second part of the PLAB test takes the form of an Objective Structured Clinical Examination (OSCE), which features 14 five-minute scenarios. The four skills that are assessed in this part are Clinical examinations, Practical skills, Communication skills and History taking. Many doctors who took their PMQ in an English-medium university will have an understanding of technical terms such as 'gastroenteritis'. However, the linguistic challenge of the PLAB exam is that they are required to communicate on various levels and would need to understand patients' self-diagnoses of 'tummy aches'.

Although my role as a trainer in IELTS strategies was extremely rewarding, it was also frustrating, as a number of the clients of the WARD group were held back at this initial stage. Having read much about 'fossilization', I was curious to find out why this particular group of intelligent, motivated learners with the many opportunities to practise that living in the target culture affords, were not acquiring the language to a standard that was sufficient to pass the IELTS test at the required grade. I decided to base the research on the participants' own analysis of their SLEs and the research questions were developed accordingly.

Displaced medical healthcare professionals are a specific group who, while they have been arriving to the UK for many years, seem to be surrounded by controversy. In order to ensure that they are fully trained and suitably qualified to work in the UK, the most recent GMC guidelines include a minimum level of English assessed by the IELTS test with an overall band score of 7.5 and a minimum score of 7.0 in each skill: listening, speaking, reading and writing. While language skills at this level are undoubtedly essential for safe and effective practice in medicine, it is frustrating for many medical healthcare professionals who have trained for many years, to be held back by not being able to achieve this minimum language requirement. It is also a loss to the NHS as training a doctor from the beginning is a lengthy and costly process. In retraining previously qualified refugee doctors, it allows highly intelligent and motivated refugees to integrate and contribute to their host society, thus restoring their dignity and alleviating the financial burden to the government of supporting displaced people.

2.2 The Condition of Contemporary Displaced Healthcare Professionals

In order to define the groups involved in this study this review of the literature will attempt to examine the profile of the participant group through the available literature. Conducting research with refugee groups is notoriously difficult. Stewart (2004) indicated that neither Hansard, nor Home Office, nor EU/UNHCR, nor Census, nor questionnaire data from small-scale questionnaires could give the full picture of the refugee situation in the UK. Crawley and Crimes (2009) acknowledge that, due to the lack of baseline information, it is impossible to know the full statistics for the wider refugee population living in the UK and, in the case of this thesis, in Wales. The main reason for this is the status of 'refugee'.

There is a distinction to be made between asylum seekers and refugees. According to the Geneva Convention on Refugees, a refugee is a person who:

...owing to well- founded fear of being persecuted for reasons of race, religion, national- ity, 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. [sic]

(UN 1950: 14)

In light of the Geneva Convention, an asylum seeker with a compelling case may be awarded refugee status and be granted leave to remain in the UK, unless there is a major permanent change in the country they have left within five years of being granted refugee status, in which case they will be required to return to it (Welsh Government, 2012). Once this status has been granted to individuals, it is likely, according to Wyatt (2005) that they will focus on long-term integration on two levels. The personal level would lead them to access services and provisions and at the community level, they would look for housing, schooling for children and other needs. The successful conclusion of this is that these individuals are fully integrated into the community and are no longer likely to make use of the services offered to them as refugees. Often such individuals may migrate within the host country. Thus, the status of refugee could be viewed as a transient one, between seeking asylum and full integration.

In a series of case studies of refugee healthcare professionals from the UK (ROSE 2011b), many of the respondents who were interviewed mentioned that they were held back by a lack of evidence of their medical qualifications and employment references.

Ong, Bannon and Paice (2004) drew a distinction between refugee doctors and overseas doctors. In summary, they stated that refugee doctors had less lead-in and

planning time before arrival, less of an idea of what to expect and less money and supporting documents amassed before leaving their country. Their departure would often have been more traumatic and their conditions more difficult in terms of leaving their professional lives behind.

A further part of the context that requires scrutiny is that of the social stigma of the term 'refugee'. The Oxford dictionary definition of refugee is:

A person who has been forced to leave their country in order to escape war, persecution, or natural disaster

(Oxford Dictionary, 2011)

Yet, this definition does not reflect the social connotations of the word as a label.

Stewart (2004, p.38) mentions that there are commonplace ideas in the UK that asylum seekers inundate the country. While she goes on to explain that the UK has a substantially lower intake of asylum seekers than other countries in the EU, this does not appear to appease those who believe that opening the doors to displaced people is a threat to their way of life. It sometimes appears that the right-wing British media is worried by the 'deluge' of immigrants 'diluting' the essence of 'Britishness' (Glover, 2007). Such irresponsible reports reflect the ideals of the National Front over the 1970s and 80s that led to perceptions that immigrants were stealing jobs and living off the state. Such reports fail to consider that those who find themselves on UK shores subsequent to fleeing persecution and/or danger frequently encounter xenophobia, in spite of their ability to contribute to their host society (Vertovec, 2007; Mulvey, 2010; Smyth and Kum, 2010). In Wales, this is also the case (Wyatt, 2005; Dunkerly *et al.* 2006).

The effect of language on culture, and vice versa, is a subject of much debate (Deuttscher, 2010) but it is difficult to argue that the term 'refugee' has not been stigmatised over recent years. As with all labels, the word refugee can provoke very strong reactions in many different areas of life. It is common, especially in times of

economic hardship, for migrant groups to face accusations of draining local funding if they are unable to find work or exhausting employment opportunities if they do secure a job (Watson, 2012).

In giving some comparative statistics across European countries, Stewart (2004) tried to alleviate some of the fears of the British press. She states that Britain received just 1.5 asylum applications per 1,000 of the existing population in 2001 as opposed to 3.3 and 3.7 for Norway and Austria respectively. Blinder (2014) reported the figure for 2014 at 0.47 per 1,000 people. However, these statistics are not likely to make the headlines of British newspapers that support a curbing of British immigration policies.

Another interesting point raised by Stewart (2004) is the possibility of the press' sway of public perception through the use of collocated terms such as 'illegal immigrant' and 'bogus asylum seeker'. Coupled with the interrogations and biometric fingerprinting that are familiar to the majority of immigrants to the UK, the public image of refugees appears to be considerably negative. A fear of the opportunities for diversification and learning from other cultures potentially stands to break with traditions that defined 'Britishness' at the height of the Victorian Empire.

In their report, which attempted to address the dearth of research into the refugee condition in South Wales in their questionnaire examining skills, experiences and barriers to inclusion, Crawley and Crimes (2009) stated that the respondent refugees based in Wales were unevenly spread throughout the country, which is a distinction from other refugees in the UK. Over half of the known refugees living in Wales were in Cardiff, with the second highest population at 24.2% being in Swansea. Only 3.2% of refugees in Wales were in the north. The 'Audit of Refugee Skills and Qualifications in Wales' (Welsh Refugee Council, 2007), showed that of at least 10,000 refugees living in Wales, 60% had a further or higher education qualification

but that 60% were unemployed. It is not known what percentage of the refugees living in Wales are doctors.

The number of refugees living in Wales has grown since 2001 when the region was identified as a dispersal area. Prior to this, Crawley and Crimes (2009) described Wales as having relatively low numbers of refugees compared to other parts of the UK, apart from the aforementioned areas.

According to the Information Centre about Asylum and Refugees (ICAR) website (2010), Cardiff has one of the oldest ethnic minority populations in the UK. This was largely due to European, Somali and Yemeni immigrants who began to travel to the area because of industrialisation in the 19th century. In 2010, the Welsh Refugee Council celebrated its 20th anniversary and it has expanded considerably since its inception in the 1990s. Alongside this, there are various other voluntary sector refugee groups who operate across South-East Wales including Freedom for Refugee Education (FREd), Women Connect First and DPiA, which is an affiliate organisation of the WARD group.

2.2.1 Integration

Integration means many things to many people but was defined in the context of refugees in the UK as a working definition by a report commissioned by the Home Office as:

An individual or group is integrated within a society when they:

Achieve public outcomes within employment, housing, education, health etc. which are equivalent to those achieved within the wider host communities, and

Are in active relationship with members of their ethnic or national community, wider host communities and relevant services and functions of the state, in a manner consistent with shared notions of nationhood and citizenship in that society.

(Ager and Strang, 2004, p.5)

A broader term that is often used in this context is 'inclusion'. The Welsh Government describe inclusion as taking place when an individual participates and contributes in all areas of life in the community e.g. politics, culture and the economy. The main distinction between inclusion and integration according to the Welsh Government is that inclusion applies to general areas of society and culture, as experienced by groups. On the other hand, the Welsh Government states that integration is defined as how and what the individual chooses to participate in, within the sphere of inclusion. The Scottish Refugee Council acknowledges difficulty in defining these terms and is careful to add that neither integration, nor inclusion should be interpreted as 'assimilation' (Scottish Refugee Council, 2010). In the context of this study, which examines the highly personalised opinions of the proposed participants who at the time resided in south Wales, the term integration will be used as defined by the Welsh Government.

A more difficult definition to make is that of 'British society'. Traditional British culture has diversified and individuality is increasingly prioritised above a homogeneous national identity. During the last century, adolescent men went from aspiring to fight for king and country in the war to end all wars, to aspiring to win victory in televised singing contests. Legrain (2007) described the changes that British society has undergone in the last fifty years with respect to the changes in societal core values. He calls into question the idea that there is a single definition for British society and sympathises with immigrants to the UK when they are accused of failing to fit in with the British way of life. UK citizens are now generally much more tolerant of single-parent families, mothers are encouraged to work and the discrimination of gay people is against the law. This shifting landscape is progressive but it does present a challenge for traditionalists from both British and non-British backgrounds to keep up. This in turn can be something of a cultural shock. The Home Office require that applicants for settlement in the UK take a test called 'Life in the UK' (Home Office,

2013) which is informally known as the 'Britishness Test'. This test was designed to assess an individual's practical knowledge, needed to take part in society but it has been criticised widely in its selection of aspects of British culture (Johnstone, 2005). Ultimately, British culture is dynamic and in a large part, this is due to immigration into the country. Anyone who watches the BBC after watershed can observe that racist language has become a greater taboo than sexually explicit language in the UK.

Integration is reciprocal (Legrain, 2007) and it is also something that needs to be worked at by communities at large. In order to prevent ghettoisation, receiving communities must be willing to be receptive (Legrain, 2007). In the Refugee Inclusion Strategy (Welsh Government, 2012) the Welsh Government identified problems within receiving communities, stating that many dispersal areas are also areas of low socio-economic growth. In such areas, there is greater competition for resources and this is cited as being a barrier to inclusion. Threadgold *et al.* (2007), however, produced research that shows that integration is just as fractured in white working-class communities on council estates as it is for ethnic minority groups. The conclusion made in this research calls attention to social cohesion in general but there is no denying the additional matters of inter-cultural religious differences and racism. Legrain (2007) tells us that many of the aforementioned changes in attitude in UK society, such as tolerance towards homosexuality, contravene some religious doctrines and thus present a challenge for newcomers from less secular nations. In turn, tolerance of the right to practise one's religion is vital to cross-community cohesion. Immigrants must accept and be accepted in this context and integration can be achieved through a 'live and let live' approach. Notwithstanding this, Crawley and Crimes (2009) reveal that 49.6% of the refugee respondents to their questionnaire felt that they have been discriminated against on the grounds of their

culture or skin colour. It may be that only through sustained contact with people from other communities; these barriers to inclusion will be overcome.

The attitude observed by Legrain (2007) in his work that a nation will crumble under the weight of cultural dilution, due to immigration, seems somewhat irrelevant in the 21st century. Cultures are already diverse and greater diversity is inevitable. Legrain (2007) observes that cultures are constructs and therefore can be reconstructed.

This has been proven, to various degrees of success, in the United States, Canada and, perhaps to a lesser extent, in France, where societies have absorbed the culture of all immigrants. Refugee integration is possible, as the history of the UK has proven since the Huguenots of Elizabethan Europe began to teach members of their community how to work within their host community. Ager and Strang (2004) explained that cultural competence is essential for integration into the wider community and that knowledge of English is the key to this. Through competence in these areas, refugees are able to begin to build their lives, access local services and forge meaningful relationships within their host communities.

Societies need to make every effort to ensure that everyone feels included and has an opportunity to participate fully in economic and social life. But they also need to accept the diversity of all of their members – not just those of foreign descent – while insisting that all adhere to the fundamental principles on which they are based. The watchwords are tolerance and respect for the law. Learning the local language and how local institutions work, and promoting cultural understanding are also important, without seeking to impose a uniform culture or behavioural norms.

(Legrain, 2007, p.283)

This is not to say that they will not encounter racism or other problems. For example, in Wales, according to Stewart (2004), there is a hidden culture of ignorance, disbelief and denial when it comes to racism. Stewart's point is that there is a low level of support for refugee groups in Wales due to an oversight in acknowledging the existence of racism (Stewart concedes that this is true throughout the UK).

Stewart (2004) adds that there is a lack of data on refugees in general. This hiatus in information includes a lack of knowledge about their social networks, insufficient research on their dispersal zones and strategies, and the practicalities of their integration. In particular, Stewart adds that there was a clear hiatus in information on refugee groups in Wales.

The displaced medical healthcare professionals who made up the participant group had the opportunity to participate fully in economic and social life through their work. They had small social groups formed through accessing services offered to them by organisations like WARD and they had a common goal: to complete registry with the GMC. As mentioned before, there is also a problem with pinpointing exactly how many displaced medical healthcare professionals are in the UK. Ong *et al.* (2004) state that the number of refugees who have medical qualifications in the UK is unknown. In 2004, they posited that the figure lay between 200 and 2000. Ten years on, it is likely to be more than that, but the exact figure is still elusive.

2.2.2 Identity

According to Bloch (2002) the main refugee groups entering the UK changed in the period from the 1980s to the millennium, as detailed in the table below. In the third column are statistics about the source countries of mass refugee displacement between 1962 and 2008, as reported in the United Nations High Commissioner for Refugees (UNHCR) Statistical Yearbook 2008. In the fourth column is the country of origin of the respondents to Crawley and Crimes' (2009) 'Refugees Living in Wales' survey.

Table 2. The changing trends in refugee arrivals since the 1980s

| <i>1980s & 1990s (Bloch, 2002) Alphabetical order</i> | <i>2000 (Bloch, 2002) Alphabetical order</i> | <i>Sources of mass displacement 1962-2008 (UKHNCr, 2008) In order of volume</i> | <i>Respondents to Refugees Living in Wales Questionnaire (Crawley & Crimes, 2009) In order of volume</i> |
|--|---|--|---|
| India | Afghanistan | Afghanistan | Iraq |
| Nigeria | China | Eritrea/Ethiopia | Iran |
| Pakistan | Former USSR | Rwanda | China |
| Somalia | Iran | Iraq | Zimbabwe |
| Sri Lanka | Iraq | Former Yugoslavia | Pakistan |
| Turkey | Pakistan | Liberia | Eritrea |
| Vietnam | Romania | Sudan | Sudan |
| Yugoslavia | Somalia | Congo | Afghanistan |
| Zaire | Sri Lanka | Mozambique | Somalia |
| - | Turkey | Burundi | Others |
| - | Yugoslavia | Somalia | - |
| - | - | Angola | - |

The table above indicates the arrivals of refugees to the UK from these communities over the years and, in the case of the last column, the refugees that have arrived to Wales. The statistics as reported by Crawley and Crimes in 2009 appear to have changed slightly over time. The Migration Observatory (Blinder, 2011) provides UK figures for 2011, which feature the same ethnic groups applying to receive indefinite leave to remain in the UK, with the only differences being in the number of application from the top ten countries of origin. There were apparently far fewer applications from former residents of Sri Lanka. The most important distinction is that Blinder's (2014) chart in figure 3 features applications for leave to remain in the UK, whereas in table 2, Crawley and Crimes (2009) discuss refugee dispersal, therefore counting only those applicants who were successful. Nonetheless, the countries of origin seem to have equal representation in each case.

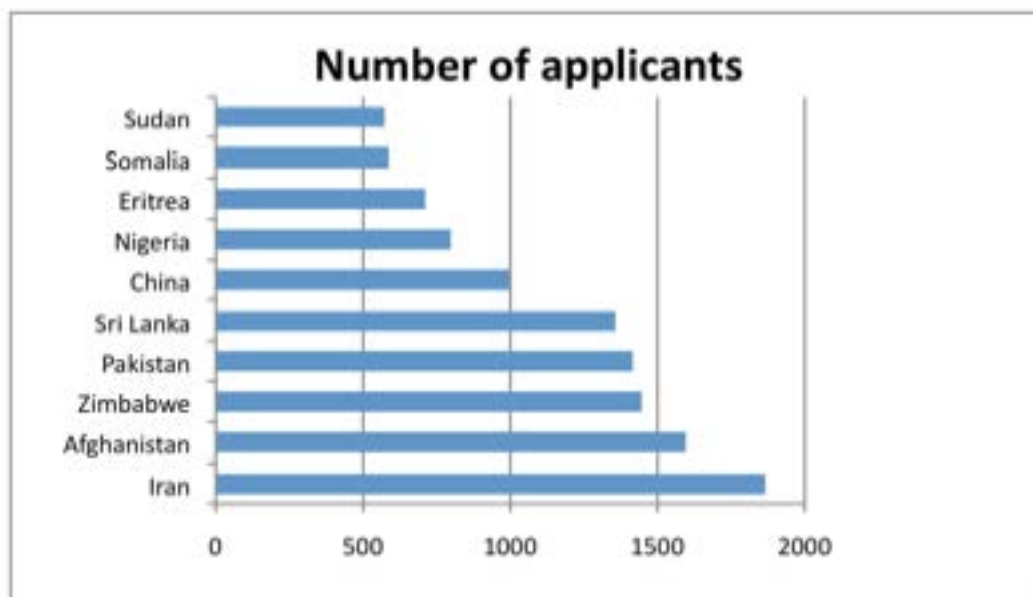


Figure 3. Number of asylum applicants UK (Blinder, 2014)

While cultural identity most often stems from one's country of origin, there are also other forms of identity to consider, such as social identity, socio-economic status and gender. In many cultures, the role of a doctor has a high status attached to it. In taking flight from their home, doctors may lose their documents and along with it, their status. According to Winkelmann-Gleed and Eversley (2004) some doctors may even feel pressured into changing their names in order to facilitate their integration into their host culture. This is not the only difficulty related to a loss of social standing described by Winkelmann-Gleed and Eversley. Refugee doctors meet with great competition from doctors already working in their host country, questions about their practices and distrust from patients. This situation is similar for other displaced medical healthcare professionals.

In order to maintain displaced medical healthcare professionals' currency in knowledge and professional practice, it is important to minimise any gaps in their employment. Groups such as WARD try to assist with the transition from doctor to refugee and back to doctor again. If the gap is too great, Smyth and Kum (2010) warn of deprofessionalism, whereby a person can become so out of touch with their profession that they may need to retrain for the same job.

The idea of getting qualified professionals back into work suits the individual, the host country and all other stakeholders. Finlay, Crutcher and Drummond (2011) discuss the long-term benefits for the country of exile when the threat to the displaced people has passed and they are able to take their knowledge and skills back to their home country. This would serve to maintain the identity of displaced medical healthcare professionals and, perhaps, add the prestige of having worked overseas.

The case studies of Dr. Kader and Dr. Tanin in Kader and Tanin (2004) detail the struggle with identity that refugee doctors face. Dr. Kader describes the prestige of having studied in Baghdad University and the challenges of studying in an English medium faculty. He describes his trajectory to becoming a distinguished paediatrician and lecturer prior to his displacement and the impact of the loss of status that displacement had caused. The social challenges that Dr. Kader faced were feelings of isolation and insecurity, in spite of the more secure political situation in the UK. The difference in status of being a doctor in the UK also challenged Dr. Kader, as he was not accustomed to taking bloods as this was the role of the nurses in Iraq and this meant that he also had to engage in a lot more practical training.

Dr. Tanin (Kader and Tanin, 2004) describes similar obstacles in retraining for less senior posts after displacement from Afghanistan in the early nineties. The competition for any posts was fierce and she had to learn very basic skills of CV writing as well as obtaining good references. Dr. Tanin goes on to state:

For five years, I repeatedly felt ignored, despite my experience, enthusiasm for work and my knowledge of different cultures and languages. Ignored because the system was based on an ignorance of those professionals who are seen as a burden rather than an asset for the economy; ignorance of employers who rather accommodate their own choices; ignorance of a culture which sees refugees with a black and white judgement of tabloid media and xenophobic thoughts of extreme right. Refugee doctors, like other refugees, have been discriminated against.

(Kader and Tanin, 2004, p.50)

Although both of the above case studies had a positive outcome and both doctors are now working in their specialities, the impact of their loss of status and of their culture is evident within these testimonials.

2.2.3 Prior Learning

Stewart (2004) again highlights the lacuna of research into the refugee condition. In her study, she shows that while Britain, Sweden and Australia collected information about the education levels of refugees in these countries, it was only Australia that collected data on English Language skills. In the UK, the main problem with prior learning in linguistic competence is that it is not always formally assessed. Most people involved with ELT will be familiar with the IELTS or other similar exams. Yet L2 English users only tend to take these rigorous tests if it is completely necessary. Many of these academic exams are robustly designed to assess a person's ability to use English in the context of applying for entry into a university (Universities and Colleges Admissions System, 2014). However, if a person does not need to take such an exam, as they do not need it for their work or further study, any assessment is often left up to the individual.

In the Crawley and Crimes (2009) survey of refugee Skills in Wales, the majority of the respondents were answering questions about their level of English on arrival based on self-assessment. Richards and Lockhart (2007) state that a learner's self-perception has an effect on how learning is prioritised as well as how learning opportunities are exploited. If this is the case, we may glean results from enrolment onto courses after arrival. Cebulla, Daniel and Zurawan (2010) indicate that enrolment and attendance onto English language courses, for those who were streamed into lower skilled groups, was at its highest 15 months after arrival. This may be attributed to a number of reasons such as access to information, courses, childcare or other services. For those streamed into medium and high skilled groups, attendance on English Language courses diminishes with time. It is worth noting that

those who have progressed from medium to high language skills are not reflected in these statistics. Crawley and Crimes (2009) cite a number of reasons for students' non-attendance onto courses, mostly connected to the hidden costs of attending i.e. travel and child-care costs. There is another potential reason for people leaving their English classes, which is that the learners have satisfied their communicative needs, at least temporarily (Corder, 1978; Canale and Swain, 1980; Johnson, 1996; Klein, 2003; Han 2004).

As discussed in the introduction chapter, worldwide many trainee doctors have learnt some English before earning their PMQ. For example, those who did their PMQ in Baghdad would have taken a large part of the qualification itself through the medium of English. Language learning experiences vary greatly from rote-based learning to styles that are more communicative. Honey and Mumford (1982) produced a learning style inventory, describing learners as being reflectors, theorists, pragmatists or activists. These learning styles can inform learners on how to recognise their strengths and weaknesses in a given learning situation and allow trainers to cater for each learning style when preparing and delivering sessions.

Learners have many different motives for learning languages, for example, to relocate to a country where the target language is spoken, for business or because they have a natural talent for languages. Cook (2001) describes a learner with 'Instrumental motivation' as possibly not having a great deal of interest in integration into the target culture. An instrumental learner may need to learn the language as a way of getting by on a day-to-day basis. Once this level of communication is achieved, there may not be a greater drive to continue engaging in the learning process. This, according to Cook (2001), is the weakest form of motivation in terms of promoting near-fluency in the target language.

This is quite understandable and very commonplace. In his influential paper, Maslow (1943) describes his hierarchy of needs, which ranges from very basic physiological needs to the nourishment of the spirit at the top of the hierarchy or 'self-actualisation'. In the context of learning a language to survive in a country with a different first language from one's mother tongue, communication will play a crucial part in satiating the basic needs within the hierarchy. The other stages in Maslow's hierarchy of needs are not concerned with life or death and while Maslow argues that an individual may feel unfulfilled without realising these needs. It could be argued that if a person is able to communicate their higher order needs in one's first language, there may be little motivation to do so in a second.

There are other descriptions of motivation that may apply to displaced immigrants. Kumaravadivelu (2006) explains that the alternative to 'instrumental motivation' is defined by social psychologists Gardner and Lambert as 'integrative' i.e. a person who is motivated to some degree by the desire to integrate into a target culture. If the ultimate goal of a refugee who has been granted leave to remain in the UK is integration, then Cook (2001) states that they are much more likely to achieve near-fluency than instrumental learners. Kumaravadivelu (1984) adds that both of these forms of motivation are more likely to be driven by extrinsic needs such as gaining approval or status, rather than intrinsic needs, which are manifested by pleasure or enjoyment.

Further to this, Klapper (2006) proposes that there is a third form of motivation and calls it 'resultative motivation', also referred to by Kumaravadivelu (2006) as 'achievement motivation'. This would account for those learners who neither need to learn a language nor love the target culture but perhaps have a natural flair for a particular language and therefore do well in assessments of it. Regardless of Klapper's (2006) assertions that these learners should fall in between instrumental and integrative learners in terms of achieving near-fluency, it seems that this

motivation is more likely to occur in classes often described as English as a Foreign Language (EFL) in non-English L1 countries. That is to say, learners motivated by resultative reasons are less likely to need the language for long-term 'survival' in a host country, nor do they hold a great fascination with the target culture.

Phillimore *et al.* (2003) state that in their household questionnaire, the main motivation was to learn English in order to get a good job or improve career prospects but there are social ills and problems with self-esteem identified in the survey. Charlaff *et al.* (2004) show that many of the respondents to their audit on skills and aspirations within the refugee community in Scotland have a high motivation for contributing to life in the larger community. The Welsh Government describe volunteering in their Refugee Inclusion Strategy (2008) as providing a route into employment and opportunities to support the community, maintaining self-esteem and increasing knowledge and skills for volunteers. This point of view is reflected in Singh (2007) where motivation and self-worth are described as defining characteristics of cohesion through the empowerment of a community. Other research (Phillimore *et al.* 2003; Heckmann, 2008; Furlong and Hunt, 2009) reinforces the view that learning, and in particular learning English, is tantamount to empowerment for migrants to the UK.

This appears to be a panacea for many of the challenges surrounding integration but keeping motivation high is another matter. De-motivation can occur after being placed in a low-skilled job, according to Phillimore *et al.* (2003) particularly if an individual comes from a culture with a 'job for life' ethic. They also talk about dissuasion from further study in relation to the length of time it would take an individual to re-qualify. A case study featured in the Welsh Refugee Council audit (2007) attributes de-motivation to the realisation that the subject's self-assessment of their English was higher than it should have been and with that came a sense of demoralisation. Apart from the aforementioned contributing factors to the reduction

of attendance at English classes as described by Crawley and Crimes (2009) e.g. a lack of child-care and travel costs to and from classes, the timing of classes and the level of English being taught in the classes which were available were also cited. Many felt that their English was at a higher level than that of the classes they were offered. While these factors do not directly influence the motivation of an individual, they are very real barriers to learning which often do not have a pragmatic answer. In these cases, there is very little that educational institutions constrained by their own budgets can do to provide opportunities for these otherwise well-motivated learners.

Returning to learning is not always a straightforward path. There are a number of psychological barriers to adult learning and conditions needed to favour learners.

Knowles, Swanson and Holton (2011) outline the core principles of adult learning as follows:

- Adults are internally motivated and self-directed
- Adults bring life experiences and knowledge to learning experiences
- Adults are goal oriented
- Adults are relevancy oriented
- Adults are practical
- Adult learners like to be respected

Knowles, Swanson and Holton state that, provided these core principles are in place, learners can succeed in learning. In my personal experience of working with displaced medical healthcare professionals, they are motivated internally and externally by their goals to join the GMC. They bring a great deal of their own experiences to their learning and at times, this is sometimes to their detriment. For example, on more than one occasion, doctors would question the accuracy of an article on medicine that was used in IELTS training materials, rather than performing the linguistic task that they were faced with. They were highly goal-oriented and their goals were entirely relevant and clear to their progression. The refugee doctors that I worked with were practical in their learning and understanding of their situation. I

also understood that they liked to be respected and witnessed the frustration that some of them felt at the loss of status that they had experienced in their physical and social displacement. The principles of adult learning and their application to andragogy reflect Vygotskian principles of pedagogy: 'In play, a child always behaves beyond his average age, above his daily behaviour; in play it is as though he were a head taller than himself' (Vygotsky, 1978, p.102).

Both adults and young learners need to be extended within, but not beyond their 'Zone of Proximal Development' ZPD (Vygotsky, 1978) i.e. the psychological sphere where they are challenged, but not bewildered, by learning tasks. With this understanding, I wanted to explore the participants' attitudes towards learning or re-learning English. I questioned whether the core principles would apply and whether there would be any development, if learners felt that the task was unpalatable or beneath them in some way. Khan and Naish (2004) refer to the 'esoteric nature of IELTS' as having the effect that refugee doctors find the subject matter in the IELTS test, and therefore the training materials, irrelevant. Again, this is likely to have a demotivating effect on these learners.

2.2.4 Language Training Provision for Displaced Medical Healthcare Professionals

While the IELTS test is perceived by displaced medical healthcare professionals as a significant barrier to their progress (Cohn et al, 2006), a solid linguistic grounding forms a necessary step towards the PLAB exams and eventual certification by the GMC. There are a number of regional projects that have similar goals to those of the WARD group, for example the Building Bridges Programme (Refugee Council, 2014), and most include the provision of IELTS classes. This provision is based on the standard IELTS Academic test and, as such, there is frequently less focus on

general English practice, which supports the training for the test as well as in day-to-day social interactions.

For those displaced medical healthcare professionals who are at the first stages of rebuilding their lives in the UK, the findings of the European Science Foundation project of the mid 1980s (Norton, 2013) are still highly relevant. Norton (2013) states that the project highlighted the difficulties that migrants faced in accessing and maintaining successful social interactions, thus leading to a premature cessation in their language learning.

2.3 Fossilization and Stabilized Language Errors

Selinker (1972) identified learners' internal grammar, as they absorb the rules and patterns of a second language, as their 'interlanguage'. In the same text, he provided his original working definition of fossilization, or the premature cessation of language learning. As a result, fossilization studies have formed a significant part of SLA theory over the past forty years. It has also been the subject of much debate in its various definitions, methods and implications. The overarching causal factors of fossilized errors will be explored here and the study will focus on the perceptions of displaced medical healthcare professionals about stabilized errors.

2.3.1 Fossilization in the Literature

According to Klapper (2006), Selinker's work was intended to develop the field of 'error analysis'. Among other things, error analysis set out to examine the mistakes made by second language learners, rather than hypothesise about them, as was being done in the field of 'contrastive analysis' (Lightbown and Spada, 2006). The importance of the theory of interlanguage is described by Cook (2001), who states that the attitudinal shift in the way that developing language skills are viewed paved the way for the communicative teaching and learning styles, which are still at the forefront of language training today. Prabhu (1984, cited in Kumaravadivelu, 2006,

p.153) summarises the phenomenon of fossilization well when he describes it as the situation where a learner's interlanguage becomes 'too firm, too soon'. Defining the term fossilization represents the nub of the controversy that has always beleaguered the theory. Prabhu's explanation is just one of many definitions that have been posited over the years since the term was created. In the decades since his original paper in 1972, Selinker has modified his attempts to conceptualize it. He began in 1972 asserting that:

Fossilizable linguistic phenomena are linguistic items, rules and subsystems, which speakers of a particular native language will tend to keep in their interlanguage relative to a particular target language, no matter what the age of the learner or amount of explanation and instruction he receives in the target language.

(Selinker, 1972, p.215)

Selinker's work identified a permanent state of non-native like fluency that some learners would experience in their language learning. As time went on, the definition of fossilization was challenged, particularly the idea that the state was permanent. Selinker (1989) defended this concept but strove to define fossilization in terms of its domain and its context, citing a minimum persistent period of fluctuation between two and five years, regardless of readily available input from the target language environment.

According to Han and Odlin (2006), Selinker's first conceptualisation of fossilization is based on five tenets. The first is that interlanguage features are different from the target language. The second is that it can exist in phonological, morphological and syntactic forms. The third is that fossilization persists and resists. Fourth, it can transpire with learners of all ages. The last is that it manifests itself as 'backsliding'. Although this supplied a theoretical framework for the concept, it required refining. Through a great deal of collaborative work, Selinker continued to expand the term to represent backsliding, cessation of learning and ultimate attainment (Han and Selinker, 2005). Han (2004) lists various phrases for the phenomenon, including

'virtual halt', 'linguistic monstrosities' and 'rigor mortis': many of which suggest a chronic condition that is unalterable. Ellis (1985) takes a more positive view of fossilization, which alludes to the process of automatization, where target language is eventually produced naturally and without hesitation. Ellis suggests that if a piece of language is automatized in its correct form, it is fossilized correctly, if it is not in its correct form, it can become a fossilized error.

Long (2003) illustrates the extent of the popularity of the theory of fossilization in mentioning that 'fossilization' is the only SLA term which has ever been entered into a non-specific dictionary. It is a monumental puzzle that once resolved, could change language training forever. With popularity came diversity. Birdsong (2005, p.174) describes fossilization as a 'protean, catch-all term that begs for a unitary construct to refer to.'

Table 3 is based on Long's (2005) survey of research into fossilization. It shows that, for more than five decades, research has been conducted on the premature cessation of second language development. Interestingly, Corder's (1967) findings related to learners satisfying their communicative needs and stabilizing their language development predate Selinker's (1972) definition of 'fossilization' by five years. It is also noteworthy that cognitive processes such as unwillingness to risk restructuring, processing constraints and age related loss of sensitivity to language data do not surface until the 1990s. Table 3 also shows the breadth of factors that have been identified as the possible causes of fossilization, yet there is still a lack of an overarching definition for the phenomena that it is intended to represent. It appears that we may be looking for the cause without adequately identifying the symptoms.

Table 3. List of some of the proposed causal factors of fossilization, according to the literature (Long, 2005)

| Proposed causes of fossilization | Research |
|--|---|
| Lack of negative feedback on error, both external and internal, in the form of self-monitoring, and/or provision of positive feedback on successful communication despite error, especially when the latter co-occurs with unavailability of negative evidence in natural L2 input | Higgs and Clifford, 1982; Vigil and Oller, 1976; White, 1987; Yorio, 1994 |
| Insensitivity to negative feedback | Lin, 1995 |
| Age-related loss of sensitivity to language data, caused by learners reaching the steady state in the L1 | Schnitzer, 1993 |
| Maturation constraints | Seliger, 1978 |
| Lack of access to various components of Universal Grammar (UG), either computational resources, with mapping problems between the lexicon and syntax, representational resources, or representational resources not instantiated in the L1 | Beck, 1998; Eubank, 1995; Hawkins, 2000; Lardiere, 1998b; White, 2002 |
| Loss of access to UG altogether, L1 transfer | Bley-Vroman, 1989; Clahsen, 1988; Meisel, 1991, 1997; Selinker, 1972 |
| Idiosyncratic transfer of L1 elements which particular learners (as opposed to all learners from that L1 background) perceive as equivalent to elements in the L2, so as to avoid duplicating them in the new language | Nakuma, 1998 |
| A combination of L1 transfer and one or more other factors, such as perceived typological markedness or a desire for symmetry, converging on the same error, as expressed in the weak form of the Multiple Effects Principle (MEP), in which L1 transfer is a privileged factor | Kellerman, 1989; Selinker and Lakshmanan, 1992 |
| The strong form of the MEP, in which L1 transfer is a necessary factor, in combination with one or more other factors | Selinker and Lakshmanan, 1992 |
| Processing constraints (as distinct from lack of grammatical knowledge) producing fossilized random variation, especially of semantically light morphology | Schacter, 1996 |
| Failure to acculturate, a variety of social-psychological variables, premature communicative pressure | Higgs and Clifford, 1982; Preston, 1989; Schumann, 1978 |
| Automatization of incorrect forms and rules, with resulting errors more likely to appear in casual than careful style due to less attention to form being exercised there | Hulstijn, 1989 |
| Satisfaction of communicative needs | Corder, 1967; |
| The ease of using what learners may know is a simplified system, but one that handles their basic communicative needs | Klein, 1986 |
| Communication breakdown, leading to avoidance of contact with native speakers, and hence to early fossilization | Perdue, 1993 |
| Inability to notice input-output discrepancies, that is, the 'Matching Problem Hypothesis' | Klein, 1986 |
| Unwillingness to risk restructuring | Klein and Perdue, 1993 |
| Ungrammatical input from native speakers or non-native speakers | Gass and Lakshmanan, 1991; Harley and Swain, 1978 |

It is possible that refugee immigrants using socio-affective strategies to practise their English may not receive sufficient input or feedback on errors. It may also be that without guidance, they do not process it in an appropriate way to enable further learning. It is also possible that age, including its implications e.g. loss of access to Universal Grammar (UG) and maturational constraints, of the participants plays a part in the cessation of their language learning. Interference from L1 can affect all learners to a greater or lesser extent but immersion in the target language culture can help with overcoming this (Gajo, 2001). Other processing constraints such as false automatization, the proceduralisation of incorrect forms, or over-simplification, can contribute to the discrepancy between input and intake (Kumaravadivelu, 2006). However, these are not likely to be distinctions between displaced medical healthcare professionals and other L2 learners in terms of susceptibility to these factors. Displaced medical healthcare professionals are likely to feel considerable premature communicative pressure as they attempt to return to their professional lives and integrate as soon as possible. The positive aspect of pressure to integrate is that the satisfaction of communicative needs is not likely to be an adverse factor, at least until the IELTS and PLAB exams are passed. The remaining factors are psychological, such as the unwillingness to risk restructuring, avoidance and the 'matching problem hypothesis' (Han, 2004). Again, these factors are unlikely to be emphasised with the participant groups for this study.

Long (2005) questions the methodological credibility of fossilization research based on a lack of longitudinal data, assumed rather than proven fossilization, selection of inappropriate learners for the study, findings based on limited data and inadequate analysis.

He posits that just three studies over the last thirty years are of adequate length, two to five years, to stand up to scrutiny. Han and Odlin (2006) draw the distinction that longitudinal studies monitor data and attempt to ascertain whether fossilization exists, whereas other research must assume that it is present. Interestingly, Han (2014) states that longitudinal studies in the last two decades have provided a convincing argument that learning continues, even when learners exhibit all of the traits of 'fossilized learners', thus fundamentally reviewing the validity of much fossilization theory.

On assumed fossilization, Long (2005) cites the bases for assumptions being made as a priori deductions based on common errors, assumptions about length of residence in the target language community or prior learning experience. It should be remembered that the research Long provides as examples are very small-scale projects and case studies. Han (2004) raises some of these points as being examples of empirical evidence that has been used to support the concept of fossilization. Further samples of empirical studies of fossilization are provided by Han and are presented in appendix 2. The 'typical-error approach' is used when learners of the same first language are acting as informants of the study. Han (2004) is a proponent of this approach when it has been used and commends Kellerman (1989) and Schouten (1996) for ensuring that there was what Han describes as a 'pseudo-longitudinal' element to their respective studies. Although Han does not deal with prior learning explicitly, she does refer to the participants' responses to learning environments when she discusses corrective feedback (Han, 2004) as a method for assessing fossilization. The idea is that learners should be assessed for their openness to learning, if its cessation is to be ascertained. Methods assessing corrective feedback are often combined with assessments of length of residence and/or age of arrival to the language-learning environment.

When Long (2005) describes the selection of inappropriate learners for the study, he refers to participants that may not have studied a language for long, and therefore do not meet the profile of a learner with fossilized errors as described in the literature. He describes this as a pervasive problem as the number of participants in any given study will be restricted. Han (2004) is also concerned with working with appropriate participants, which she describes as 'advanced learners'. Ensuring that the participants have been engaged in language learning for some time makes it more credible that learners' errors are characteristic of fossilized learning rather than simply the result of a short time learning the language. If the findings are based on limited data, for example the five pieces on fossilization research that Long (2005) describes, which have few participants informing on just a few samples of learner error, it would be very difficult to prove fossilization because the process of language learning has not been considered.

Long's (2005) final doubt revolves around the inadequate analyses of data. Interlanguage is a highly individual phenomenon and some studies on fossilization have grouped together participants, test scores or types of errors in order to carry out analysis.

Further debate on fossilization revolves around whether it is seen as a product or as a process (Han, 2004; Han and Selinker, 2005; Birdsong, 2006; Fidler, 2006; Han and Odlin, 2006) or as Long (2005) describes it, as *explanans* or *explanandum*.

Selinker's (1972) original definition describes fossilization as features of interlanguage that remain removed from the target language in some way i.e. fossilization as a product. Immediately, Selinker (1972) goes on to describe the need for an explanation of the recurrence of these features and how it is the recurrence of these features that paved the way for the fossilization theory. This has led to the debate on whether the focus should be on fossilized linguistic phenomena or fossilization. The majority of the literature focuses on the view that it is the product,

rather than the process. Long (2005) also raises the pertinent question of whether an explanation at all is needed:

Surprisingly, no one seems to have considered the possibility that if fossilization is, as Selinker (1972) claimed, a cognitive mechanism producing the non-target-like end-state also called “fossilization,” there is no need for other explanations, or conversely, that if L1 transfer, learnability, markedness, etc., or some combination of linguistic and psycholinguistic factors is responsible, there is no need for “fossilization” as an explanation.

Long (2005, p.387)

The point Long makes here is that the explanation is either sufficient or superfluous. It is more likely that, even though fossilization is more widely regarded as a product, the process is the area that may be of more interest. It has been suggested that because such linguistic problems are often considered to be brought about by the formation of ‘bad habits’ (Gajo, 2001), most researchers are interested in how learners might avoid forming these habitual errors in the first place.

2.3.2 Han’s (2004) Six Domains

Han’s (2004) work goes the furthest in summarising the literature and she lists fifty putative causal factors of fossilization. These causes have been categorised under six factors: environmental, knowledge representation, knowledge processing, psychological, neuro-biological and socio-affective. A discussion of each of these factors will follow. They inform the conceptual framework for the data analysis and part of the research design.

From Han’s taxonomy (2004), the putative causal factors of fossilization are featured in table 4 below.

Table 4. Han's (2004) putative causes of fossilization

| | | | |
|----------|------------------|---|--|
| EXTERNAL | Environmental | | <ul style="list-style-type: none"> Absence of corrective feedback Lack of input Reinforcement from linguistic environment Lack of instruction Lack of communicative relevance Lack of written input Language complexity Quality of input Instruction |
| INTERNAL | Cognitive | Knowledge representation | <ul style="list-style-type: none"> L1 influence conspiring with other factors L1 influence Lack of access to UG Failure of parameter-resetting Possession of a mature cognitive system Non-operation of UG learning principles Learning inhibiting learning Representational deficits of the language faculty |
| | | Knowledge processing (receptive / productive) | <ul style="list-style-type: none"> Lack of attention Inability to notice input-output discrepancies False automatization Automatization of the first language system Using top-down processes in comprehension Lack of understanding Use of domain general problem-solving strategies End of sensitivity to language data Lack of opportunity to use the target language The speed and extent to which automatization has taken place Processing constraints Failure to detect errors Failure to resolve the inherent variation in interlanguage Reduction in the computational capacity of the language faculty Lack of verbal analytical skills Lack of sensitivity to input |
| | | Psychological | <ul style="list-style-type: none"> Inappropriate learning strategy Change in the emotional state Reluctance to take the risk of restructuring Simplification Natural tendency to focus on content, not on form Avoidance Transfer of training |
| | Neuro-biological | | <ul style="list-style-type: none"> Changes in the neural structure of the brain Maturational constraints Age Decrease of cerebral plasticity for implicit acquisition Neural entrenchment Lack of talent |
| | Socio-affective | | <ul style="list-style-type: none"> Satisfaction of communicative needs Lack of acculturation Will to maintain identity Socio-psychological barriers |

'Environmental' factors refer to the circumstances surrounding a language learner.

These range from a lack of quality input to a lack of instruction at all. Many writers (Vigil and Oller, 1976; Nation, 2007; Qian and Xiao, 2010) discuss the importance of accurate feedback in avoiding SLEs. How a student deals with the feedback that

they are given links to the psychological factors of fossilization, which will be discussed later. The input that a learner receives is crucial to their progress. Kumaravadivelu (2006) illustrates this point by stressing the need for learners to seek out input. The concept can be reduced down to the simple equation zero input equals zero progress. According to this correlation, we may assume that, in many cases, the quality of input that is available to learners will have an effect on their linguistic progress.

Krashen's (1982) Input Hypothesis began the debate on comprehensible input in SLA. He describes optimal input as being intelligible, germane, natural and abundant (Krashen, 1982). In other words, the best way to receive comprehensible input is for learners to immerse themselves in the L2 environment. However, this has not been universally accepted and Klapper (2006) suggests that one reason for the controversy about Krashen's theory is the lack of explanation for the high occurrence of fossilized errors exhibited by graduates of immersion programmes. This is exacerbated by the fact that Krashen had been a major proponent of immersion teaching. It could also be argued that poor instruction will have an impact on language production and in extreme cases; repeated reinforcement of non-standard forms can lead to the diversification of languages, even to the point of creating new pidgin languages (Holm, 2000). Graddol (2008) reminds us that over time, this kind of language change stands to diminish the position of the English language on the world stage, in much the same way as with Latin two millennia ago.

One of the most fundamental needs for a language learner is input. Useful input can take the form of text or speech and can be at a variety of levels (Kumaravadivelu, 2005). A lack of input could inhibit learning and may limit learners to a very narrow scope of use. Zhang and Mi (2009) offer an explanation of the difficulties that Chinese students encounter, when they begin their studies in English speaking countries, as being attributed to a lack of aural input.

With regard to the effects of a lack of written input, Baleghizadeh (2010) observes that students who are trained following the principles of Long's Interaction Hypothesis (Long, 1996) and are afforded the opportunity to use texts to negotiate meaning, as well as spoken English, had greater comprehension skills. Conversely, it might be assumed that those who do not have access to English language texts are at a disadvantage. In the case of the participants in this study, the opportunities to access texts were very good, particularly in the DPiA drop-in centre where full access to the internet was available, as well as access to a library of reading materials on the IELTS test, PLAB parts one and two.

While taking care to extol the benefits of corrective feedback, Wang (2011) acknowledges that teachers can lapse into what Van Patten (1988) describes as 'fossilophobia'. Wang mentions the fact that fossilization often occurs in spite of corrective feedback. Of course, this does not mean that instructors are not, in part, responsible for their learners' successes, and the form and level of instruction is highly important. Han (2004) discusses the extent to which instruction can aid acquisition and mentions the differences in the risk of fossilization between 'street learners' who have had very little or no formal instruction, and those who have received instruction. The interesting points that Han raises are that instruction tends to be more successful if it is explicit and focussed on grammatical forms. Han (2004) also mentions the benefits of immersion plus instruction. This circumnavigates the inherent drawbacks with immersion teaching, for example, lack of focus on form (Han, 2004) or the criticisms of Krashen as outlined above. It offers all of the opportunities (comprehensible input, embedded language learning etc.) to acquire a second language that such a programme can offer. This reflects the approach of Content and Language Integrated Learning (CLIL) programmes.

Zhang and Mi (2009) discuss the lack of communicative relevance that English is given, in spite of official policies to encourage students to use English for

communication. The problem, we are told, stems from the size of classes and the focus on reading and writing that suits class sizes. As such, students develop a good knowledge of the language but not such a strong ability to use it communicatively. This also bleeds into another putative causal factor of fossilization, which is reinforcement from the linguistic environment. Romaine (2005) writes that the linguistic environment is extremely influential in the early stages of language development. In a negative linguistic environment, some learners may even fossilize poor pronunciation patterns due to peer pressure or a reluctance to imitate the sounds of another language in certain situations.

The complexity of a language is the final factor categorised under 'environmental factors' by Han (2004). Simply put, some languages may be too complex for a large number of people to acquire them fully. Selinker, Kim and Bandi-Rao (2004) state that an understanding of the theories that hold the cognitive view of the learning system in a central position such as modularity theory, top-down/bottom-up processing, input theory, language transfer and fossilization theories may be able to help with this challenge. In their paper, Selinker, Kim and Bandi-Rao (2004) propose a unification of all these SLA cognitive theories to attempt to solve complex challenges in language learning.

All of these factors are likely to feature in the study as environmental factors. This domain is fairly broad and the participants may well have encountered at least one of them in their learning.

Han (2004) also links some factors from her second domain, 'knowledge representation' with a lack of instruction. She observes that an instructor is able to help to point out and clarify particular instances where a learner's L1, or even when prior learning, is interfering with their current L2 learning. Transfer from L1 to L2 causes a great many problems for adult L2 learners and, in my professional

experience; it is common for learners to ask why one language differs from another when an acceptance of the syntactic rules would facilitate learning more rapidly. Odlin, Alonso and Alonso-Vasquez (2006) examine L1 influence and other similar factors that can cause fossilized errors, including L2 and L3 influences. They conclude that stabilization can not only be the product of affective factors, but also can contribute to the process of further stabilization in learning an additional language. Doughty (2005) adds that understanding the demarcations of languages or parameter resetting is described as essential in some theories such as the full-transfer full-access hypothesis. This is where positive input, or to put it another way, well-modelled input, constructs a solid framework for the development of an effective interlanguage system. A failure to do this will allow the L1 to interfere with L2 development. The way in which an Interlanguage represents itself to a learner can also be problematic. Representational deficits of the language faculty as discussed by White (2005) can allow a learner to believe that they are closer to their goal in language learning than they actually might be. An example of this in my own experience is when learners, who frequently use the informal question tag 'innit' because it reflects similar functions and forms in their own language, are surprised that they may lose marks in speaking assessments due to its lack of formality as a slang item.

The notion of interlanguage is one of a learner's self-development in SLA. One main idea that challenges SLA theory is the Critical Period Hypothesis. This is the development of Universal Grammar (UG) theory (Chomsky, 1959) whereby it is suggested that an individual only has access to their UG until early puberty. UG principles are commonly identified by a learner's intrinsically having knowledge of grammatical forms beyond the input that they receive. White (2005) describes the first ten years of research into UG and the exploration of the availability of access to UG, as the study of whether interlanguage is constrained UG. Assuming that a lack

of access to UG is likely to hinder an L2 learner, the Critical Period Hypothesis is likely to confound all but the young. While the ratio of learners who achieve native-like fluency to those who do not is high, a lack of access to UG being the sole contributing factor to fossilization is controversial, as acknowledged by Selinker when he later discussed the 'Multiple Effects Principle' (Odlin, 2005).

Cook (2001) develops Selinker's ideas of interlanguage by arguing the case that although interlanguage rests between L1 and L2, the interlanguage, when combined with a learner's knowledge of their own L1, forms multi-competence. While the existence of two languages in one mind represents bilingualism, it can also cause confusion for the learner. Han (2004) discusses Schacter's (1996) suggestion that in learning our L1, we are culling the parts of our UG that we are not required to use. This limits our ability to attain fluency in a second language. Alternatively, those who argue the case that UG does not disappear in adulthood, view these kinds of errors as a failure to open one's mind sufficiently to set new language learning parameters. This failure may be unintentional, as in simply overlooking the rules, or completely unavoidable, as in a deeper cognitive issue such as a mental health problem.

The assumption of non-operation of UG learning principles, also covered by White (2005), raises the question of the extent of L1 interference. Are the principles of UG only in operation when grammaticality judgements are the same in L1 speakers as L2 learners? The assumption that this is the case is also heavily reliant on the preconception that the target language is native-like fluency. The dynamism of target language will be discussed further later in this chapter. Ellis (1996) describes the Critical Period Hypothesis as being 'an inadequate account of the role played by age in SLA'. Yet the possession of a mature cognitive system is another putative causal factor. Long states that it:

...focuses on the overall relation between language and cognition. The problem-solving approaches that adults use in other aspects of life can also be used in second language acquisition – but perhaps at a cost. For example, the deductive reasoning used in many kinds of problem solving can also help in analyzing unfamiliar grammatical patterns in the new language. Even so, the strain on neural processing resources to perform such analyses may make it harder to adopt simpler but ultimately more successful learning strategies, ones presumably used by young children.

Long (2005, p.353)

However, Long (2005) later argues that, in the absence of a cut-off point for the Critical Period Hypothesis, the research that is used as evidence of its existence is somewhat unsubstantiated.

Han (2004) also describes 'learning inhibiting learning' as being part of this taxonomy. This is connected to the perceived neural pathways that are created in learning in a particular fashion and the possibility that a different learning style may challenge this neural entrenchment. Information may become conflated when replacing older information with new learning and a learner may suffer from 'crossed wires'.

Again, these factors may well surface in the course of this thesis as the participants were all above the critical period age and likely to have had some degree of hiatus in their English studies.

Han's (2004) next domain is referred to as 'knowledge processing'. A major aim of SLA is to identify and understand the cognitive processes of learning akin to other human learning processes. Klapper (2006) describes this shift from 'declarative knowledge' or knowledge about the facts and rules to 'procedural knowledge', knowledge about how to articulate the rules, as being a central theme for knowledge processing. Any imperfections in knowledge or misunderstandings about the implicit processes could lead to language being internalised incorrectly. The gradual shift from reliance on a rule to using forms and structures, without having to consider them, is called automatization (Han, 2004). If a structure is automatized incorrectly,

then it is the error that will become automatic, thus leading to an SLE. If a learner is successful in a highly communicative way, it can also lead to a premature cessation in their learning. It is often argued that a focus on function is at the expense of form. This could lead to important details that when mismanaged are characteristic of SLEs being overlooked. To some extent, knowledge processing is connected to individual learner styles but it would seem that, in this taxonomy, it is the extroverted experimentalist learners who are at risk of generating SLEs. There may also be cultural issues attached to knowledge processing such as learners' attitudes to the target culture or even their teachers. If reception is adversely affected by these attitudes or other interference such as difficulty in hearing, then the interlanguage may suffer.

Knowledge processing also represents the ability to 'notice' and analyse the contrastive features between the L1 and L2, as well as the skills of assimilating linguistic information. Klein (2003) describes the difficulties in what he calls the 'Matching Problem'. Simply put, learners often experience difficulties when attempting to approximate their output to the input that they receive. They may often be in the situation where they perceive themselves using the language in the same way that they hear others using it, but the perception is false.

As discussed, input in one way or another is essential for language learning, yet we must consider its limitations. While it provides a condition for learning, it can only be deemed as a tool for learning and, as with any tool, the user needs to manipulate the tool in order to make any gains. Kumaravadivelu (2006) draws a distinction between input and intake, or the subsection of input that is actually assimilated by a learner. This also assumes that learners have the opportunity to use the target language and generate some output (Kumaravadivelu, 2006). Processing input can be hampered by a lack of attention or sensitivity to the features and forms of input (Han 2004), a lack of understanding (Han, 2004), which lends support to the argument that

simplified input is appropriate to L2 learners, which might assist in raising a learner's awareness of input and increase the potential for intake.

There are two theories in fossilization literature that refer to sensitivity to input and output. One is the Noticing Hypothesis (Richards, 2008), where learners are able to process input into intake if they are able to notice distinctive characteristics within the input. A failure to notice features of input can lead to a plateau in language development. The other is Klein's Matching Problem Hypothesis (Klein, 2003) where he suggests that a lack of ability to perceive the inconsistencies between input and output would lead to fossilized forms. Han and Odlin (2006) see this as a failure to resolve the inherent variation in interlanguage. Lightbown and Spada also relate this to the slowing down of developmental interlanguage: '...in making it difficult for [learners] to notice that something they are saying is not a feature of the language as it is used by more proficient speakers.' (Lightbown and Spada, 2006, p.94).

Han (2004) also posits a reduction in the computational capacity of the language faculty as a potentially causal factor of fossilization. O'Grady (2005) asserts that the computational system is the cognitive system which put word classes into the correct 'slots' to form sentences and allows a learner to understand input. He also asserts that a deficit in this may be exhibited in adult learners and can result in complex structures being less clear than simple ones. If, as is suggested here, maturity limits capacity, then an end of sensitivity to language data is also a possible cause of fossilization (Schnitzer, 1993).

The way language is processed should not to be taken for granted and there may be constraints on this stage of language development. Han (2004) discusses 'language variation' where learners seem to produce grammatically correct sentences intermittently, and mistakes are often made after mastery of a particular form. The sheer amount of data that we process in using a second language has been held

responsible for these 'silly' mistakes (Pienemann, 1998). Within the information-processing view of fossilization, the term 'automatization' describes the availability of L2 forms. A fully automatized form means that it is produced without the L2 user having to access their memory to recall it. Should a learner have to recall it, the form would not be considered automatized. Fossilized forms can occur when L2 is automatized prematurely and/or incorrectly. This erroneous automatization may manifest itself in the syntax of the L1 or containing other errors (Han, 2004).

The last factors under the 'knowledge processing' domain are brought about by learners' approaches. Engel, Fries and Singer (2001) write that fossilized errors can be created by learners using top-down processes in comprehension, for example, understanding via cues and hints rather than understanding the sum of the parts of a text. If only a general understanding of the input is achieved, it is likely that accuracy will suffer and errors will linger. The use of domain general problem-solving strategies or as it is more commonly known, and most recently described by Al-Baldawi and Saidat (2011), 'over-generalisation'. This is when rules are applied to forms and structures where they may be expected to do so, but do not belong. Irregular forms are often conflated with regular rules due to over-generalisation. If these forms go undetected by the learner, it is likely that they will remain.

It is difficult to predict how heavily this domain will feature in the study as an assumption might be made that the participants will have had a great deal of experience in processing knowledge connected to their professional qualifications. Doctors, by nature, are often assumed to be analytical and well organised in their cognitive processes.

Kumaravadivelu's (2006) three kinds of motivation that describe some of Han's (2004) fourth domain, 'psychological factors'. The most common is instrumental motivation, which is exhibited by a person who does not have a great deal of interest

in integration into the target culture. An instrumental learner may need to learn a language as a way of getting by on a day-to-day basis or for another functional reason. Kumaravadivelu (2006) also discusses achievement motivation, which Klapper (2006, p.84) alternatively describes as resultative motivation. This form of motivation accounts for those learners who neither need to learn a language, nor have a great interest in the target language's culture, but have a natural flair for a language and therefore do well in exams. Kumaravadivelu (2006) explains that the alternative to instrumental and achievement motivation is defined by social psychologists Gardner and Lambert (1972, cited in Kumaravadivelu, 2006, p.40) as integrative motivation. A person who is motivated to some degree by the desire to integrate into a target culture is said to have integrative motivation. Cook (2001) advises that learners with integrative motivation should be more likely to achieve near-fluency than learners exhibiting other forms of motivation. We can conclude that the forms of motivation that are driven by extrinsic needs, like gaining approval or status, present more of a challenge when a learner is attempting to avoid or overcome SLEs.

Even though the ultimate goal of a refugee who has been granted leave to remain in the UK is integration, we cannot assume that a person has integrative motivation simply because they are politically bound to integrate into a host culture, as is the case with many refugees. As such, motivation will be investigated further in the course of this research.

Klein's (2003) observations on learners' strategies in 'getting away with errors' is, as Klein claims, starkly obvious to any second language instructor who has observed their students blurring utterances in order to communicate their message. This may be more prevalent when using a language that is as widely spoken as English, due to the broad range of dialects and accents within the language. Other strategies that can inhibit L2 acquisition are avoidance of the more challenging aspects of

interlanguage development, timidity and a prioritisation of communicative skills over form.

Simplification of forms at the cost of accuracy is very similar to over-generalization discussed under the last domain. However, while over-generalisation is unintentional, simplification is recognised as a learner strategy and is therefore deliberate, at least in its initial stages (Al-Baldawi and Saidat, 2011). The simplification continuum ranges from simplification by restructuring, all the way to complete avoidance of certain structures (Han, 2004). Wang (2011) refers to avoidance in the context of Chinese learners of English and in the researcher's experience, avoidance of certain structures, such as passive forms. Swan and Smith (2011) substantiate this by acknowledging the trouble that Chinese speakers have with English passive forms.

Zheng (2010) stresses the need for an appropriate learning strategy. Although not prescriptive, Zheng claims that choosing the right strategy can not only facilitate learning but also overcome fossilized language errors. Conversely, an inappropriate strategy can lead to problems. If a student has a natural tendency to focus on content, not on form, Han (2004) describes this as a particularly adult trait. The will to communicate overshadows the will (and need) for analysis of the input that they are receiving. The drawback is that there is a distinct possibility of developing fossilized errors. Adults may also exhibit a reluctance to take the risk of restructuring. This is another advantage that younger and possibly less inhibited learners have over adults (Lakshmanan, 2006). Other changes in the emotional state can also lead to language plateaux, or even 'backsliding', which Ross (2007, p.2018) defines as 'how the candidate apparently 'loses' proficiency after having earlier reached a benchmark threshold'. Han (2004) mentions that if some form of attachment to a language is lost, then a lack of motivation, in particular integrative motivation, may hinder further progress in learning the target language.

The last of the psychological factors identified by Han (2004) is the transfer of training. Wang (2011) gives the example of the traditional format of the product-focussed writing class in China against the more passive, teacher-centred methods of writing classes in the West. Wang posits that the process of the western style writing class is fossilized and training may actually interfere with the learners' progress in acquiring English.

The factors that are categorised under Han's (2004) fifth domain 'neuro-biological' include matters regarding an extant inhibited capacity for learning either naturally or brought about by mental or physiological trauma. Similar to the lack of access to UG, which is categorised under the knowledge representation domain, these factors are more difficult to rectify without a holistic approach to potential solutions. Krashen, Scarcella, and Long (1979) provide a frequently cited overview of the problem:

- adults proceed through early stages of morphological and syntactic development faster than children (where time and exposure are held constant):
 - older children acquire faster than younger children (again in early stages of morphology and syntax, where time and exposure are held constant: and
 - child starters outperform adult starters in the long run.
- (Krashen, Scarcella and Long, 1979, p.573).

Accordingly, the majority of these factors relate to age and its accompanying maturational constraints. This is beyond the concept of being over the age of the purported critical period and runs more deeply into the effects of the ageing process. Hyltenstam and Abrahamsson (2005) refer to the on-going neuro-chemical process of myelination as inhibiting the connection of neighbouring neurons. The effect is an inhibition in the acquisition of phonological and syntactic systems and a lesser effect on semantics, pragmatics and vocabulary. This is described by Han (2004) as a decrease of cerebral plasticity for implicit acquisition.

On the other hand, Hyltenstam and Abrahamsson (2005) describe a study by Bialystok and Hakuta, which was conducted on 63,690 respondents who were non-

English L1 immigrants who had had at least ten years exposure to the English language. In the study, the researchers Bialystok and Hakuta (1999) claimed that there was no correlation in the performance and production of English between the respondents regardless of their age or whether they had started their studies prior to the end of puberty. Another point of view is that a learner may exhibit fossilized forms due to neural entrenchment. Eubank and Gregg (1999) explain that if a specific neural architecture for language acquisition is already in place, it can be hard for an adult learner to reconstruct it to accommodate an additional language.

The final factor in this domain is what Han (2004) calls a lack of talent. While some people may excel at some subjects, it is natural that they may struggle with others. With this in mind, it stands to reason that some people do not possess a neurological architecture that is sufficiently structured, in the linguistic sense, to progress past a certain point of language acquisition.

Other changes in the neural structure of the brain are more difficult to define and there is less research on the potential interference of other mental conditions on language acquisition. It is difficult to assess how this domain might have fitted into this study. People who have suffered some degree of trauma prior to, or during, displacement are not always willing to discuss the most intimate details of their experiences, nor are they obliged to do so. The causes of SLEs under this grouping are often perceived to be irreversible. Although much of this domain would represent issues that are highly personal to an individual, there is some room for debate about this. Distinguished Professor in the Department of Psychology at York University, Toronto, Ellen Bialystok (2014) gave a lecture on her research, which found a correlation between bilingualism and a resistance to the effects of ageing. In 2010, other studies were announced in Wales (Gathercole *et al.* 2010) that relate bilingualism to sharpness of mind, particularly in old age. It is interesting to consider the psychological effects of ageing and those of bilingualism as being opposite ends

of the same continuum, in which case, language learning could reduce the very issues that are reported to prevent it. The clients of the WARD group are all adults who fall between their mid-twenties to retirement age. While they do not come under the ideal age for exploiting UG i.e. pre-adolescence, there are many doctors who succeed in passing the IELTS and PLAB examinations after receiving training from the WARD group.

The final domain as categorised by Han (2004) is the 'socio-affective' domain. The majority of the literature on SLEs concludes that language learning cessation or plateaux are caused by socio-affective influences such as a satisfaction of communicative needs (Long, 2005), a lack of acculturation (Han, 2004), will to maintain identity (Schumann, 1986) or other socio-psychological barriers (Tarone, 2006).

The satisfaction of communicative needs seems to be a key feature in developing SLEs. Corder (1978) suggests that one might amend Schuman's (1974) assumptions that learners only learn a language when there is a need. Corder pushes this to its logical conclusion, that the learner will immediately cease to learn at the point where they are able to communicate sufficiently and views this as a strategy for learning in non-didactic situations. Johnson (1996) carries this theme even further and views a willingness of L1 speakers to understand non-L1 users encourages reliance on this strategy. Klein (2003) agrees that diminished motivation to carry on learning is represented by learners settling for communication at a lower level than their true potential. Qian and Xiao (2010) try to find teaching methods and approaches that counter Klein's selective strategies but examine only the classroom experiences of learners. In the literature on fossilization, the satisfaction of communicative needs is the most widespread reason for a lack of progress in language learning. Once a learner is able to live comfortably with their level of linguistic ability, there is little in the way of instrumental motivation to keep them

interested in learning more (Han, 2004). Although this factor is commonly identified in studies, it may not be as absolute as it has been described. Taking the example of children learning their L1, Long states:

First, it is well known that language development continues to progress in many individuals long after they are capable of satisfying their communicative needs.
(Long 2005, p.389)

While the satisfaction of communicative needs may be a major cause of SLEs in learners, it must be remembered that displaced medical healthcare professionals are required to meet external standards set by governing bodies. Therefore, it seems unlikely that learners in this study will have satisfied their communicative needs that are imposed upon them by the relevant council, even if they feel that they can communicate sufficiently well enough in their daily lives.

Another socio-affective characteristic that can lead to SLEs is a lack of acculturation. This is likely to be driven by an instrumental or resultative form of motivation, as it does not fit in with the ideals of an integrative learner. Siegel (2005) discusses acculturation as being dependent on the social and psychological distance that a learner has to the target language culture. If the distance is too great it may inhibit progression in language learning.

People attend to stimuli in the environment in very different ways. We have shortcuts that we use to organize data. Invariably, these shortcuts introduce some biases into communication. Some of these shortcuts include stereotyping, projection, and self-fulfilling prophecies.

(Behera and Tripathy, 2009, p.15)

If learners do not overcome these barriers, it is likely that they will struggle to meet their goal of acquiring the target language. It was expected that the participants in this research would exhibit some of these factors, unintentionally or otherwise. From my own professional experience of working with refugee doctors, displacement is harrowing and post-arrival experiences can intensify nationalistic pride (positive and

negative) or disenchantment with the host culture. A sense of a loss of culture is bound to be a concern to people who have endured forced migration and there is often a will to return to the country of origin, in many cases to restore the lives that were once led there.

In the case of displaced medical healthcare professionals, there is a very strong integration agenda. The Home Office (2004) definition of integration is straightforward. Their report on the indicators of integration defines it as such:

An individual or group is integrated within a society when they:

- achieve public outcomes within employment, housing, education, health etc. which are equivalent to those achieved within the wider host communities;
- are socially connected with members of a (national, ethnic, cultural, religious or other) community with which they identify, with members of other communities and with relevant services and functions of the state; and
- have sufficient linguistic competence and cultural knowledge, and a sufficient sense of security and stability, to confidently engage in that society in a manner consistent with shared notions of nationhood and citizenship.

(Great Britain, Home Office, 2004)

This is not to say integration will eliminate any barriers to acculturation, it simply attempts to harmonise cultures within the UK. Many L2 learners maintain a will to retain their identity and this can manifest itself, possibly, through SLEs in pronunciation. These kinds of errors are forgivable and often thought to be endearing, especially in a language as widely spoken as English. Due to the diversity of English styles, L1 speakers are used to their own idiosyncratic regional and socio-economic pronunciation forms, as well as the pronunciation of L2 users. In addition, this factor may be less pertinent to the displaced medical healthcare professionals in this study, as they still need to satisfy external assessments of their level of English. If this is the case, what is the importance of addressing SLEs? Are there specific linguistic and cultural challenges attached to the social standing of being a doctor, for example, would a classical Received Pronunciation (RP) accent to indicate a socio-cultural position be seen as desirable by everyone?

Han's description of the socio-affective domain appears to aim to encompass the remaining socio-affective factors that were not discussed under the preceding domain subheadings. What remains is by no means insignificant: satisfaction of communicative needs is an extremely common reason for a cessation in language learning but it does not fit the profile of the participants in this study. The participants may have experienced some conflict in their will to maintain identity insofar as they may wish to continue to use their L1 and pass it on as a heritage language, but need to learn English to maintain their status as a doctor in the UK. Similarly, a lack of acculturation conflicts with the integration agenda that drives the participants.

Han (2004) asks an extremely pertinent question: 'Does fossilization arise from the lack of ability to learn or does it occur due to the influence of individual-oriented variables such as the socio-psychological ones?'

Such socio-psychological factors are exemplified by Ortega (2012) as a talent for learning the language, a positive view of the target language culture or, as Klapper (2006) describes it, resultative motivation where positive results in tests and successful performance in the past serves to further motivate learners.

The factors above may not be acting in isolation. The idea that stabilization may be caused via a number of factors working alongside each other has been described as the Multiple Effects Principle (Selinker and Lakshmanan, 1992). A learner may have more than one factor, which could cause them to slow down in their acquisition of a second language. A number of features conspiring to slow the language learning process may be more difficult to overcome than a single barrier. This theory has become increasingly popular since it was first posited in the late twentieth century. In order to acknowledge this, the research was designed to allow participants to select any number of causal factors and domains that they felt were appropriate to them.

Lightbown and Spada (2006) discuss developmental sequences of acquiring the English language and, although there are distinct phases in the sequence, they advise that the stages may bleed into one another. While Han (2004) argues that fossilization is modular in nature, she indicates that stabilization is not and can occur at any given time, rather than during a period of skill consolidation or prior to another surge of learning. Long also supports this point of view when he rationalises the exploration of stabilization rather than fossilization:

In fact, however, in the absence to date, at least, of convincing evidence of fossilization as product, the more relevant object of study for researchers becomes stabilization, not fossilization, and explanations for that. From a theory- construction perspective, too, such a shift in focus has several advantages: (i) the existence of stabilization is not in doubt; (ii) it avoids the methodologically problematic “permanence” issue; (iii) it makes an additional subset of claims empirically testable; and (iv) unless and until solid evidence appears of the psychological reality of fossilization, it lightens the burden of SLA theory and theories by one variably operationalized and as yet empirically unsubstantiated construct.

Long (2005, p.393)

... given that both U-shaped behaviour and renewed language development after periods of plateau-like stability, some lasting for several years, are widely attested characteristics of normal child first and second language acquisition (see, e.g., Bowerman, 1982; Harley and Swain, 1984, respectively), understanding the causes of stabilization (and destabilization) would seem to promise as much for SLA theory as work on fossilization, and do so without fossilization's attendant theoretical and empirical baggage.

(Long, 2005, p.372)

In this study, these language problems are categorised as being stabilized errors, rather than fossilized errors. This is to account for the above discussion and to present a more temporary stance on the cessation of language learning, as described by Han (2014), in the light of recent longitudinal studies on the subject. For example, Lardierie's (1998, 2007, cited in Han, 2014) studies of Patty, a Chinese national who had been a resident of the United States for 18 years at the time of the first study. Multiple analyses of interview transcripts collected over ten years indicated that some areas of her interlanguage were found to be fossilized, whereas

others were not. The work of Ellis (1992) exemplifies an instance where a longitudinal study on two learners, featuring multiple forms of analysis of their ability to make accurate requests, was sufficient to evidence that stabilization had taken place in the language systems of the two learners. Notwithstanding, Han (2004) states that this study failed to provide evidence of fossilization due to the length of time the learners, complete beginners at the start of the study, had been learning English.

Han's work covers over four decades of fossilization theory and provides an excellent basis for examinations on language learning cessation. In her book, *Fossilization in Adult Second Language Acquisition*, Han (2004) supports the Multiple Effects Principle in noting that it is unlikely that just one causal factor may be working in isolation.

2.3.3 Target Language

Selinker (1972) estimated that just 5% of language learners overcome what he terms 'interlanguage fossilization'. Since then more optimistic figures have been quoted that run between 15% and 60% (Han and Odlin, 2006). It is vital to at least attempt to define a target when discussing achievements in language learning and its barriers. This is no simple task in itself as language is dynamic and the target is often moving. There has been much in fossilization literature, and related theories regarding a learner's 'end state'. Klein (2003) defines the end state as being the point at which learning ceases for an individual. However, Birdsong (2006) informs us that others have described this cessation as final state, ultimate attainment and even asymptote, which Birdsong disputes as a valid term due to its semantic implication of gradual progress towards a goal, which, he argues, could describe a mature L1 user's cessation in picking up technical jargon or slang forms. He goes on to define ultimate attainment as being 'the end point of L2A, irrespective of degree of approximation to the native grammar'. Han and Odlin (2006) hold higher

expectations when they propose that ultimate attainment lies somewhere between being highly successful in a language and achieving native-like fluency. Others challenge the very concept of imposing expectations of ultimate attainment as it is exhibited in L1 upon L2:

In the case of foreign language acquisition, where the proficiency levels attained are known to fall very short of nativelike proficiency, the association of ultimate attainment and nativelikeness is clearly inappropriate.

Muñoz (2008, p.580)

Muñoz echoes a number of writers (Cook, 1999; Siegel, 2005) in making the point above. For the purpose of this research, target language competence is defined by an indicative benchmark of proficiency in IELTS of 7.0 in all skills, in line with the barrier to progress that this test represented at the time of the data collection.

The context of use beyond achieving a score of 7.0 or above overall in IELTS is also interesting. The participants were not only learning to a level of IELTS 7.0 or above to improve their proficiency in the English language, but also to register with the GMC and work as doctors. There is, therefore, an important contextual implication in accessing the medical profession. Gwyn (2002) describes the differences in discourse when doctors communicate with other doctors, the complexity of medical terms and when dealing with patients and the use of euphemisms e.g. when discussing alopecia or sexual health. The majority of these linguistic challenges are dealt with in training for the PLAB examination, which forms the subsequent stage of the process in joining the GMC.

2.4 IELTS Skills

Learners can exhibit uneven profiles in their strengths in listening, speaking, reading and/or writing. It is also entirely possible that learners from a particular linguistic group may achieve higher results in, for example in the speaking section, than

others, who may be more accomplished in writing. This may be to do with transfer from one language to another, or to do with prior learning and teaching and learning styles. To give an example from my experience, students who have Arabic as a first language are often more capable in spoken communication but have trouble with the orthographic differences between their L1 and English. Conversely, students from China frequently tend to have studied English in very large classes where the opportunity to practise their speaking skills is minimal.

Fitzgerald and McCarter (2004) describe the assessment of the four skills, listening, reading, writing and speaking, as it is carried out in the IELTS test. Listening is assessed via four extracts with ten questions pertaining to each. Candidates are required to demonstrate their ability to prepare to answer questions prior to listening to an excerpt. To record the answers accurately whilst continuing to listen, to recognise nuances in expressions and to follow descriptions of processes or procedures.

Reading in the Academic IELTS test is based on answering forty progressively difficult questions on three passages in sixty minutes. The passages may contain quantitative and qualitative data from a variety of sources. The questions may take various forms such as multiple choice, gap-fill exercises, heading and sentence matching and so on, and all are designed to test comprehension of the passages. Topics are global and the questions relate to the passages themselves, thus there is no requirement for any knowledge of the subject prior to the test.

The written section of the academic IELTS test is split into writing a report on a chart, table or diagram and essay writing on a global topic. The former requires 150 words and allows roughly 20 minutes and the latter requires 250 words and allows roughly 40 minutes. Syntax, range of vocabulary, cohesion and coherence and ability to address the task are all taken into consideration in the assessment of these tasks.

The fourth assessment is the speaking test, which is divided into three sections, an introduction, individual long turn and a two-way conversation. The introduction will be based on a test-taker's response to questions about their interests or things that they talk about frequently in their language. The 'long turn' asks test-takers to prepare to speak for two minutes on a preordained topic. This reflects the Supplied in Obligatory Context (SOC) assessment that Long (2005) mentions in his discussion on methods of assessing fossilized language forms. The final two-way conversation is based on the topic for the individual 'long turn' phase of the test but deals with more abstract ideas on the theme. The focus in the speaking test is on communicative strategies and grammatical forms are not overly assessed in this element.

The skills that are most prevalent in research examining interlanguage and stabilized errors are the productive skills, speaking and writing (Selinker, 1972; Schumann, 1978; Holm, 2000; Klein, 2003; Long, 2005; Han, 2004; Birdsong, 2006). The main reason for this is that interlanguage is the subsystem of an individual's internal grammar and this is manifest by the language they produce. Learners have very little control over the language that they receive as input via listening and reading, and whether it is understood by the learner or not, most L2 English input that learners receive will be of native quality. While there are exceptions to this, such as 'interlanguage input' (Kumaravadivelu, 2006) where non-native speakers provide input to one another, and negotiate meaning, 'foreigner talk' (Ellis, 1985) where native speakers may simplify language to an unnatural degree with learners who are still developing their internal grammar systems. There is little to attach a learner's trouble in understanding a language to fossilization research. On the other hand, we must also consider that learners will more often than not make an attempt to improve their skills fairly evenly. It should also be remembered that even though stabilized errors will only be apparent in the productive skills, they provide a window into a

learner's overall level of English. Richards (2008) advises that in order to improve spoken production, a learner must try to improve holistically in the four skills. Although it is not overtly tested in the IELTS exam, usage of language including grammar and syntax exists within the four skills in its own right.

Gillet (2013) estimates that an IELTS test taker can improve by one IELTS band score in three months of full time study. If taken literally, this could be interpreted to mean that a candidate's IELTS score can increase from 1.0 to 7.0 in eighteen months. In reality, this does not account for learners' individual pace of acquisition, or the other variables that need to be accounted for such as quality of instruction, linguistic ability, learning environments or barriers to learning.

2.4.1 The IELTS Training Dilemma

Green (2007) discusses 'washback', more commonly known as teaching to the test, as being a reputedly negative phenomenon in language learning. Many believe that the test should assess a student's holistic knowledge, rather than their knowledge of the format of a test, or what is likely to be asked in examinations. He is careful to state that this reputation is somewhat undermined by the results of empirical research and his thesis discusses the ways in which 'washback' teaching can be used positively. There is, however, something of a paradox in some IELTS training courses, as represented in figure 4.

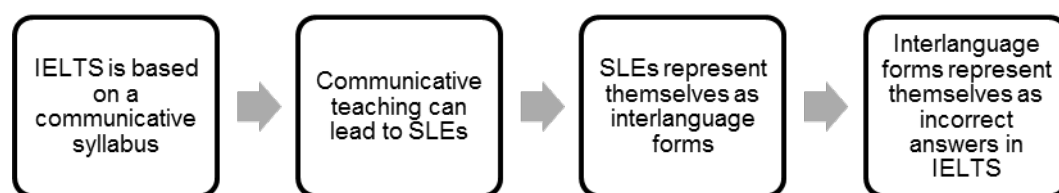


Figure 4. The contradiction in IELTS training

If the IELTS test is based on a communicative syllabus as suggested by its grounding theory (Howatt, 2009; IELTS, 2014) then it would be logical for any training toward the test to use a communicative syllabus that focuses on function. While communicative syllabi have dominated language teaching practice for many years, they are not without criticism. Gajo (2001) reminds us that a focus on function, as extolled by the communicative movement, can lead to fossilized interlanguage through its lack of focus on form. Communicative teaching can even encourage SLEs, which often represent themselves as erroneous interlanguage forms (Han, 2004; Han and Odlin, 2006). In the context of IELTS, such forms often represent themselves as incorrect answers in the test, thus raising the question of how much IELTS focuses on function over form.

Moore, Moreton and Price (2011) conducted a survey of the construct validity of the reading section of the IELTS exam for university entry. In particular, they examine the level of engagement required in the exam ('global' or 'local') and also the type of engagement ('literal' or 'interpretive'). In the report 'global' refers to obtaining an overview of the text or 'top down' comprehension, conversely 'local' refers to locating specific information in a text, also known as 'bottom up' comprehension. The 'literal' type of engagement requires learners to locate specific answers within a text whereas 'interpretive' engagement is, as the name suggests, centralised around reading between the lines to identify the function of a text, the author's attitude or

opinion, inference and the intended audience. In Moore, Morton and Price's survey, the findings were that the vast majority of reading texts focus on 'local' and 'literal' levels. The implication of this could be that a reading task in IELTS tends to have a greater focus on form over function and bottom up strategies, than its communicative roots portray and any IELTS syllabus should bear this in mind.

In the listening section, the imbalance appears to be similar. Although the test begins with a section based on 'getting by', which focuses on 'survival' English, for example, booking an hotel room or a course, the move away from the communicative soon becomes apparent. Students are required to record information on the test sheet that is orthographically and grammatically correct, and deviations from the script are considered inaccurate and therefore incorrect. Field (2009) conducted a study on the lecture-based final section of the test and found that the focus was far too heavy on word-level analysis rather than testing a test-taker's understanding of the overall meaning of a script. He recommends that assessment be much more global in the requests for student responses and less cognitively demanding during the act of processing the listening script.

The focus on communication is apparently more balanced with a focus on form in terms of the productive skills. Band score descriptors for productive skills are provided by IELTS (2014) in appendix 3 and, in the rubric for writing skills, illustrate the top-down skills of 'task achievement' and 'coherence and cohesion'. These are balanced with 'lexical resource' and 'grammatical range and accuracy', which are naturally aligned with bottom-up processing. With regard to the speaking test, Brown (2007) warns of the dangers of over-prescribed criteria for assessment, recommending that oral assessments should attempt to maintain an interactive and communicative nature. However, in comparison to the written test, the bias towards communication is lessened with 'fluency and coherence' representing language

usage and 'lexical resource', 'grammatical range and accuracy' and 'pronunciation' all assessing a focus on the details of language use.

The fact that the IELTS test requires input focused on form and function is not to its detriment and, from my experience, it presents a more holistic challenge than is realised by many test-takers who undertake specific IELTS training courses. It should be acknowledged that the majority of test-takers are instrumentally motivated (Klapper 2006) to take the test as a means to an end and therefore may not be driven to progress their English language learning beyond achieving the desired band score. In many ways, the IELTS test can be credited with maintaining standards in English and preventing it from diversifying into a set of creoles through a tendency to prioritise communication over accuracy.

2.4.2 IELTS in the Context of this Study

This study focussed on candidates who were taking the IELTS test for a specific reason, for example, registering with the GMC. In this case there were targets, which were to achieve an IELTS band score of 7.0 or above in each skill, in one sitting of the test (General Medical Council, 2012). Since the 18th of June 2014, the requirement has been raised to a minimum score of 7.0 in all skills with an overall score of 7.5 (General Medical Council, 2014c). IELTS (2010) provides analyses of test performance and reasons for taking the test in 2010. Table 5 refers to all test takers who were taking the IELTS test for registration as a doctor in 2010. It is interesting to note that this reason for taking the academic IELTS test yields a higher percentage of results above 7.0 than any other reason provided, both in overall and in each band score step. This may be an indicator of the motivation of the candidates, the elevated band score necessary for registry with the GMC, strategies for learning, preparation courses or the cognitive abilities of the candidates. It is also noteworthy that 42% of those who were taking IELTS for registration as a doctor

scored under 7.0 and that this figure of 42% has remained roughly the same since 2008 (2008 = 43%, 2009 = 42%), when the available records begin.

Table 5. Academic candidates: Reason for taking IELTS in 2010 (Overall Band score by %) (IELTS.org, 2010)

| Academic | <4 | 4 | 4.5 | 5 | 5.5 | 6 | 6.5 | 7 | 7.5 | 8 | 8.5 | 9 |
|---|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|----|
| For employment | 0% | 1% | 3% | 6% | 12% | 18% | 22% | 19% | 12% | 5% | 1% | 0% |
| For higher education extended course (three months or more) | 1% | 3% | 8% | 15% | 21% | 20% | 14% | 9% | 5% | 2% | 1% | 0% |
| For higher education short course (three months or less) | 2% | 4% | 11% | 18% | 20% | 17% | 13% | 8% | 5% | 2% | 0% | 0% |
| For immigration | 0% | 1% | 2% | 6% | 12% | 17% | 19% | 17% | 12% | 8% | 4% | 1% |
| For other education purposes | 2% | 4% | 9% | 16% | 21% | 19% | 14% | 9% | 5% | 2% | 0% | 0% |
| For personal reasons | 1% | 4% | 9% | 15% | 19% | 19% | 16% | 10% | 5% | 2% | 0% | 0% |
| For professional registration (NOT medical) | 1% | 1% | 3% | 5% | 9% | 14% | 21% | 21% | 13% | 8% | 3% | 0% |
| For registration as a dentist | 0% | 0% | 1% | 3% | 6% | 15% | 23% | 23% | 16% | 9% | 3% | 0% |
| For registration as a doctor | 0% | 0% | 1% | 2% | 5% | 12% | 22% | 23% | 18% | 11% | 4% | 1% |
| For registration as a nurse (including CGFNS) | 0% | 0% | 1% | 2% | 7% | 17% | 25% | 22% | 13% | 7% | 4% | 1% |
| Other | 1% | 3% | 8% | 13% | 17% | 19% | 17% | 12% | 7% | 3% | 1% | 0% |

To refine this more in relation to the participant group of refugee doctors, information that IELTS (2010) published on the results according to first languages was also examined. The first languages of the likely participants based on Crawley and Crimes (2009) are Arabic, Chinese, English, Farsi, French, Pashto and Urdu, with a grouping for other languages to cover smaller languages and dialects. Table 6 provides a focussed summary on these groups provided by IELTS (2010).

Table 6. Language groups from the Crawley and Crimes questionnaire and their skills

| First Language | Overall score | Strongest skill | Weakest skill |
|----------------|---------------|-----------------|--------------------|
| Arabic | 5.3 | Speaking | Writing |
| Chinese | 5.7 | Listening | Writing |
| English | 7.3 | Speaking | Writing |
| Farsi | 6.0 | Speaking | Writing |
| French | 6.6 | Listening | Writing |
| Pashto | 5.7 | Speaking | Listening |
| Urdu | 6.0 | Speaking | Listening |
| Other | 6.4 | Speaking | Listening /Writing |

Six out of the eight groups whose first language is identified above, scored most highly in the speaking part of the test. Chinese and French L1 speakers scored most

highly in listening. Five of the groups found that the writing part of the test yielded the lowest scores, with L1 Pashto and Urdu speakers scoring lowest on the listening part and the undetermined 'other' category being awarded their lowest scores for writing and listening equally. Arabic speakers achieved the lowest band scores and, apart from those test-takers who identified themselves as L1 English speakers, French L1 speakers achieved the highest overall scores. This reflects my own professional experience and provides an insight into extended periods of study that many of my L1 Arabic and L1 Chinese students required before reaching their goals in IELTS. An examination of the common problems that users of these languages experience when learning English will follow in the next section.

It must be remembered that SLEs manifest themselves in the productive skills of speaking and writing. According to the table above, speaking does not represent itself as a problem for many of the potential participants and for all but the Chinese and the French, it is their strongest skill. Writing, on the other hand, is ranked as the weakest skill for six out of the eight groups in the table and does not appear as the strongest skill for any of them. In terms of the research design, it was assumed that data collection via multiple-choice questionnaires and face-to-face interviews would achieve the maximum opportunity for self-expression for respondents and interviewees.

2.5 Possible Language Groups within the Study and Predicted Problems

Another factor in the strengths and weaknesses of students in each of the skills is language transfer. While it is generally agreed that the language family directly correlates to language transfer, the degree to which a first language interferes with a second language has been debated for over forty years of research. Han (2004) summarises the findings of the various studies to draw distinctions between the

various stages of language transfer and access, and their impact on L2 learning. Transfer can benefit a learner in early stages, for example, when learning cognates or calques but is predicted to hinder with the later stages of L2 fluency. Transfer is only of true benefit when it is moderate and accompanied by sufficient access to L2 input.

It was difficult to find out from the statistics provided by the BMA (2008) how many of the doctors at each stage of progress towards joining the GMC, represented Iraqi nationals. There was no explicit correlation in the figures (BMA, 2008) between Iraqi doctors who had studied for their PMQ in English and their progress towards employment. Nevertheless, in my experience of working with refugee doctors trying to pass the IELTS and PLAB exams, there were, at that time, a large number of Iraqi doctors who were struggling with the linguistic demands. In general, most of the errors they displayed were either semantic or syntactic. In production, the syntactic errors seemed to be more problematic and semantics caused more misunderstandings in receiving information. Syntactical errors manifested themselves in things like 'subject-verb-object' constructions, adjectival order and noun/verb agreement. The semantic errors were represented by misunderstandings of words that appear to share etymology such as the words set (v) and set (n) or confusion between homographs or homophones (Swan and Smith, 2011).

The next largest group of 199 registered doctors was from Afghanistan. The WHO AVICENNA Directories (World Health Organisation, 2011) only offered details of one university in Afghanistan, namely the Shaikh Zayed University Faculty of Medicine in Khost City. English was shared with Pashto-medium instruction in this university. In Iran, the country with the third highest figure for refugee doctors registered with the BMA, the WHO AVICENNA Directories listed 49 faculties and colleges of medicine. Only 13 of these had shared English and Farsi delivery and the Sharood Faculty of Medical Sciences and Health Services is unique, in that it appeared to instruct in

English only. In fact, according to the WHO AVICENNA Directories, seven of the top 10 countries of origin for the refugee doctors registered with the BMA (2008) had institutions that provided English language instruction. These ten countries alone accounted for 902 of the 1,199 doctors in the list. In comparison to the statistics presented in the BMA statistics, this appeared to be disproportionately higher than the 45% of registered refugee doctors who had not met the required IELTS score, and possibly even in addition to the remaining 21%, who were not yet at the 'job ready' stage.

It was considered that some of the doctors may have studied medicine outside their country of origin or even in a faculty that did not offer English medium provision. Nonetheless, the GMC guidelines (2011b) made some provision for applicants who had studied in an English-medium faculty, given that they could provide evidence that they were awarded their PMQ twelve months prior to applying for registration or applying to sit PLAB Part 1. The GMC assisted refugee doctors with examination fees, so it seemed unlikely that the barrier was directly related to financing these tests. The high proportion of doctors who were not at the 'job ready' stage indicated that there was another element that was holding back a substantial number of them, regardless of whether their instruction was in English or not.

Access is one area in which the potential participants in this study have an advantage in being immersed in the target language. While ghettoisation, or same language groups living in insular or isolated communities, may limit the amount of input that a learner receives, the refugee populations in southeast Wales are limited in size and number. The majority of learners had a broad variety of opportunities to practise in their daily interactions and a good level of access to the target language in the media.

Table 7 is based on information in Swan and Smith (2011), which deals with L1 interference from a number of major language sets when learning English. The information has been adapted to make it appropriate to the study. For example, information on intonation and pronunciation does not feature in the table, as it is not a major element of IELTS assessments. In the speaking test, the focus is on functional communication. Similarly, the languages featured in the table are the main languages spoken in the countries with the highest number of applications for asylum according to Blinder (2014) and Crawley and Crimes (2009).

Table 7. L1 interference according to language groups likely to feature in the study (adapted from Swan and Smith, 2011)

| Language | Orthographic problems | Grammar features | Word Order | Problems with interrogative s & negatives | Differences with tenses | Differences with auxiliary verbs | Problem word classes | Differences with subordinate clauses | Vocabulary learning problems |
|-----------------|---|--|--|--|---|---|--|--|---|
| Arabic | Alphabet; Cursive right-to-left system; Spelling and vowel representation; Capitalisation; Reversed punctuation | Passive forms similar to active for; Confusing range of verb patterns in English; Gerund forms | Verb - subject | No 'do' equivalent; Negative particle before verb | Past / perfect tenses which lead up to the very recent past; Formation of past perfect / continuous; Reported speech used in the present (as originally stated); One present tense | No 'be'; | No indefinite article; Differences in the use of articles; Adjectives agree with nouns; Differences in the use of prepositions; No phrasal verbs | Relative pronouns distinguish gender but not human / non-human; Conditionals use two 'if' equivalents | Very few cognates |
| Chinese | Non-alphabetic spelling system; Recognition of words can be slow to start | Problems identifying parts of speech; over generalised irregular verb forms; Subject-verb agreement | Topicalised sentences; Statements and questions are identical | The use of 'do'; Over use of 'is it?' as a question tag | Tenses are affected in inflection and adverbials, rather than verbs | Limited, yet similar range of modals | Pronouns are often dropped; no articles; No gender distinction | Position of adverbials e.g. time placed at the front; Misuse of conjunctions | False friends; idiomatic expressions |

| | | | | | | | | | |
|--------------------|---|---|---|--|--|---|---|--|---|
| Farsi | Alphabet; Cursive right-to-left system; Spelling and vowel representation; Capitalisation; Reversed punctuation | Passive forms are similar but less common; | Subject – object – verb; Adverbs of time between subject and object | No 'do' equivalent; Omitted auxiliary 'do'; Problems with 'not' positioning | Past resembles present perfect; Confusion between past continuous and past perfect; Reported speech used in the present (as originally stated); Broad functions of present tense; | Modals inflect main verbs; Similarities in tense of 'must' between past and present; Range of English Modals | No equivalent of definite and indefinite articles; Adjectives tend to substitute adverbs; No gender distinction; No plural nouns; Differences in the use of prepositions; No phrasal verbs | One relative pronoun; No ellipsis of object pronoun; Differences with 3 rd conditional; 'Although' and 'but' used in same sentence; Overuse of 'and' as a conjunction | Few cognates; Generalised false friends |
| French | Spelling, capitalisation of days, months, languages and nationalities | Use of final 's' in verbs (pronunciation); Complex passives; Passives using 'One' in lieu of reconstruction | Adjectives after nouns; Noun + noun compounds less frequent; Head-first word order; Adverbials after verbs | No 'do' equivalent; Problems with 'not' positioning; Question tags with 'no?' | Past resembles present perfect; Present resembles present continuous; Past progressive resembles past; No present progressive | 'Have' & 'be' confusion; Modal + to-infinitive; Must & should = devoir; No 'shall' for suggestions; Use of Would for 3 rd conditionals | Use of articles; Gender of pronouns; Countable / uncountable nouns; Adjectives and adverbs; Reflexive pronouns; Relative pronouns; Conjunctions; Prepositions | Over-generalisation in subordinate clauses without pronouns; Particles and prepositions | False friends |
| South Asian (Urdu) | Alphabet; No direct L1 interference but punctuation can cause problems | No corresponding verb 'to have'; No superlative form; intensifiers are indistinct; | Postposition s rather than prepositions; verb comes at the end of a sentence | No 'do' equivalent; Problems with 'no' substituting 'not'; Over use of 'isn't it?' as a question tag | Verbs of state being used in continuous forms; Confusion between past simple and past perfect; Uses of present perfect in place of past simple; more use of future tenses than English | 'Could' used as past attainment; greater general use of 'polite' modal forms; | Major problems with articles; gender of objects; pluralisation | Fewer subordinate clauses; | Some pidginised forms; abundance of loan words |

According to Swan and Smith (2011), all languages in table 7 lack an equivalent of the verb 'do' and users will be likely to conflate the past and perfect verb tenses. Modal verbs are also likely to be the cause of some confusion as are articles in English. The English use of subordinate clauses is likely to cause problems with each language but it is likely to manifest itself in different ways, for example, in relative pronouns in Arabic and Farsi but in preposition in Chinese and French. With the exception of French, all languages featured in table 7 have scripts different from the Latin alphabet making word recognition a slow process to begin with. In addition, Arabic, Farsi and Urdu all follow a right to left cursive system, which can require some retraining in using Latin scripts. Arabic, Farsi and French speakers will be more likely to have trouble with passive forms. There is a spectrum of calques under the heading 'vocabulary learning problems' in table 7, depending on where origins of the language are formed e.g. French will have a confusing number of words that misrepresent themselves as cognates, whereas there will be fewer loan words between Arabic and English. It also seems likely that learners from all L1 language sets will struggle with auxiliaries, including the range of modal auxiliaries that feature in English.

Swan and Smith (2011) also indicate that the features that set these language groups apart are gerundial forms, verb-subject syntax, a lack of a 'be' equivalent and the dual use of 'if' in conditionals in Arabic. In Chinese, the unique features are its non-alphabetic script, its topicalised sentences and the tense system relying on adverbials. The distinctive features of Farsi are the subject-object-verb syntax, the inflection of main verbs by modals and its lack of an indefinite article. French speakers' English learning problems differ from speakers of the other languages in the table because of the complicated passive system, conflation of 'must' and 'should' and a tendency for over-generalisation in subordinate clauses without

pronouns. Urdu differs from the rest in its lack of a superlative form and its use of postpositions.

The data that were collected in the study revealed that the participants' first languages did not completely fit the profiles that were initially established in looking at the literature. , There were sixteen Arabic speakers, no Chinese speakers, one Farsi speaker (as well as two speakers of the similar but dialectically different Dari), no French L1 speakers and one speaker of Urdu. In addition, the study featured participation from two speakers of Burmese, and one speaker of Russian and Azerbaijani, which were given equal status as their L1. These additional languages that were not initially identified in the study were taken in to consideration upon the analysis of the data; for example applicable entries from Swan and Smith (2001) were reviewed in preparing table 15 in Chapter 4.

2.6 Summary

Refugee doctors are a largely untapped and very valuable resource in the UK. The need for doctors in the UK and the desire of displaced professionals to contribute to their host community creates a mutually beneficial situation. Notwithstanding, there is a clear need for standards in the NHS to be maintained and for vetting processes to be suitable stringent. One vital standard is the ability to communicate on a professional level in order to provide patients with the best service possible and reduce the margin for error. It is often assumed that intelligent people are more likely to succeed in adult language learning. It is also assumed that doctors are excellent scholars. The synthesis of these assumptions is that learning English to a professionally competent level should not be a problem for refugee doctors but this is not the case. From my experience of working with refugee doctors, the effort to learn English and qualify (linguistically) to register with the GMC can be frustrating, dispiriting and, at times, insurmountable. When one considers the hardship that

many forced migrants have had to endure, it is surprising that, at one time or another, many of the clients of the WARD group have found this to be the hardest hurdle to overcome.

The work of Han (2004) provides an overview of the literature on fossilization and in her description of the six domains; Han provides the taxonomy of fossilization research that has been conducted over the last forty years. Han is a proponent of the Multiple Effects Principle (Selinker and Lakshmanan, 1992) and, while these six domains provide a theoretical framework for the data collection phase of this research, they will be treated as a continuum, rather than in isolation.

In reviewing the literature, I have attempted to add clarity to the research questions. In doing so, I have contextualised the intended participant sample of this study. In addition, I have uncovered the common causes of SLEs, examining the impact of learning experiences, learning styles, first languages, maturity and social influences. I have also provided a critical view of the IELTS test in the context of this study. In the next chapter, I will discuss the methodological concerns in the development of the project, including the development of the data collection tools, ethical considerations and methods for analysing the data.

Chapter 3. Research Design

3.1 Introduction

This chapter will describe the preparatory stages of the research, from developing the research questions to selecting and developing research tools that provided maximum results in terms of answering the research questions. It will also document the ethical steps that were taken in order to provide a clear voice to the participants while protecting them and providing anonymity, wherever possible. This was particularly interesting due to the status of the intended participants. As the participants intended to re-qualify as doctors, considerations were made as to whether the National Research Ethics Service (NRES) needed to approve the project, alongside the university ethical approval and the British Educational Research Association (BERA) guidelines. As the participants had been displaced, a discussion on their vulnerability was essential and a working definition of 'vulnerability' was created.

3.1.1 Developing the Research Questions

Extensive experience of ELT in a number of different contexts informed this research. Motivation, reflective learning and teaching, emergent language teaching were all topics of interest in my professional practice and added to my store of knowledge in approaching the research. In particular, I drew on my experiences of training displaced medical healthcare professionals in IELTS strategies. These individuals spent many years in a country where English is spoken, yet they still required linguistic support in preparing for the exam. It seemed that language learning had stalled in spite of high levels of motivation, opportunities to practise, attempts at truly autonomous learning and a great deal of reflection on their situation, both linguistically and socially.

I saw that my former students, the displaced medical healthcare professionals, had input from the environment, were able to receive and process knowledge sufficiently to qualify as doctors or other professions within the field of healthcare. They were psychologically uninhibited in terms of their language learning. They did not outwardly exhibit any neuro-biological barriers and were keen to integrate into a normal social life in their host country. These attitudes more than adequately reflect Han's (2014) prerequisites for further studies in fossilization, namely participants' exposure to input, motivation and opportunities for further practice. I began to wonder whether there might be a particular combination of the existing reasons for my former students' language errors stabilizing. I wanted to find out what their perceptions of their SLEs were and how their particular situations may have contributed to their SLEs. I was also curious to see if there were other reasons that were specific to displaced medical healthcare professionals.

The research was designed to examine the beliefs of the participants about their own language errors. In gathering the perspectives of the participants themselves, it would provide an insight into the factors that they thought might have caused them. An important principle of the study was to collect the reflections of the participants, to have this at its centre. In addressing these matters, the following research questions were designed:

1. What are displaced medical healthcare professionals' perceptions of their own common SLEs?
2. In the participants' views, what is the impact of life histories, educational histories and other experiences on SLEs?
3. What are the participants' responses to the emergent findings of the study in research questions one and two?
4. What are the views of expert witnesses on the training and language skills of displaced medical healthcare professionals?

These questions aimed to provide displaced medical healthcare professionals with a voice on their own reasons for having SLEs. Stakeholders, such as IELTS trainers

working with refugees, people involved in setting policies for displaced medical healthcare professionals and researchers into this under-researched field may be able to use the findings to understand the issues that directly affect the participants. In order to do this, careful selection of research methods was required.

3.2 Quantitative and Qualitative Research Methods

Cohen, Manion and Morrison (2013) identify two main categories of assumptions made by researchers: firstly, ontological beliefs about the state of being and secondly, the epistemological beliefs, which focus on the accrual of knowledge. Traditional scientific research, supported by 'purists', is more frequently tied into ontology, where validity is established by a series of proven hypotheses. This is also known as positivism and, according to Cohen, Manion and Morrison (2013), this point of view is characterised by its claim to provide the clearest possible representation of knowledge.

On the other hand, the social sciences are more frequently concerned with individual experiences and fit epistemological assumptions, which are based on the experiential accumulation of knowledge of the individual. Cohen, Manion and Morrison (2013) refer to the proponents of this approach as 'pragmatists'. They advise that the study of human nature either focuses on the individual as a capricious entity exercising their own judgements about the world or as a product of their environment, responding to external stimuli. Non-positivists support the latter view, stating that the positivist ideas can de-humanize the participants in a research project. The research was designed with the views of the participants at its forefront.

In the field of linguistics, research design and tools can take many forms. Second language researchers Mackey and Gass (2005) list some of the more common methods such as 'correlational research', which uses predictions based on correlational relationships, for example, between motivation and choice of language

school. Another research design that they mention is the 'test, teach, test' design that measures the effect of treatment or the efficacy of an intervention and assesses its impact. Mackey and Gass (2005) then discuss the 'repeated measures design', which assesses participants' responses are tested over a series of exercises over a period of time. They also mention the 'factorial design', where one of a series of variables is removed and the results are recorded. Subsequently, another variable is removed from the original set and results are recorded. When each of the variables is removed from the original set, the results are recorded. One of the less common research designs that Mackey and Gass (2005) mention is the 'one-shot design'. This design is not ordinarily considered to be experimental, as it does not feature an intervention, but aims to provide a snapshot of language learners' attributes or prior learning.

These tools must be carefully employed in order to complement each other effectively (Rasinger, 2010). Quantitative research design may be a cross-sectional study, for example, a questionnaire conducted on as broad a sample of a population as possible. The common alternative to this is a longitudinal study, which revisits participants to monitor changes over time. The participants are either a random cross section, referred to by Rasinger (2010) as a panel, or they will be linked in some relevant way and known as a cohort. This method can be complicated by the need to find participants who are willing to provide information on a number of occasions over a span of time.

It is understandable that qualitative research methods are dominant in research into language training and linguistics due to the social aspect of the field. In recent years, such research has benefitted from combined methods being employed. Another influencing factor in research of this nature is the fact that many researchers are teachers and have often used the interventions of action research in order to progress current thinking on the subject. The main qualitative methods in research

into language training and linguistics are discussed next and how they might feature in the study.

3.3 Divergence and Convergence of Research Methods

Divergence as described by Cohen, Manion and Morrison (2013) refers to the expanding number of possibilities that become available to a researcher when they are considering how to conduct their data collection. While quantitative studies could yield interesting information on the statistical results of displaced medical healthcare professionals who are trying to pass their IELTS test, I did not feel that they would lead me any closer to answers as to why the doctors felt that they struggled with this exam. Action research was considered early on in the study but acquiring access to such a specific group of participants over a period of time would have proven very difficult.

The first phase of the data collection would seek answers to the first two research questions, which aimed to gather participants' ideas about their own SLEs and the impact of their life histories, educational histories and other experiences. In the second phase of the data collection, participants were asked to provide their views on the emergent data and these were crosschecked with expert witness interviews. The development of the latter stages relied on the information uncovered during the earlier stages. Because of the use of emergent data that informed developments within the study, member checking with the participants was also a feature. Not only did it ensure that the data was as credible and robust as possible, but it also gave some ownership to the displaced medical healthcare professionals who participated in the study.

Other methods such as observation, ethnographic studies and use of corpus linguistics were also considered but did not seem immediately appropriate to the research design. Observations would yield interesting information on the training of

the participants, as well as their responses to the training, but would draw the focus away from the aims of the research, which were to examine their self-perceptions of their SLEs as well as their life histories. Ethnography would be extremely difficult due to the diversity of the cultures of the participants as well as their highly individualised experiences, which led to them retraining to work in the medical healthcare system in the UK. Using corpus analysis of the participants' interview transcripts was considered but again, it was felt that it would detract from the aims of the research, which were to gather the participants' perceptions of their SLEs, rather than to test them.

3.3.1 Questionnaires

In the social sciences, the questionnaire is often used with the motive of proving a hypothesis, disproving a null hypothesis or leading to a further discovery. It is not strictly accurate to say that questionnaires belong firmly in the quantitative domain. If an electronic format is used, or the questions are mostly closed, then it is more likely. On the other hand, if the questionnaire features areas for free expression they can fit well into a qualitative research design. Dörnyei (2003) is cited in Mackey and Gass (2005) listing second language research topics that utilise questionnaires as spanning topics from 'computer familiarisation' to 'teacher anxiety'. The broad range in Dörnyei's list reflects the flexibility and popularity of the questionnaire as a research method in research into language training and linguistics.

Questionnaires can guide respondents to consider matters that they had not thought of previously or to look at them in a particular way. The elicitation of information in this way need not influence participants in their thinking, but could uncover ideas that had not been completely formed prior to the research (Rasinger, 2010). They allow for flexibility in data and in research methods in their various uses and the format of a questionnaire can vary broadly, from a paper-based exercise to dedicated software (Mackey and Gass, 2005). Rasinger (2010) concurs on the practicality of this data

collection method. Questionnaires are easily sent to respondents and returned. This also means that they are more economical than some other methods. As a result, questionnaires are appropriate to longitudinal studies that need to revisit participants on a number of occasions. They are also able to elicit large quantities of comparable data from a broad range of participants. Questionnaires are particularly good in gathering information that is not mediated by outside influences (Edley and Litosseliti, 2010).

In second language research, a major consideration should be accessibility of the research instruments. The proficiency of the respondents can affect their understanding of questions put to them and can limit nuances that may feature in responses given in their first language. More open-ended questions, while offering more scope for reflection, may again disadvantage less proficient language users. In addition, Rasinger (2010) stresses the need for piloting because once a questionnaire has been sent out; it cannot be recalled without having an impact on the research. There is sometimes a danger when dealing with some cultures, that the responses will be more kindly than honest in order to show politeness or respect (McKay 2006).

Mackey and Gass, (2005) offer a number of solutions to the potential pitfalls of using questionnaires to gather data. If respondents are at a low level of literacy, it may be beneficial to record oral questionnaires. It is also prudent to allow as much time as is needed to respond so that the answers are as well considered and full as they can be. The format should be simple and uncluttered so as not to daunt potential respondents and the questions must be as clear and unambiguous as possible. Before sending the questionnaires, a pilot should be carried out and it would be ideal to get the questionnaire scripts reviewed by peers as well. It is also suggested by Rasinger (2010) that questions are comprehensive, objective and limited to those that yield only essential information.

There is much debate over what stabilization is and its depth and severity (Han, 2004; Long, 2005). Testing and judging a language learner's language performance via a questionnaire may not be to the benefit of the participant the research. Firstly, a test that would highlight SLEs in all of their forms would necessarily be long and cumbersome and therefore daunting to potential participants. Secondly, this may negatively influence participants' own self-assessment if they should find themselves making mistakes that are not characteristic of their usual language usage. Lastly, the participants would have trained for the IELTS exam and should therefore have some idea of their own linguistic shortcomings.

Another pragmatic reason that a questionnaire was chosen was that it was easy to distribute to the members of the WARD group. As mentioned in the introduction to the study, many of the refugee and asylum seeking doctors who had received help and support from the WARD group had since been dispersed to NHS posts throughout the UK. An electronic questionnaire facilitated an increase in the sample size.

Lastly, the use of a questionnaire that gathered largely quantitative data was intended to aid the triangulation of the data and hence offer greater credibility to the research findings.

3.3.2 Interviews

Both qualitative and quantitative data can be gathered through interviews, depending on how they are structured and how the questions are written. Interviews and focus groups have become very popular research techniques (Edley and Litosseliti, 2010). Edley and Litosseliti go on to inform us that, while interviews are sometimes linked to quantitative data collection in questionnaire-based research, semi-structured interviews belong more to the qualitative domain. In contrast, unstructured interviews are exclusively qualitative, as they do not yield information that is easily

quantifiable. Similar to semi-structured interviews are focus groups, which are interviews that are based on stimulus from the interviewer and other participants (Mackey and Gass, 2005).

Interviews gather information on internal individual reactions such as perceptions or attitudes. Another benefit of interviewing is that questions can be followed up immediately for information that is more explicit. In gathering data on language training, interviews could also be conducted in the participant's L1 (Mackey and Gass, 2005). When questions are followed up well, interviews can consolidate old information as well as discovering more. They yield information from different points of view about the same topic.

It is important to pilot the study as far as possible and the interviewer must develop good interviewing skills. These are described by Mackey and Gass, (2005) as: sensitivity, ability to encourage open-ended discussion, anticipation of communication problems, putting interviewees at ease, placement of key questions in the middle and mirroring responses to confirm interviewees' points.

Most data collection in the area of refugee studies, a limited evidence base currently, takes the form of semi-structured interviews (Stewart, 2003; Fiddian-Qasmiyeh, and Qasmiyeh, 2010; McPherson, 2010; McKeary and Newbold, 2010; Smyth and Kum, 2010). This is mainly due to the richness of quality that one can get from interviews, which can be held over a reasonably short timeframe. The opportunity for gathering information and focussing on particular key areas in interviews is unparalleled. This is especially important when considering the volatility of a migrant group such as refugees and their overarching aim of integration into their host society, as discussed in the literature review chapter.

3.3.3 Focus Groups

McKay (2006) notes that focus groups act as an opportunity for participants to share their views in the presence of peers and that this is advantageous to the researcher, as a number of ideas can be aired in a relatively short space of time. Edley and Litosseliti (2010) support this view and add that this form of interviews should be observed as a sort of social interaction. When participants are carefully selected with a common goal, this may yield interesting results and encourage the other members of the group to speak more freely than in solo interviews. Notwithstanding, when the data collection method is based on a focus group we must remember that group dynamics can lead to false consensus, bias and manipulation from dominant members (Edley and Litosseliti, 2010). In conducting focus groups, the researcher must be careful to allow all participants a chance to voice their views on the topics being discussed without inhibition, but also without dominating other members of the group who may be less forthcoming with their views and opinions.

For the purpose of this study, focus groups were intended to follow up the stage of individual interviews and questionnaires. This allowed individuals to voice their opinions and experiences in a one to one environment before participating in a focus group situation. This facilitated a level of trust to be gained between the participants and the interviewer prior to the group discussion and also allowed them to speak freely on their personal experiences before further discussing the topics covered in the presence of other participants, if they wished to do so. It also allowed for observations on interactions to be made (Silverman, 2011) as well as enabling the participants to observe and analyse each other's statements.

3.4 Ethics

Ethical clearance is essential in any research project and it needs careful consideration. Cohen, Manion and Morrison (2013) describe the issue of ethics in

social research as being broad and potentially problematic. They discuss ethical dependability of each aspect of the research: the topic, the context, the subjects, the procedures, the data and the results.

The research was based in the field of English language training. Its aim was to discover some of the reasons why displaced medical healthcare professionals, who do not ordinarily fit the profile of language learners with SLEs, exhibit these linguistic traits. As McKay (2006) states, there is an obligation of linguistic empowerment towards the participants in second language research. I was indebted to the participants for offering their experiences and hoped that taking part in the research might in turn enable them to improve their second language skills. MacKay and Gass (2005) reinforce the potential benefits and add that there are negligible risks to participation in second language research. However, the level of reflection and self-examination by participants requires robust mechanisms to safeguard them from any potential harm arising from participating in such research, such as brining up painful memories or experiences.

The fact that the participants were all asylum seekers or refugees meant that there were some sensitive areas in dealing with potentially vulnerable adults. BERA discusses the protocol for working with vulnerable adults:

In the case of participants whose age, intellectual capability or other vulnerable circumstance may limit the extent to which they can be expected to understand or agree voluntarily to undertake their role, researchers must fully explore alternative ways in which they can be enabled to make authentic responses.

(British Educational Research Association, 2011)

This raised the question of the definition of a vulnerable adult. One definition according to UK law is provided in the Safeguarding Vulnerable Groups Act (SVGA) 2006 (see appendix 4). Another definition from the NHS (2011) described vulnerable adults as people with learning difficulties, elderly people or people with mental illness. While none of these definitions correlate directly with the definition of

refugees or asylum seekers, it must be remembered that there may be areas of intersection where care needed to be taken to maintain ethical integrity and safeguard the wellbeing of participants while they were engaged in the research study. As such, particular attention was given to ensuring that informed consent to participate was given and, wherever possible, anonymity and confidentiality were ensured.

One of the principal concerns was whether the doctors had enough knowledge of English to participate in the research. The letter of consent was worded in simple English and tested via the Fleish-Kincaid Grade level test (Grossman, Piantadosi, and Covahey, 1994) in order to keep the level of English close to that of a ten-year old, as recommended by MacKay and Gass (2005). In the cases of low-proficiency learners, translations would also be made available. The letter of consent that was sent to participant organisations to disseminate to potential participants (see appendix 5) detailed the procedures and purposes of the research, the potential risks and benefits, who to contact regarding the study and their rights as participants and specific steps regarding confidentiality (MacKay and Gass, 2005).

The diagnostic language quiz was considered as a vetting process for further participation in the interview stage. It was likely that the respondents who agreed to participate would understand the interview process in part, having already undertaken the diagnostic language quiz. The interviews were semi-structured and participants were encouraged to talk as much as they wished. The histories of refugees are often filled with hardship and recounting their experiences can be painful. Yow (1994) offers sound advice on prioritising an interviewee's comfort and sensitivity in interview techniques. The participants were also to be given a transcript of the interviews to review and comment upon and suggest any corrections or omissions.

As with any research, anonymity was an important ethical consideration. All participants were anonymous, unless they wished to exercise their right to be named and recordings were destroyed after the project ended. This is also in accordance with BERA (2011) guidelines. Mackey and Gass (2005) offer advice on safeguarding confidentiality of participants, including the suggestion that second language researchers should check with refugee participants before using any data that may identify them. It was also necessary to be explicit in the definition of anonymity due to the various 'levels' of anonymity: completely anonymous, anonymous apart from to the researcher or anonymous within the research team. In this research it is defined as 'anonymity means that only I will see data from questionnaires and transcripts that can identify participants and that all such records will be destroyed after the research is complete.'

It was the intention of the project that the results would be published in academic and professional contexts and used as a basis for discussing the findings in support of recognising the key characteristics of SLEs in displaced medical healthcare professionals and possible other professional groups of refugees and asylum seekers. All steps toward publication followed BERA (2011) guidelines.

The university application for ethics approval was agreed prior to the start of the data collection and included letters to groups and participants. Since the study involved members of the NHS, there were additional ethical considerations. I had obtained ethical approval via the university's ethics processes and was advised to enquire with the NHS whether further ethical approval via the NHS was required. As the study did not fit the descriptions outlined in the National Research Ethics Service (NRES) ethical review of student research, I contacted the NRES and was given the response that no additional clearance was needed (please see appendix 6).

The process of getting university ethical clearance proved to be challenging, mainly due to the nature of the intended sample group. The participants would necessarily be non-English L1 users who were refugees and connected to the NHS. All of these aspects required careful consideration when planning to gather data. In order to strengthen ethical compliance in obtaining informed consent, the following questions were added to the consent forms:

1. I am aware that I am able to withdraw from the project at any time.
yes/no
2. I understand that no names will be used in reports of this project.
yes/no
3. I understand that information will be held securely until the research is completed, when it will be destroyed.
yes/no
4. I would like an audio recording of this letter.
yes/no

The fourth question was intended to help those potential participants who may be stronger in listening than reading. I added to the findings of the Flesch-Kinkaid readability test by passing a sample of the letter around other English language students at a similar level to those likely to take part in the study. I also drew on the work of Smyth and Kum (2010), which has some similarities with this project as it also conducted interviews with refugee professionals in English. These processes allowed me to gauge understanding of the text and assess its readability. In particular, the students who had read the consent forms felt that they fully understood the text and that providing translations would be excessive at their level. During the semi-structured interviews, understanding of the letter of consent was checked orally before the interview.

Furey *et al.* (2010) advise that there are times when confidentiality is not a guarantee. In giving the informed consent letters to the participants in the project I stressed that confidentiality would be sought but only in keeping with the researcher's legal duties. The main ethical challenge that was foreseen during the interview stage was that of disclosure of confidential information. I did not wish to assume that the participants would divulge any information connected to a contravention of the laws of the land, yet I understood that some illegal activities could take place in refugee dispersal houses as people struggle to survive. Wiles *et al.* (2008) present a very strong case for researchers acting solely as observers in their research. This includes maintaining their guarantee of anonymity, irrespective of the nature of any illegal activities that researchers are made aware of during interviews. Wiles *et al.* (2008) also acknowledge the risk of subpoena in this approach, although they noted that there have been no cases in the UK where social researchers have been forced to reveal information that was collected for research purposes. Suite, House and Park (2004) write in the British Sociological Association (BSA) ethical guidelines that confidentiality does not enjoy legal privilege. In the case that anything harmful be divulged that were to threaten the researcher, or the participants, morally or legally, this would be referred back to the supervisors of the project and taken to the schools' and university's ethics committee. This is in accordance with BERA (2011) guidelines 29 and 30, where disclosure may take place after deliberation and close record keeping. Disclosure represented potential danger at this stage to the participants and myself as the researcher and accordingly I developed a strategy to deal with any ethical matters that might arise during the interviews as discussed below.

Having worked with refugee doctor groups in the past, I am well aware of the implications of discussing life histories through having previously asked students to discuss their hometown, a respected family member or other questions that came up

in IELTS preparation classes. While such stories are not easy to hear, one may put oneself into the position of the participant in order to reflect on their hardship. It was the intention that this research would examine the causal factors of SLEs in displaced medical healthcare professionals. Wiles *et al.* (2008) discuss the management of confidentiality and advise researchers to discuss the need to disclose information prior to interviews. Prior to the interviews, I ensured that participants were aware that I would seek to maintain confidentiality wherever possible and would remind the participants of the aims of the research, which focus on language learning. As part of the ethical procedure, I also asked participants to approve transcripts in the post-interview stage. Ethical clearance for the research also applied to the expert witnesses who took part in the interviews for phase two of the data collection and they agreed to take part on this basis.

3.5 Rationale for the Selection of the Methods

After tracing the history and evolution of the idea, a review of empirical studies on fossilization, including some recent longitudinal work, will show almost all to have suffered from one or more of four problems: assuming, not demonstrating, fossilization; selecting inappropriate learners for study; basing findings on insufficient data; and using inadequate analyses

Long (2005, p.370)

The parameters of this thesis were mostly based in qualitative approaches, but quantitative methods were used to complement this overall paradigm. Having been through divergent and convergent stages of method selection following Cohen, Manion and Morrison (2003) and having decided on robust, practical methods, the framework for planning the data collection was in place. The research tools featured questionnaires, semi-structured interviews and focus groups. Han (2004) describes five main methodological approaches to gathering data for the study of language cessation: longitudinal, typical-error, advanced learner, corrective feedback and length of residence (LOR). In a study of this scope and scale, with a volatile, mobile

population, a longitudinal study was unfeasible. Corrective feedback is also difficult to incorporate into this study, as observations of learning did not take place, due to access. In order to reflect the 'typical-error' and 'advanced learner' approaches, described by Han (2004) as 'pseudo-longitudinal', this research adopted a similar approach by asking for intermediate to advanced learners' reflections on their own language errors.

As discussed in the previous chapter, the study was carried out with a focus on stabilized errors rather than fossilized errors. Its main focus was to gather historical data, potentially establishing the roots of the participants' SLEs, while examining the problems described by advanced learners i.e. people with an average IELTS score between 5.0 and 8.0. The participants exhibited causal factors of fossilization from each of the domains identified by Han (2004), although the extent to which domain featured was surprising once the data were collected.

3.5.1 A Conceptual Framework of the SLEs Affecting Displaced Medical Healthcare Professionals.

Figure 5 below shows the conceptual framework for the study. The idea that a lack of linguistic facility is preventing qualified and experienced healthcare professionals from performing their roles is frustrating. Particularly when there is a shortage of doctors and a comparative surfeit of refugee doctors and other displaced medical healthcare professionals who are struggling to find employment in the UK. In order to identify the SLEs that are the barriers to gaining qualifications, which in turn, enable displaced medical healthcare professionals to register with the GMC, an audit of language problems was conducted. In the first instance, this audit was a self-assessment from the target group themselves. The rationale behind this was that these problems are persistent but, rather than assuming fossilization, which was criticised by Long (2004) and others in the literature, the participants were asked to

assess and reflect upon the language traits that they exhibited. It was expected that they would have some awareness of their linguistic shortcomings through feedback that they received in their IELTS training and other language courses. The data collection measures were designed to yield information on both the types of problems they experience according to common interlanguage errors between their L1 and English (Swan and Smith, 2008), as well as common errors in IELTS scripts at level 7.0 or above (Moore, 2011). The synthesised findings might lead to a profile of SLEs within the refugee doctor community in south Wales and it was hoped that these findings would lead to strategies in which the individuals could reflect on their errors and their causes and help them progress in their language use.

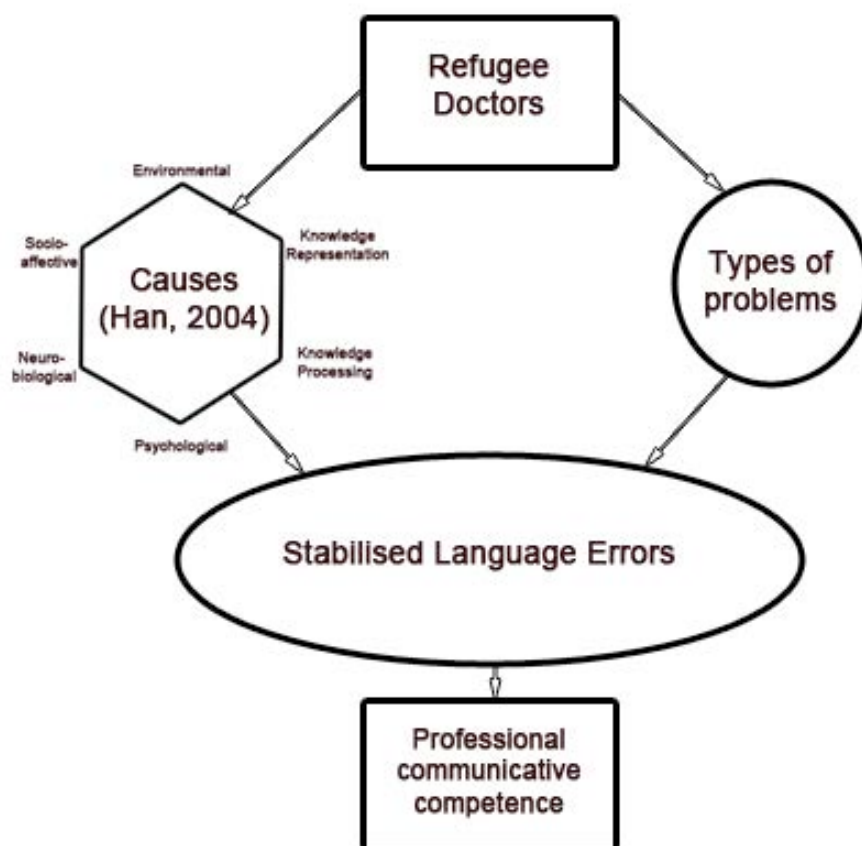


Figure 5. Conceptual framework for the study, drawing on Han’s putative causal factors
 Figure 5 reflects the aims of the project and the areas that were explored, namely the kinds of SLEs that the participants exhibited and their possible causal factors,

relating to Han's (2004) six domains. The diagram shows how the data on each area was combined to form an overall profile of the participant groups' views on their SLEs and how an understanding of these may reveal insights into improving their professional communicative competence. Instead of assumptions being made by the researcher, the project was designed to ask the people who exhibited these various language problems and who, to a greater or lesser extent, had suffered because of them, to engage in a reflective dialogue about their SLEs. It attempted to understand the problems that the participants felt that they had and also to understand why they felt that they could not easily overcome them. It examined the relationship between the participants' views on their own SLEs and the generalised characteristics of the aforementioned interlanguage errors between their L1 and English (Swan and Smith, 2008) and the more common errors in IELTS scripts at level 7.0 or above (Moore, 2011). Table 8 maps each research question to its appropriate methodological stage and the intended results. This is discussed in detail in the next chapters.

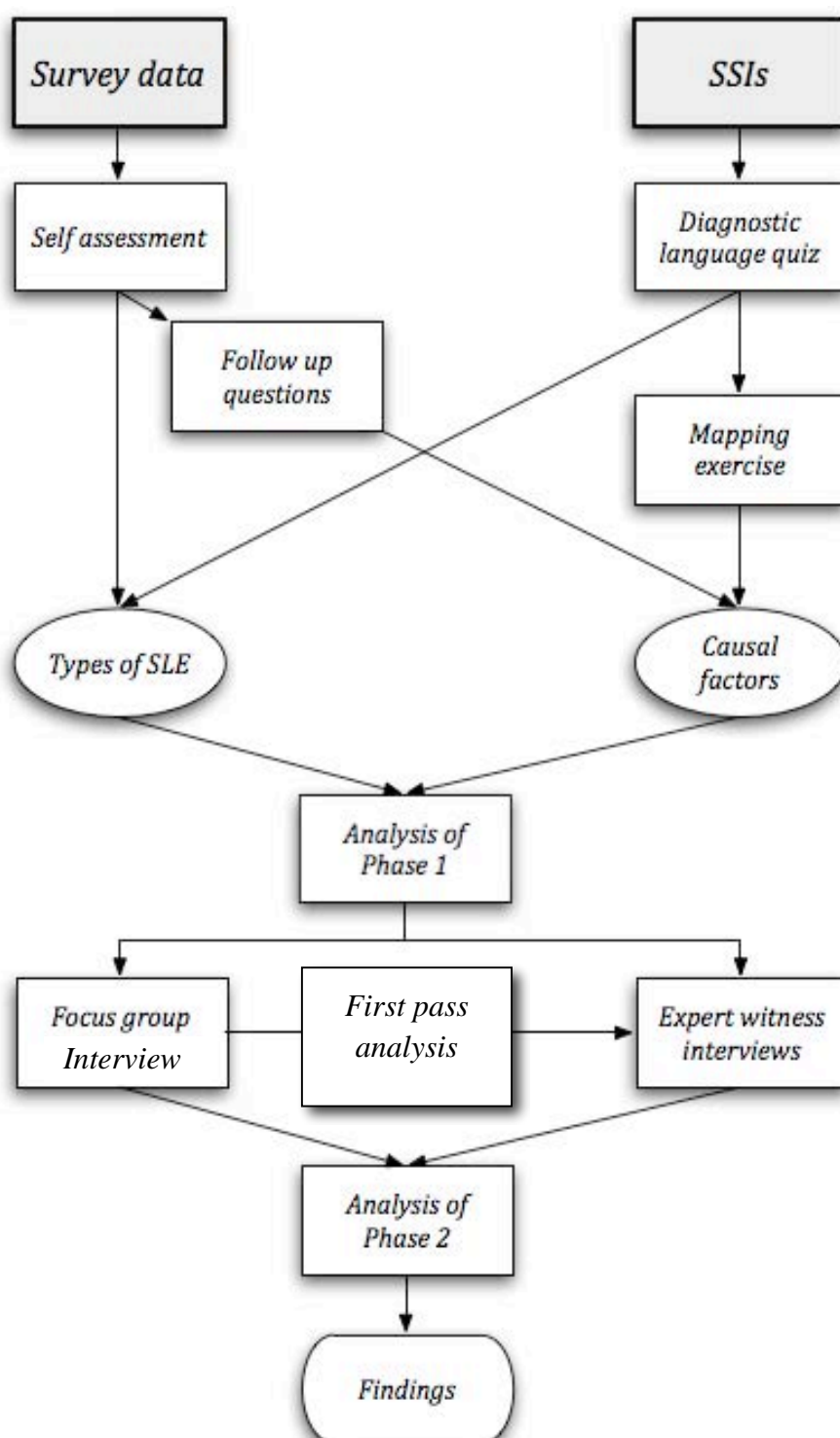
Table 8 was developed to capture the data as effectively as possible. It was anticipated that the sample would be volatile due to the itinerant nature of refugee dispersal and so having a second opportunity for data capture would be prudent.

Table 8. Research questions mapped to data capture events and the expected results

| Research Question | Data Capture | Expected Outcomes |
|--|---|--|
| Phase One (November 2012 – April 2013) | | |
| 1. What are displaced medical healthcare professionals' perceptions of their own common SLEs? | <ul style="list-style-type: none"> Electronic questionnaire on common SLEs, including the common mistakes according to specific languages and those made at level 7 or above in IELTS, and their causes. Initial diagnostic language quiz and semi-structured interviews. | Identification of which SLEs are likely to feature in the study and what their causes may be. |
| 2. In the participants' views, what is the impact of life histories, educational histories and other experiences on SLEs? | <ul style="list-style-type: none"> Semi-structured interviews. Follow up open answer questions via email to questionnaire respondents. | Establishment of the impact of prior learning and life histories on SLEs. |
| Phase Two (June 2013 – July 2013) | | |
| 3. What are the participants' responses to the emergent findings of the research questions one and two? | <ul style="list-style-type: none"> Focus group seminar with the SSI participants. | Observations from participants and providing them with an opportunity to reflect on the findings of the study |
| 4. What are the views of expert witnesses on the training and language skills of displaced medical healthcare professionals? | <ul style="list-style-type: none"> Interviews conducted via Skype, when possible. Open answer questionnaires where Skype interviews are not possible. | Information on the views of professionals involved in teaching, testing and policy making connected to displaced medical healthcare professionals. |

The outline of the stages of data capture for the project in figure 6 illustrates the activities that took place in each phase of the process. Phase one began in November 2012 with the questionnaire, which was sent out to all clients of the WARD group and aimed to yield results on both the causes of SLEs and the types of SLEs that the participants perceived themselves to have. Also, as a complementary method within phase one, face-to-face interviews took place with attendees of the WARD IELTS classes' to gather their views on the causes of their SLEs. The first visit to the WARD drop-in IELTS classes was intended as an initial introduction to the project, to myself as the researcher, and to explain what the volunteers would be asked to do. The initial meetings also gathered informed consent from the

participants and asked them to complete a diagnostic language quiz, which was based on common errors between their first language and English as well as common errors in IELTS at level 7.0 or above. Conducted with nine individual attendees of the IELTS classes between November 2012 and April 2013, the subsequent interviews were semi-structured interviews, where the results from the diagnostic quiz were fed back to the participants and they were asked to reflect on their individual SLEs. The data from the questionnaires and interviews were analysed to identify any patterns in the SLEs and the causes of SLEs in this particular group. The methods of analysis will be discussed in detail in section 4.4 of Chapter 4.



November 2012.....April 2013 May 2013 June /July 2013 March 2014

Figure 6. An overview of the stages of the project

The results of phase one were compiled and returned to the participants in order to gauge their opinions on the findings in the focus group during phase two of the data collection. The analysis also examined any relationship between their perceptions on their SLEs and the literature on L1 transfer, as well as the possible causes of their

SLEs and fed into the development of the research. The results from phase one were used to identify themes for discussion during the focus groups and these data, in turn, informed the topics that were explored during the expert witness interviews.

3.6 Reliability of the Methods

In the 2011 BERA report, Gardener (2011) describes the aspirations of educational researchers as being complex, in particular the concepts of reliability and validity in educational research. This is particularly true of second language research. Mackey and Gass (2005) break down the protocol for checking the validity and reliability of methods used in second language research into the following areas: general validity, internal validity, external validity and reliability.

General validity, which includes content validity, face validity, construct validity and criterion related validity, represents the broader issues, which should feature in the research design. Content validity refers to how well an instrument measures the features that it sets out to measure. In the case of this research, the main focus was to gather the opinions and views of displaced medical healthcare professionals and to foreground their voice. While Clough and Nutbrown (2012) combine the use of voice with action research, a project of this scope could only hope to contribute to the discussions that inform policy makers when proposing potential action on helping displaced medical healthcare professionals to re-join their careers. Nonetheless, the questionnaires and semi-structured interviews all aimed to amplify the voice of the main participant group. In doing so, it was important to ensure that the linguistic forms that were used in the data collection methods were at an appropriate level, and appropriate to the linguistic backgrounds of the proposed participants. It was also important to make sure that the six domains of causal factors for SLEs were adequately described to the participants, without slipping into subject-specific jargon. Face validity is about the participants being able to see the value in their participation

and the tasks that they were asked to participate in. The challenge was to make the questions relate to the common errors that are made by IELTS candidates who achieved 7.0 or above, while attempting to eliminate any mistaken responses caused by unfamiliar terminology. As such, the questions in the diagnostic language quiz were tailored to represent the common errors, but to be written to feature medical situations, thus reducing problems with unfamiliar vocabulary.

Construct validity attempts to cover other variables such as length of exposure to the language, maturational constraints, aptitude and learning styles. These variables were at the heart of the study, and wherever possible, covered in all forms of the data collection. Nonetheless, some assumptions were made before the data collection stage such as the general profile of the participants through their being clients of the WARD group, indicating that they were asylum-seekers or refugees in the UK and as such their nationalities would broadly be nationals of countries from which the UK accepts refugees. It was also assumed that they would be medical healthcare professionals and of average intelligence or above.

Criterion-related validity refers to the use of tests in a study. The main focus of this study was the taxonomy provided by Han (2004) and the potential impact of the factors described within it, on the progress of medical healthcare professionals towards achieving their desired grades in the IELTS test. In turn, this set the criteria for discussions on levels of English in terms of the diagnostic test and the relevant training.

Internal validity examines factors such as the participant characteristics, accuracy in reporting the findings, participants' attitudes and possible inattention, the location of the data collection and any potential power relationships. It also covers other factors that were less directly relevant to this study in terms of the benchmarking of subsequent tests and giving the goal of the study away. The characteristics of the

participants were collected in the questionnaires but were also ascertained via the selection method for the semi-structured interviews. The fact that they were recruited via the IELTS classes delivered on behalf of the WARD group meant that they would be asylum-seeking or refugee healthcare professionals. In both of the main forms of data collection, information on their L1, language learning experiences and proficiency were explored. The expert witnesses were selected by their roles and therefore defined by their professional characteristics. To ensure that findings were as credible as possible, they were reported as accurately as possible and if, for example, participants did not reply to follow up emails, this was reported as well. As discussed, the ephemeral nature of refugee groups is part of the issue and as such, low uptake and retention in participation was expected. In order to address retention of participants, a clear outline of the study and its goals was provided at the recruitment stage. Questionnaires were electronic and therefore accessible and only displayed the question sets that were relevant to the initial responses in the early stages of the questionnaires. The semi-structured interviews were designed to be flexible in length so as not to inconvenience the participants, while allowing them to talk as freely as they wished.

The location of the interviews was considered to be an important feature in the research, as they were held in the offices of DPiA, where the doctors received IELTS support. This meant that the participants were ready to use English for a prolonged period of time and it was also hoped that there would be some sense of familiarity for the participants as a result. The questionnaires and expert witness interviews were carried out via the Internet and afforded the opportunity for the participants to provide their views at a time that suited them. There was a small potential for a power relationship between the clients of WARD and the researcher, as I had been employed by the WARD group to train IELTS a few years previously. This did not

seem to impact negatively; the participants were requested to be as open and frank as possible.

External validity covers the selection methods that were discussed earlier in this chapter and generalizability. In both cases the sample needed to be specific and the researcher was able to do this via professional contacts. With respect to generalizability, provided that the sample is similar, transferring the methods to another similar project would not present a problem. With some modifications, this could also be extended to other overseas healthcare professionals, such as the Philippine nurses that featured in pilot of the questionnaire or to refugee teaching professionals as described in Smyth and Kum (2010).

Reliability can be described as having two main features: inter-rater reliability and instrument reliability (Wang, 2009). Inter-rater reliability refers to the testing and analysis to check whether different examiners or analysts would reach the same findings. In this case, the results and transcripts were shared among the research team, my Director of Studies and my Supervisor, and themes were compared.

At this stage, a couple of discrepancies between the raters' analyses were noted. For example, my Supervisor had suggested that two of the statements that I had analysed as belonging under the 'environmental' domain, might belong under the 'socio-affective' domain due to them representing a lack of communicative relevance. These discrepancies were discussed in meeting with my supervisory team and, after the discussions, it was felt that these overlapping statements belonged slightly more in the environmental domain. In one instance, this meant that the statement that was taxonomised under 'Reinforcement from the linguistic environment' was moved under the heading 'Quality of input'.

In order to test the instrument reliability, each stage was piloted with groups at a comparable English language level. The diagnostic language tests were shared with

other professionals engaged in teaching language at a comparable level in a university based English language school.

3.6.1 Credibility, Transferability and Dependability

Mackey and Gass (2005) advise that credibility should be in the foreground at all times in second language research. This can be achieved through the researchers' knowledge of the research topic as well as a breadth of data collection via more than one channel. This study features elements of these techniques, in that I had worked with a large number of displaced medical healthcare professionals on helping them to achieve their goals of achieving the GMC IELTS requirement. In addition, in order to add a different context to the study, questionnaires were distributed electronically, therefore reaching participants who had progressed past the GMC IELTS requirements as well as those who had been in training for the test.

Qualitative research also faces a challenge in terms of transferability, as no two studies are completely replicable. Similarities can be drawn through 'thick description' (Geertz, 1973), which allows other researchers to draw parallels in as many ways as possible in order to produce research that has similarities to a particular study. Davis (1995) defines thick description as comprising the following: particular description giving representative examples from the data, general description providing information about the patterns in the data and interpretive commentary, which explains the phenomena researched and interprets the meaning of the findings with respect to previous research.

Particular description in this study came from a thematic analysis of the data and selection of the key findings that emerged from the study. General descriptions came about through the correlations and differences that also emerged from data that came from the analysis of both phases of the data collection. The interpretive commentary was provided via the wide body of literature on SLEs that formed the

backbone of the research and the results, which were interpreted against previous research on these problems that are summarised in Han's (2004) coverage of the putative causes of fossilization.

3.6.2 Comparing and Corroborating Results

The two approaches to data collection in phase one allowed for a wider range of participants, potentially at different stages in joining the GMC. The electronic questionnaire attempted to reach both doctors who were currently preparing for the IELTS test as well as those who had achieved the GMC's minimum IELTS requirement. The interviewees were recruited via the IELTS preparation classes and therefore gathered the views of those who had not yet reached the minimum requirements.

While there were many similarities in the themes of the questionnaires and semi-structured interviews, the methods used gathered different data forms. Some of the data collected in the questionnaires were quantitative, whereas the interviews allowed for richer qualitative data to be collected. The data from each were compared and contrasted during analysis and therefore allowed triangulation between the data collected.

Using focus groups, the study asked participants to review the data that had come from the interviews. This was carried out for two reasons, firstly to provide refugee and asylum seeking medical professionals with further opportunities to express their views and have a voice and secondly to add to the reliability of the results. To further the dependability, as with all research projects of this kind, full details of the data on which interpretive claims were based, can be made available.

The role of the expert witnesses was important in this respect as it was intended to add credibility to the findings. While the focus of the study was to examine the views of the displaced medical healthcare professionals themselves, it should be

remembered that they are not necessarily well positioned to provide knowledgeable statements on the English language training elements that the study covers. For this reason, the expert witnesses were able to provide an important professional perspective on key areas of the research.

3.7 Data Analysis

The next step in designing the project was to consider the methods for analysis of the data collected over the two separate phases from four groups: questionnaire respondents, interviewees, focus group and expert witnesses, featuring six forms of data: questionnaire responses, follow-up question replies, diagnostic language quizzes, semi-structured interview transcripts, focus group transcripts and expert witness transcripts. The different analytical tools that were used in each section were employed to account for the different sorts of materials that the data collection methods yielded. While the over-arching analytical framework is qualitative and thematic, the research design was such that different instruments were used that allowed further analysis; such as numeric analysis of statements that support certain causal factors made in the interviews and the use of the computer based analytical tools in Checkbox software for the questionnaires. These additional methods of analysis assisted in illuminating the findings and contributing to the research questions. Details of the methods of analysis for each form of data collected during each phase are provided in the relevant chapters.

3.8 Summary

The project used Han's (2004) work on the putative causes of fossilization to theoretically underpin its methods. It then sought to bridge the gap between the theory and practice and the research instruments that were designed were the vehicle for this transition. In order to ensure that the results were as reliable as

possible, Phase one collected self-selected data on SLEs in the questionnaires and these data were compared to the diagnostic quizzes carried out with the interviewees. Phase two gathered the focus group participants' views on the emergent data from phase one and all of the data collected were subsequently presented to the Expert Witnesses to gather their views. The links between each stage are illustrated in figure 7, which provides an overview of the research design including methods of corroborating data and the information yielded from each stage.

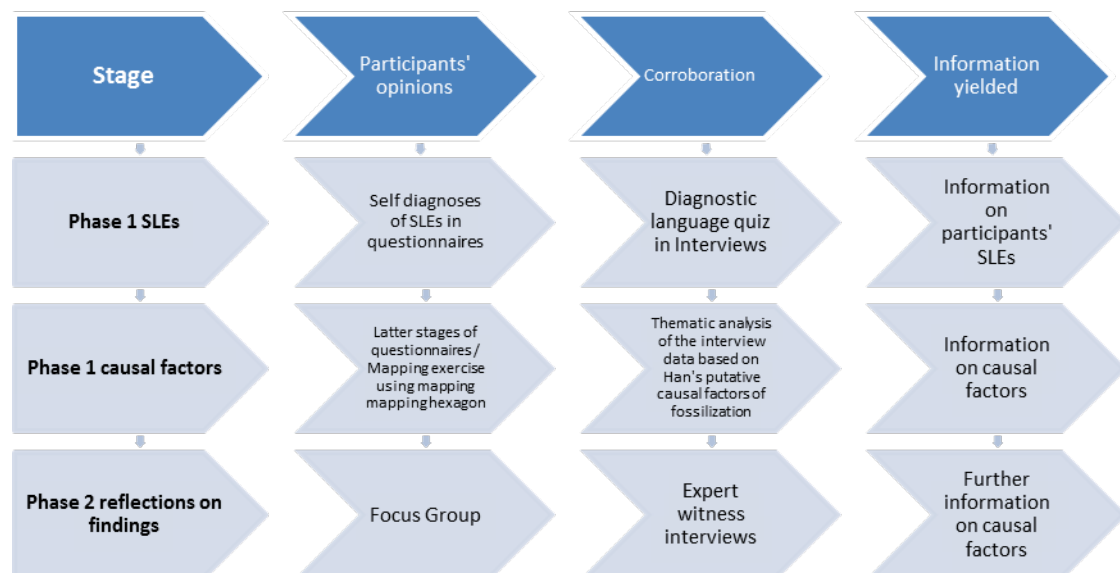


Figure 7. Overview of the research design

In the illustrating figure above, we can see that the research gathers very detailed data on the participants' specific SLEs in the early stages. As the data collection progressed, it drew on the findings from the earlier phase to develop broader synthesised discussion.

Ethical considerations were thorough and detailed in order to protect all participants in the project. Three ethical frameworks, BERA, BSA and NRES were consulted and synthesised in order to ensure this level of protection.

In the following chapters, I will describe the application of these methods, as well as to report the results and findings for each phase.

Chapter 4. Phase One: Methods, Analysis and Findings

4.1 Introduction

This chapter will cover the practicality of collecting the data, including piloting the data collection tools, accessing the sample group, collecting the data and transcribing interviews. Again, working with an unconventional sample meant that all of these aspects presented particular challenges.

This section also details the methods of analysis of the data and describes the findings from phase one of the data collection. The study took a two stage approach to gathering the data and analysing the results. This was carried out over two phases, as described in the methodology chapter. The first phase was designed to gather and analyse the views of displaced medical healthcare professionals to look for patterns and trends. The second phase sought to corroborate the findings with both displaced medical healthcare professionals and expert witnesses, who were involved with helping displaced medical healthcare professionals to join the GMC.

The first phase of the data collection was carried out in order to address the first two research questions:

RQ1. Research question one: What are displaced medical healthcare professionals perceptions of their own common SLEs?

RQ2. Research question two: In the participants' views, what is the impact of life histories, educational histories and other experiences on SLEs?

As discussed in the methodology chapter, the research design for collecting the data for these two questions was approached in the following ways:

- An electronic questionnaire was sent to all of the clients of the WARD group. Where possible, this was followed up with open answer questions, which were sent electronically to respondents who provided their email addresses.

- An initial diagnostic language quiz was conducted with the current attendees of the IELTS classes, which are delivered at DPiA on behalf of the WARD group. Where possible, this was followed up by semi-structured interviews, which asked participants to attribute SLE s or weaker areas of language knowledge to one of Han's (2004) six domains.

Due to the potential for a low rate of participation that can often occur when dealing with high volatility sample groups such as refugees, both approaches sought to collect similar data and were carried out within the same timeframe from November 2012 to April 2013. The electronic questionnaire and subsequent open answer questions were intended to reach clients of the WARD group who may not necessarily still reside in regions served by the organisation. The questionnaire collected mainly quantitative data whereas the follow-up open answer email questions collected data of a more qualitative nature. It was assumed that the majority of the respondents to the questionnaire would have achieved the necessary IELTS requirement to join the GMC. This assumption was based on the idea that those who would still be trying to complete the IELTS test with the necessary band score would still be in training and could be reached via the classes delivered by the WARD group.

The language quiz and subsequent semi-structured interviews had similar themes but afforded the opportunity to collect richer qualitative information, particularly during the interviews. It was assumed that, as the participants were recruited from the IELTS classes delivered by the WARD group, the participants would not yet have reached the GMC requirements.

A small difference in the data collected in the questionnaires was that in the case of the questionnaires, participants were asked to select reasons for choosing each

domain from a list. In the interviews, the participants were asked for the reasons that they placed the SLEs within the particular domains, this forming more of a bridge between the first and the second research questions.

4.2 Methods for Phase One

Chapter four described the theoretical aspects of the research design for the thesis as a whole. In this section, I will discuss the practical application of the selected methods, including the preparatory stages for each method, the practicalities of collecting the data, reporting the data and the data analysis methods that were used.

4.2.1 Preparing for the Questionnaires

Questionnaires were selected to be the first means of data collection with the potential sample group. Rasinger (2010) states that this method of data collection is effective in finding out respondents' attitudes towards languages and this was the primary role of the questionnaires in this research. The purpose of this questionnaire was to garner information on the participants' reflections on their own SLEs and the possible reasons for them having these problems. It also set out to gain an understanding of learner beliefs and how the learners think they can achieve their goals.

The questionnaire was designed to promote the participants' reflection on their English language skills and, more importantly, their own analysis of their SLEs. In order to provide the participants with a framework within which they could begin their reflections, an indication of potential causes of SLEs was necessary. As discussed in the literature review chapter Han (2004) collates much of the literature into her taxonomy of 'external' and 'internal' factors. These factors are further sub-divided into 'environmental', 'knowledge representation', 'knowledge processing', 'psychological', 'neuro-biological' and socio-affective' factors.

Although Han's taxonomy features fifty causal factors, Rasinger (2010) advises that a questionnaire should not feature any more questions than would be necessary to garner the information needed to complete the research. A lengthy questionnaire might have been off-putting to participants.

The study focussed on people who were experiencing difficulties in learning English as a second language, and so consideration was needed in simplifying the terminology, so that the respondents could clearly understand what was being asked of them. To facilitate understanding of Han's (2004) putative causes of fossilization, I rephrased the categories into personal statements that the respondents could select if they felt that they applied to them. The factors themselves were also rewritten for ease of understanding of both the language and concepts that they represent. This can be seen in appendix 7, and formed the basis for the self-diagnosis of respondents' SLEs in the questionnaire. The questions were written in plain English and tested against the Flesch Reading Ease Test and the Flesch-Kincaid Grade Level Test. According to a test run on Microsoft's Word package, the statements scored 79.7 in the Flesch Reading Ease Test and 4.3 in the Flesch-Kincaid Grade Level Test. A high score in the Flesch Reading Ease test indicates that the questions were easy to read, a score of 100 being the easiest and a score of 0 being the most difficult. A score of 4.3 in the Flesch-Kincaid Grade Level Test means that a child in the fourth grade of the American education system, that is a child of nine or ten years of age, would be able to understand the text. An explanation of how Kincaid *et al.* (1975) calculate the readability of texts is given in appendix 8.

The dedicated software Checkbox was used to compile and analyse the questionnaire. Checkbox is an online questionnaire tool, which allows users to create and manage questionnaires. It collates results and has functionality that allows questionnaires to be personalised and emailed through the service. The training and subscription for this software was arranged through the university. In

using this software, I was able to prepare the questionnaire in such a way that questions would be asked which were relevant to the individual's prior responses. In addition, it would make completing it much easier and less daunting for the participants.

In a questionnaire by Shannon *et al.* (2002), members of the Questionnaire Research SIG from the American Educational Research Association (AERA) were asked to provide their views on the use of electronic questionnaires. The results showed that although the majority of the respondents were daily users of the Internet, they had mixed opinions about the use of online questionnaires. While the majority of replies stated that they felt that online questionnaires were cost effective, straightforward to complete and resistant to social desirability bias, they stated that respondents to electronic questionnaires would be those who are more comfortable with technology. Many felt that respondents would be more likely to reply to a traditional pen and paper questionnaire, as this is a more personal form of communication. They also felt that the margin for error was greater with online questionnaires. The respondents were split on whether people would prefer to complete pen and paper questionnaires to electronic ones and whether the use of electronic questionnaires yielded better quality information. The main advice to come from the study was that sending an email to potential respondents prior to sending out an electronic questionnaire could reassure them that the questionnaire is specifically targeted to the sample group. The study also recommended using email correspondence to follow up potential participants.

The mapping of the questionnaire is illustrated in figure 8, including the different branches for the various options that the participants could select. The variants converge to enquire about language learning and kinds of language errors. The former acted as a filter to see not only the respondents' level of English but also as a control for those who had achieved 7.0 or above. The latter was less important for

the collection of data but was intended to encourage participants to reflect on their own language shortcomings before selecting their beliefs about why they exhibit SLEs. If respondents elected the branch connected to SLEs, they were given a choice of the main categories as described by Han (2004) and were able to select as many or as few as they wished. These general categories were then focussed into the factors that were covered by these headings. Should respondents state that they did not exhibit SLEs, they were asked to write a little about how they overcame their language learning problems. In my experience, even those who were at IELTS level 7.0 or above would acknowledge that they still had some linguistic 'bad habits' and would describe themselves as exhibiting SLEs. The penultimate screen for participants who considered themselves as having SLEs gave them the opportunity to write about how they believed they could achieve their goals of overcoming their language learning problems. The penultimate screen for those who stated that they do not have any SLEs, afforded them an opportunity to share their advice on overcoming such problems. The final screen was an invitation to participate in interviews and gather contact details, if the participants agreed to do so.

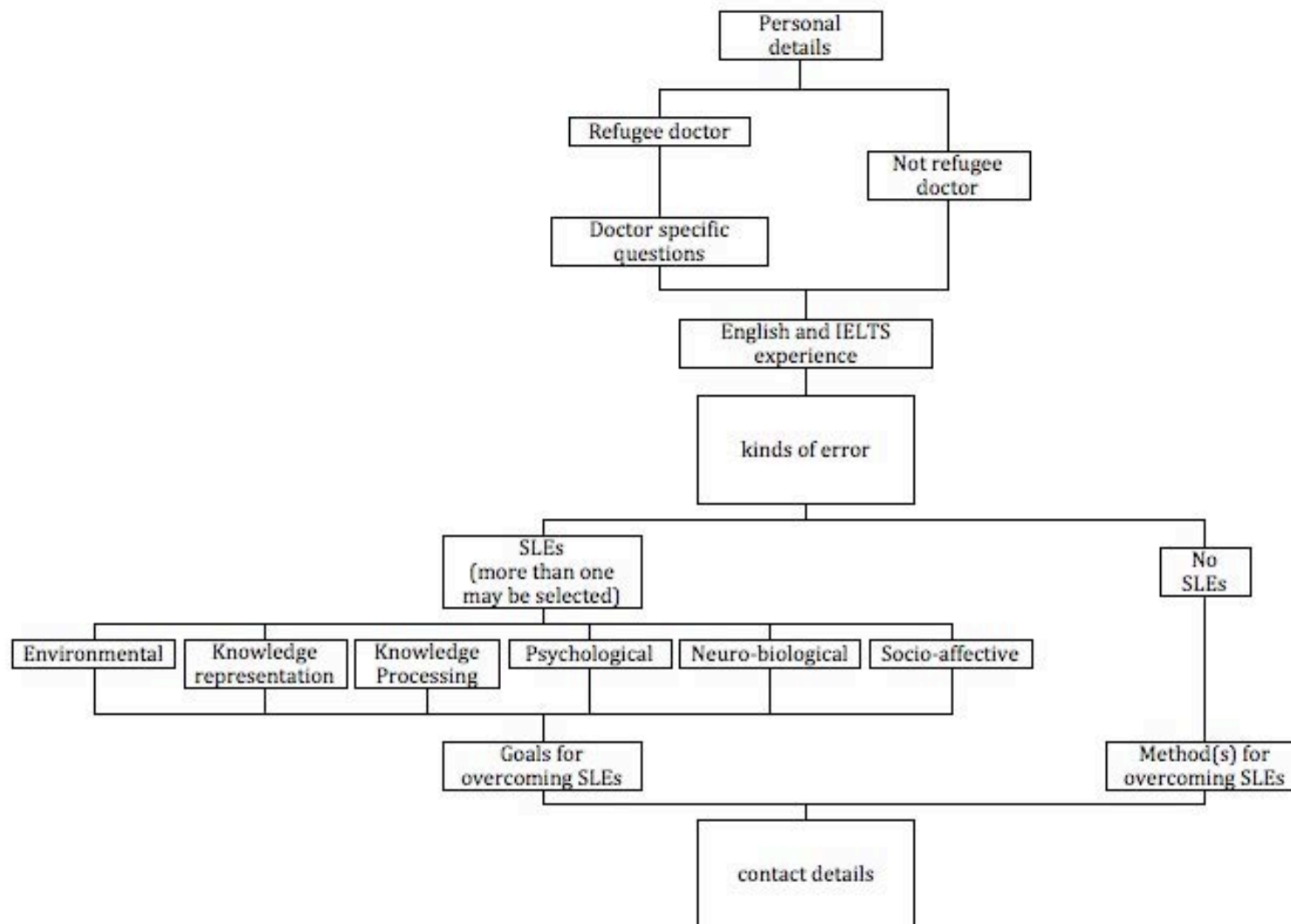


Figure 8. The mapping of the questionnaire

The first section of the questionnaire gathered generic personal details such as the participants' names, nationalities and first languages. The second related to the participant's professional experience and the third gathered information about language learning experience. The fourth section was designed to yield information on the problem areas in SLEs that they felt they exhibited. The types of grammatical error were taken from the Cambridge Learner Corpus of common mistakes made by IELTS test takers who achieved level 7.0 or above (Moore, 2007), as well as the common errors exhibited by the language groups that were expected to feature in the study (Swan and Smith, 2011). This section also enabled the respondents to reflect on their SLEs before answering the fifth section, which was directly related to the causal factors of SLEs. The following six sections allowed the participant to begin reflecting and sharing experiences on their language issues in relation to their answers to section five. The final section was a request for further participation.

The readability score changed once the metalanguage and examples of the 'Problems with my English' section were included, the questions in the questionnaire now scored 69.3 in the Flesch Reading Ease Test and 6.0 in the Flesch-Kincaid Grade Level Test. The questionnaire as a whole scored 67.6 in the Flesch Reading Ease Test and 6.8 in the Flesch-Kincaid Grade Level Test. This meant that the questionnaire should be accessible to users of English who have an ability to understand the language roughly equivalent to an eleven-year-old. It should be remembered that this was the readability of the test as a whole, rather than how it would appear to each individual participant, as this varied according to how many questions they chose to answer in section five. Mackey and Gass' (2005) advice on questionnaire design, clarity and layout, discussed earlier in this chapter, was followed in order to make engagement with the questionnaire as accessible as possible. Most importantly, input from the pilot participants allowed me to understand the extent to which the questionnaire was easy and clear to readers.

The questionnaire was given to some critical friends and colleagues initially in order to evaluate the questions from other perspectives. It was then transferred into the Checkbox format.

To avoid narrowing the already limited and transient sample of potential participants, the pilot questionnaire was sent to a group of five Filipino nurses who were working in London. This group, who all had to evidence their level of English via the IELTS test, was introduced to me via a student of a local university and thus sampled opportunistically.

Once ethical clearance was obtained, the questionnaire was sent out to the gatekeeper to pass on to the pilot participant group. It soon became apparent that there were some technical problems with the Checkbox software, which had prevented my questionnaire being returned. Although alternative questionnaire software was investigated, I persevered with Checkbox due to time and economic constraints. Initially, only two responses to the questionnaire were received and no one returned feedback forms on the questionnaires design. In order to maximise results, I wrote again to the gatekeeper to chase up responses. In communication with that person, I received some feedback on the combined consent and questionnaire forms. It appeared that they were unnecessarily cumbersome as the pilot participants had to print the forms to sign them and scan them to return electronically. I also contacted another overseas doctor via a colleague, in order to ask if they would complete the questionnaire and provide feedback but no response was received.

I received three returns to the pilot questionnaire. The first point was that the respondents were all between 25 to 30 years of age. For the main questionnaire I had to consider IT literacy across different cultures and ages. Whilst in the UK we are familiar with the 'silver surfer' demographic, the assumption that the same

demographic is as broad, or as IT literate, overseas cannot be made. Accessibility needed to be addressed.

All respondents shared the same nationality, as they were all relatives of the Filipino gatekeeper. The first languages varied, with two citing their L1 as the Karay-a/Kiniray-a dialect and one as the first language of the Philippines, Tagalog. In the analysis of the responses of the Tagalog L1 participant, there was very little that differs from the answers provided by the other participants. The only unique answer that was provided was the selection of the 'I can't easily identify things like verbs, adverbs and clauses' category.

The profession-specific answers to page two were not necessary, as it was known that the pilot participant group were NHS workers, but not doctors. All participants had been studying English for longer than seven years, but none had been living in an English-speaking country for more than three years. Two respondents said that they had been in the UK less than a year, so it is likely that they had taken their IELTS tests prior to departure to the UK. This raised the question of whether the participants remained in the UK. Until this point, I had made the assumption that all respondents would be in the UK but this may have been erroneous. During the main study, all of the respondents to the questionnaire were asked if they were still in the UK, and all of them stated that they were. Another oversight of the pilot questionnaire that this analysis identified was that it did not ask participants their maximum overall IELTS band score. This would prove useful in the later analysis of the aspects of language that hold the respondents' English back and whether there is any correlation between them and band score levels. In this case, I assumed that all participants have achieved the minimum NHS requirement for nurses of IELTS 7.0 overall.

All respondents said that they were most confident in reading but each skill was elected by at least one participant. The problem areas of English language learning were identified as being auxiliary verbs, uncountable nouns and their quantifiers, prepositional phrases, comparison and contrast and spelling and punctuation. They did not identify the other common mistakes, such as use of articles, pronouns and conditional phrases.

'Noticing' errors seemed to be the main problem for the pilot participants with two participants selecting 'problems noticing the rules and patterns of English' and one selecting 'failing to use English naturally or notice my mistakes'. Learners only detect such errors when these are pointed out to them but are then substituted by habituated but erroneous forms. Of the two respondents who chose the knowledge-processing domain of 'problems noticing the rules and patterns of English', one said that they do not have a strategy to develop their English based on the patterns they have identified and the other said that they could not identify verb clauses easily. The respondent who mentioned problems with noticing the rules and patterns of English said that the wrong L1 forms were used without thinking and added that they have a top-down approach to understanding but also do not get the opportunity to practise their English. All participants recommended maximising opportunities to practise as a goal for improving their English.

The results were categorised according to Han's (2004) factors of fossilization and in two cases, the pilot respondents selected 'knowledge representation' as a possible cause of their language learning limitations. One respondent selected 'knowledge processing' as a causal factor. As discussed in the literature review chapter, these factors are closely linked and are related to linguistic 'intake' (Kumaravadivelu, 2006).

The pilot raised some amendments that needed to be made in terms of accessibility and other missing information. As a result, the questionnaire was modified in the following ways:

- Consent was requested at the start of the questionnaire to avoid having separate forms. As such, taking part in the questionnaire constituted consent. This aimed to improve accessibility and simplify the process of responding.
- A question about the participant's current country of residence was included.
- A question about participants' maximum overall IELTS score was inserted.

Due to the small number of respondents from the group of nurses a second draft of the questionnaire was issued to fifty students at a university based English language school. These non-English L1 students were taking university access courses and the cohort had IELTS scores between 4.5 and 8.0. Thirteen students returned questionnaires.

The data yielded by the second pilot were both helpful and interesting. The feedback on the questionnaire itself was that it was very clear, easy to use and not too onerous to complete. The results from the questionnaire indicated that almost all respondents had identified that they had problems with orthography and punctuation. Half of the respondents stated that they struggled with articles. Five respondents identified problems with uncountable nouns and a further five had difficulties illustrating comparison and contrast. Four respondents said they had problems using prepositional phrases and a few had trouble with conditional sentences and the main auxiliary verbs. The results were analysed according to Han's (2004) factors of fossilization and the majority appeared to fall under the first four domains: 'environmental', 'knowledge representation', 'knowledge processing' and 'psychological'. Under the 'environmental' domain, most respondents felt that people who used their L1 surrounded them. As all respondents were living in the UK at the time, this indicated a possibility that they remained within small linguistic groups in their localities. They also felt that no one corrected them when they made erroneous

utterances. Under 'knowledge representation', the participants felt that they had difficulties identifying the forms of English and developing strategies to build on the problems they identified. They also stated that L1 interference played a part in causing problems with acquisition. The answers regarding 'knowledge processing' ranged from carelessness, top-down processing, a lack of automatization and problems noticing the discrepancy between the use of English of others and their own. In terms of the 'psychological' factors, the majority felt that they used Basic English too much and that they were unwilling to risk using new forms.

It must be remembered that although every respondent was currently studying English in the UK, only 46% of them said that they had been learning the language for more than four years. This raises the question of whether the learners were experiencing the causal factors of SLEs without having given sufficient time to their language acquisition to fully develop their skills. It must be remembered that this is significantly longer than the estimated improvement of one IELTS band score in three months that is suggested by Gilet (2013). Also worthy of note is that nine of the thirteen respondents were L1 Arabic speakers, and most of the problems outlined above also fit the profile of the difficulties that Arabic speakers have with English in general.

Feedback from this exercise, as well as the pilot interviews that are discussed in the next section, was that the pilot participants felt that the four initial ethical compliance questions were cumbersome, and that they had understood the original consent forms very well due to the inherent readability in the consent letter itself. The fourth question was deemed unnecessary and some of the feedback was that it was slightly insulting to their language abilities. For this reason, it was removed from the questionnaire, which then incorporated the first three questions electronically (please see appendix 9).

Having piloted the questionnaire, it became apparent that it would be beneficial to identify more detail on the problem areas of English language learning. In order to do this, the following questions were added to this section:

Problems with *have/be*

Problems with *do*

Problems with past and perfect verb tenses e.g. *did/ have done*

Problems with modal verbs e.g. *will do/ would do/ can do/ could do/ must do /should do*

Problems with subordinate clauses e.g. *using 'who' or 'which' to add information*

Problems with subordinate clauses e.g. *using 'at', 'in' / 'on' to add information*

Problems using the passive voice e.g. *'the food was eaten / the computer has been broken*

Problems with conditional forms e.g. *if I were rich, I would buy a Porsche*

Problems with using infinitives and gerunds e.g. *I don't want to eating/ she is eat*

Problems with subject-verb-object e.g. *I television watch / That car I would like to drive*

Problems with superlative forms e.g. *the better in the world / The more hottest*

The first two questions were introduced to replace the original question 'Problems with *have/ do/ be*' in order to separate out the universal problems with 'do' as identified in the literature review (Moore, 2011).

4.2.2 Preparing for the Semi-Structured Interviews

Doctors, *per se*, may not fit into the traditional disempowered socio-economic groups but refugees are likely to do so. This illustrates the conflicting sense of identity likely to be present in displaced medical professionals. The challenge of the semi-structured interviews was to give space to examine the duality of roles that confront displaced medical healthcare professionals.

Transcripts of the interviews were returned to participants between phase one and two. In some cases, an interviewee's level of English may be considered to prevent

accurate verification although this is unlikely in this instance because the transcripts reflected the English the interviewees themselves had produced. Every effort was made to negotiate meaning with the interviewees, on occasions where it was necessary. The detailed transcriptions of the semi-structured interviews recorded such instances.

Before this, in order to introduce participants to the linguistic concepts that they would be discussing, a quiz was conducted that allowed both participants and researcher to analyse their problem areas. The quiz featured forty questions over the twenty problem areas in English language use, as mentioned in the literature review, and asked participants to identify the incorrect entry or entries in a choice of three options. Each grammatical point was tested with two questions in order to eliminate the potential for participants to fail to identify a genuine problem area based on guesswork (Conners, 1983). To further minimise the role of conjecture, students were asked to identify one or two erroneous sentences in sets of three similar, but separate, sentences. This would not allow participants to assume that identifying one incorrect structure meant that the alternative would be correct by default, as they might with one correct option between two sentences. It was also hoped that this would test participants' knowledge more rigorously. Although the researcher designed answer sheets for analysis of the quiz, as in appendix 10, the copy that was received by the participants to complete did not have the correct answers highlighted in red text.

The quiz was developed and shown to colleagues who work in ELT, as well as the supervisors of this research project. Once ambiguities in answers were removed from the quiz, it was trialled with a group of six students at a university based English language school. These students were learners of English up to level C2 in the Common European Framework of Reference (CEFR) or an equivalent of an IELTS score of 6.0 or above. Consent forms and feedback questionnaires asking for

information on the experience of completing the quizzes accompanied the quiz. Six quizzes were returned and this enabled me to develop experience in analysing the quizzes, as well as making adjustments to the instructions for the sake of clarity.

Taking advice from experts in language research (Mackey and Gass, 2005; Blaxter, Hughes and Tight, 2009; Burton and Bartlett, 2009; Kumar, 2011 and Menter *et al.* 2011), the interviews were carried out with sensitivity to the age, race, gender and culture of the interviewees. The preamble served to inform the participants of their rights, the right to anonymity or to end their participation whenever they wished. Open-ended discussion was encouraged and any communication problems that arose were dealt with patiently, putting the comfort of the interviewee at the centre of the process. To facilitate this, the key questions were asked during the middle of the interview and the interviewer echoed responses where appropriate in order to allow opportunities for further reflection.

Edley and Litosseliti (2010) discuss the difficulties with rigidly structured interviews when an L2 learner might miss the point or meaning of a question.

Misunderstandings can lead to a loss of the richness of the data gathered or even to a loss of data altogether. Due to such potential problems, it seemed more appropriate to opt for using semi-structured Interviews (SSIs) as the interview format. SSIs are well-planned occasions where speakers are guided through a series of topics that the interviewer would like to understand, whilst allowing the speaker to provide their points of view and ideas on the subject. Due to their flexible nature, the SSIs needed to be conducted carefully.

Following the advice of Thomas (2009), an interview should have a specific, yet flexible schedule so that the interviewer does not lose control of the interview altogether, whilst allowing for the full richness of data provided by the interviewee.

Menter *et al.* (2001) tell us that a semi-structured interview is intended to allow space for a participant's own views on the topic. Although the initial interview schedule that had been prepared would yield some interesting results, it was less likely to yield information that was related to the research questions. It was also felt that the number of questions in the schedule would possibly lead participants to make comments, which they may have felt obliged to answer but may not have accurately reflected their own ideas. Clough and Nutbrown (2012) describe a risk of obscuring the participants' voices, when providing them with too many choices. This was a particular problem in the closed questions of the section that sought information on their post arrival in the UK experiences. According to Cohen, Manion and Morrison (2013), semi-structured interviews should be thematic in order to represent the research objectives and collect the most suitable data possible.

The objectives of the interview were twofold, namely to elicit displaced medical healthcare professionals' own perceptions on their SLEs and to find out what their views were about the possible causes of the language learning problems. The nature of the subject matter was potentially sensitive and care was taken to protect the participants, as covered in the ethics discussion earlier in the chapter. The interviews looked at attitudes, perceptions and opinions of the participants in as much depth as possible. With the recommendations of Cohen, Manion and Morrison (2013) in mind, the research questions were mapped onto the interviews as they appeared in the original interview schedule. Again, such a schedule would yield interesting results when examining narratives and socio-cultural perspectives yet, in revisiting the research questions, it seemed that the schedule did not do enough to gather appropriate information.

In order to ensure that there was less digression from the research questions, they were used as a starting point for the interview questions themselves, as demonstrated in table 9 below.

Table 9. Mapping research questions to the schedule

| Research Question | Interview Question | Additional Prompt |
|---|---|---|
| 1. What are displaced medical healthcare professionals' perceptions of their own common SLEs? | Bearing in mind that no one's language use is perfect, could you please try to identify your top five problems in using the English language. | "For example problems with 'a', 'an', and 'the', problems with pronunciation or difficulty using the structures of English?" |
| 2. In the participants' views, what is the impact of life histories, educational histories and other experiences on SLEs? | Which, if any, of these have you found to be a barrier to your language learning? | "A lack of progress in language learning has been attributed to many things including classroom setting, learning and teaching styles, first language interference, methods of committing language to memory, strategies for learning, the constraints of age or simply learning enough of a language to get by." |

Having worked with refugee doctors and other displaced medical healthcare professionals, I had some insight into the kinds of errors that would be exhibited but was interested to find the causal factors from the participants' perspective. The interviews required some self-analysis on the part of the participants and also allowed them to describe their learning journeys. It was anticipated that, while the participants would be highly educated, they might encounter some problems with expressing themselves during the interviews. In this case, visual aids were used to help participants understand the nature of the questions. The visual aids in appendix 11 reflect the twenty problem areas of English use as identified in the literature review. These are based on problem areas as reported in the Cambridge Learner Corpus at IELTS level 7.0 or above (Moore, 2011) and typical interlanguage errors for the proposed participant groups (Swan and Smith, 2011). Appendix 12 illustrates the map that was developed according to Han's (2004) six domains for putative causal factors of SLEs. During the interview, participants were asked to map any problem areas in English language learning that they felt that they had to these domains, which are exemplified in appendix 13. To make these areas accessible, a

simplified explanation of these domains, with exemplars was provided to each participant.

The initial round of piloting also led to the development of the marking system that was used in the final quiz. In analysing the results, two points were awarded for a fully correct identification of the problem areas, one point was awarded for a partially correct answer and nothing awarded for a fully incorrect answer. Because each problem area had two questions dedicated to it, areas of difficulty were identified as being the areas where a participant scored one point or less over both questions.

The second round of piloting showed that this system was able to identify both areas in which participants were very competent as well as their weaker areas. In one case, it seemed that one participant had possibly employed a strategy in which they would identify only one answer per question, thus giving a false reading based on a strategic approach to test taking. The redesign of the format of the quiz had much clearer instructions and examples of questions with both one and two answers.

Once each diagnostic language quiz was analysed, the corresponding interview with each respondent, which was informed by the results of the individual quiz, took place. In order to ensure everything ran as intended, a checklist with additional question prompts was prepared before each interview. The interview method was piloted on the 18th of October 2012 with one of the pilot respondents to the quiz and on the 25th with a second pilot respondent. In this first respondent's case, a score of one or less was achieved in two of the possible problem areas. There were a number of areas featured in the quiz where the respondent had failed to provide accurate answers on two measures two points, so the researcher asked the student whether these were genuine problem areas in their language acquisition. The participant selected one additional problem area, making a total of three.

Interestingly, the participant began to self-assess the putative causal factors immediately, even before the researcher had analysed their problem areas.

In the second case, the respondent's English was stronger but the respondent seemed a lot more nervous when the interview began. There was only one obvious area of difficulty as identified in the quiz. In order to promote further discussion during the pilot SSI, the interviewer gave the respondent a selection of possible areas of weakness, identified in the quiz by just one incorrect answer. The respondent selected two of these areas to discuss in the interview.

The full transcripts, as well as the photos of the problem areas identified by the participants in the mapping exercise, can be seen in appendix 14. Some of the questions that had been prepared, such as nationality, were unnecessary due to the participants being known to me as the researcher. The participants both gave positive feedback on the process in the pilot evaluation form.

Notwithstanding, the transcripts did not allow for the richness of data that I had hoped to capture and some redesign to the structure of the interviews was discussed with the supervisory team. It was proposed that the potential participants would be given a simplified explanation of each of Han's (2004) six domains and that they would consider which of the domains they felt contributed to any possible SLEs. Their reflections on this would be discussed in the first step of the interview and the mapping exercise would take place afterwards in order to further explore the issues. Wherever appropriate, field notes would be recorded to capture additional relevant information that may otherwise have been missed.

4.3 The Collection of the Data for Phase One

In a project involving displaced people, there will inevitably be issues, which do not arise, in classroom-based research with a less transient population. Often refugees

or asylum seekers will be moved to new dispersal areas or find work within the UK or other countries. It is for these reasons that a participant group such as displaced medical healthcare professionals was considered an interesting but highly volatile sample group.

Strategies for collecting data from as wide a sample as possible were discussed earlier on in the chapter, yet even so, in practice, there were distinct unforeseen challenges in collecting the data for this project. Firstly, accessing the sample was an important consideration. Ethical clearance was obtained and the questionnaire was sent to the gatekeeper of the email database in the WARD group. This created an additional step and some agreements to participate in the questionnaires were returned to the gatekeeper, rather than to the researcher. Similarly, all follow up emails had to be sent through the gatekeeper and, although the gatekeeper was extremely helpful, this may have led to a delay in the reminders of the request to participate being received. It is difficult to gauge whether this had any impact to the response rate and it should be mentioned that the last response that was included in the study was returned almost ten months after the initial email was sent out.

The final question in the questionnaire was an invitation to participate further in the project and a request for the respondents to provide their personal email addresses so that the researcher could send them follow up questions directly. Those who agreed to provide their email addresses were sent open-ended questions, which mirrored the information that would be gathered in the semi-structured interviews for those participants who were still locally based. The thirteen respondents were all doctors and referred to within this study as Dr. A to Dr. L and included a respondent referred to as Dr. IE to identify this person as the unique respondent to the follow-up questions.

The first stage for the semi-structured interviews was to introduce the researcher, explain the project to the potential participants, including their rights in respect of the interviews and gather their informed consent. After this was done, the diagnostic language quizzes were distributed. The participants were asked to complete the quiz in their own time without referring to any notes and to try to answer the questions as accurately as possible. The researcher collected and analysed the quizzes and these formed the basis of the semi-structured interviews, which were conducted over the next three months, from November 2012 to January 2013. This participant sample consisted of nine interviewees: Two Sudanese doctors, Dr. Ali and Dr. Bader, two Iraqi doctors, Dr. Cadi and Dr. Dafi, A Syrian pharmacist, Dr. Farid, two Syrian doctors, Dr. Ghanem and Dr. Hadeel, one Azerbaijani doctor, Dr. Irene and one Iranian doctor, Dr. Jasmine. The transcripts of all of the interviews were returned to the interviewees for comment via email but, as noted before, this did not receive a high rate of response.

4.3.1 Transcription of the interview data

Using a modification of the conventions from Edley and Litosseliti (2010) and Mackey and Gass (2005) (see appendix 15) as a basis for the method of transcription, the exercise was approached with a philosophy of readability and provision of dignity to those who had agreed to undertake the interviews. Due to the fact that the participants were not English L1 speakers, and were likely to have been through a number of interviews in stressful situations, for example appealing for permission to remain in the UK or indeed in the IELTS Speaking interview, I felt that it was important to focus on meaning, wherever possible. Small hesitations or pronunciation errors, which did not otherwise obfuscate communication, were not included in reports. Although most obvious gaps in speaking were recorded to 0.10 seconds and stammering was transcribed, the focus of this study was on the opinions of the speakers more than a focus on any display of linguistic shortcoming

in the interviews. Due to the level of detail featured in the transcriptions, as well as the participants' non-standard language, this roughly equated to the estimated 20 hours of transcription to one hour of recording, as suggested by Mackey and Gass (2005). In quoting the raw data in this thesis, I have attempted to improve the readability of quotations by omitting inaccurate utterances and reformulations, indicated by three dots, or adding words, indicated by square brackets.

4.3.2 Reporting the Data

In order to ensure the validity of the project, it was essential that the data be reported accurately and to their fullest. The challenge was to manage partial data, overlaps in data and additional data collected from the follow up questions. For clarity here, a graphic representation of the way that the data were handled appears in figure 9.

| Questionnaire stage | Questionnaire data collected | Combined data collected | Interview data collected | Interview stage |
|-----------------------------|--|---|-------------------------------------|---|
| Electronic Questionnaires | Self-diagnosed SLEs | Information on SLEs | Diagnostic language quiz | Initial diagnostic language quiz |
| | 13/14 | 22/24 | 9/10 | |
| | Information on putative causal factors | Information on putative causal factors | Hexagon mapping exercise | Semi-structured interviews featuring hexagon mapping exercise |
| | 13/14 | 22/23 | 9/9 | |
| Email open answer questions | Follow up questionnaire responses | Further information on causal factors | Further questions on causal factors | Semi-structured interviews featuring hexagon mapping exercise |
| | 1/1 | 10/10 | 9/9 | |

Figure 9. A description of the data that was reported upon from the data collected

Here, figure 9 indicates that in the various data collection forms that were used in phase one, and how many of the responses were used due to the reasons outlined above. The numerical value '13/14' that is reported indicates that, although there were 14 responses in total, one was not reported as it was the set of responses from Dr. Irene, who took part in the semi-structured interviews. The figure for the follow up questionnaire responses indicates that only one response to this stage was received and it was reported in the findings. The figure 9/10 under the diagnostic language quiz indicates that the partial response from the participant who did not complete the interview process was not used.

For the sake of clarity in describing the data collected from the twenty-two participants in phase one, the phrase 'participants' is used to describe the entire group, 'questionnaire respondents' is used for the thirteen respondents to the questionnaire and 'interviewees' refers to the nine people who took part in the semi-structured interviews.

4.3.3 Returning the Findings to the Participants

In a similar way to the research carried out with refugee professionals by Smyth and Kum (2010), where possible, the final data were returned to the individual participants to reflect on the observations on their possible reasons for exhibiting SLEs, and to give some ownership of the findings to displaced medical healthcare professionals themselves. Of the twenty-two participants that featured in phase one of the study, thirteen were respondents to the questionnaire and nine others took part in the semi-structured interviews. The seven questionnaire respondents who provided their email addresses for further correspondence were contacted but only one replied to the summarised findings and request for further information.

Once each interview transcript was completed and analysed, it was sent out to the nine interviewees for their records, and also to ask them for any views on the

interview, or any further information that they wished to add. One participant replied to the email that was sent to confirm that the transcript had been received, and say thank you, but no views were offered.

It should be remembered that many of the participants had families and were working hard towards their goals of integration into UK life as well as training to pass the IELTS test. In addition, many of them had friends and families who were widely dispersed in several countries. With these pressures in mind, it is understandable that there was a low uptake in on-going participation in research and this was a feature of the participant group.

4.4 Methods of Analysis for Phase One

As described in the Research Design chapter, the main analytical framework was thematic and qualitative. This section will describe the different analytical tools used within the framework to engage with the data and address the research questions.

4.4.1 Methods of Analysis for the Questionnaire

The data for the questionnaire were collected electronically using the Checkbox questionnaire software. Within Checkbox, there are a number of options for exporting the data in order to run statistical analyses, each providing a different style of output for the results. The most widely used is the Statistical Package for the Social Sciences (SPSS). This software produces numeric information for quantitative analysis. Due to the low response rate to the questionnaire, the export of the data into SPSS did not reveal any significant patterns. The data were analysed manually. Another option within Checkbox was to export the data as a standard Comma Separated Value (CSV) file in Microsoft Excel. The name of the format is potentially misleading as a CSV file in this instance simply indicates that each response is entered into its own cell in an Excel table. This table was used to perform a thematic analysis across the responses to identify commonality between

the participants. This was then compared thematically to the data collected during the semi-structured interview to look for further relationship.

Finally, the Checkbox software is also able to generate visual data such as charts and tables for each of the questions. The user can select how the data will be presented before running the analysis and a report is produced. These reports were also used to account for some of the numeric data that was collected in the questionnaire, for example the number of years since the participants had worked as doctors or more detailed responses to the participants' identification of each of Han's (2004) six domains.

4.4.2 Methods of Analysis for the Follow-up Open Answer Email Questions

The response rate to the open answer follow-up questions was poor, with only one respondent replying to the requests for further information. The information was combined with information from the interviews in the transcription summary table. As such, the response was processed in the same way as the semi-structured interviews i.e. thematic analysis, coding, summary and comparative analysis to look for similarities, differences, commonality and relationships.

4.4.3 Methods of Analysis for the Diagnostic Language Quiz

As mentioned above, the quizzes were marked in order to identify the participants' problem areas in the same way as the questionnaire respondents were asked to identify their own problem areas. According to the scoring system that was outlined during the description of the pilots for the language quizzes, participants scoring less than 1 out of 4 possible accurate answers were identified as having significant problems with the particular area that was being tested. In addition, participants who scored 2 out of 4 accurate answers were identified as having minor problems in that area. The significant problem areas were discussed during the mapping exercise in

the second interviews. The minor problems were optional areas for discussion in the mapping exercise, depending on how many problem areas there were in total.

4.4.4 Methods of Analysis of the Semi-Structured Interviews

The semi-structured interviews were meticulously transcribed and then analysed thematically. In the first instance, data on the participants' profiles were summarised. Then the transcripts were read and re-read in order to extract themes relating to the relevant research questions, as well as for indicators as to which of the six domains they may have been describing. These were codified in order to input the data into a transcription summary table. Themes were summarised under the following headings:

- Participant Profile;
- Perceptions of their Own Common SLEs;
- Impact of Life History;
- Impact of Educational History;
- Impact of Other Experiences.

Once the summary table was complete, the transcriptions were then analysed through Harding's (2013) constant comparative method of analysis. The steps of the constant comparative method were taken based on the transcription summary that was produced. Firstly, two sets of data from two participants were compared to identify similarities and differences across the sets. Once both sets had been compared, a third set of data was compared to the similarities and differences from the first two sets. This is repeated until all similarities and differences across all the data from the participants have been noted and the list amended to show the similarities and differences between all participants. This list is then examined for commonality within the sample and for relationships that might be evident in the data.

A second review of the transcripts was also used to analyse the themes under the headings of Han's six domains. This was intended to detect any statements that

confirmed or contrasted with the domains that the participants talked about during the mapping exercise.

4.5 Participant Profiles

Tables 11 and 12 below provide information on the profiles of the twenty-two participants in phase one of the data collection. They are intended to summarise the comparable data that were collected from the participants in both the questionnaires and the semi-structured interviews. A complete picture of the data that were returned from the questionnaire can be seen in appendices 16, 17 and for the single respondent to the follow up emails, in appendix 18. Correspondingly, a constant comparison of the transcript data that were collected is available in appendix 19 and a transcription summary of the data is presented in appendix 20.

In order to maintain anonymity, each of the thirteen questionnaire respondents is referred to as 'Dr.' followed by a letter that was alphabetically ordered reflecting the order in which their data were gathered. For example, the first questionnaire respondent is referred to as 'Dr. A', the second questionnaire respondent is referred to as 'Dr. B' and so on. The nine interviewees were provided with pseudonyms based alphabetically on appropriately gendered names from their countries of origin e.g. Dr. Ali to Dr. Jasmine.

Table 10. Personal details of the questionnaire respondents

| Questionnaire data | | | | | |
|---------------------------------|-----------------------|--------------------|---------------------------------------|-------------------------------------|------------------------------|
| Questionnaire Respondent | First language | Nationality | Country in which PMQ was taken | Proportion of PMQ in English | Time learning English |
| Dr. K | Arabic | - | Iraq | 90% | 7 years or more |
| Dr. I | Arabic | British | Ukraine | 80% | 1 year |
| Dr. E | Arabic | Dutch | USSR | 0% | 7 years or more |
| Dr. D | Arabic | Iraqi | Iraq | 100% | 7 years or more |
| Dr. F | Arabic | Iraqi | Iraq | 100% | 7 years or more |
| Dr. G | Arabic | Iraqi | Iraq | 99% | 2 years |
| Dr. IE ² | Arabic | Iraqi | Iraq | 100% | 7 years |
| Dr. H | Arabic (and Zaghawa) | Sudanese | Sudan | 100% | 2 years |
| Dr. A | Burmese | - | Burma | 100% | 3 years |
| Dr. L | Burmese (and Mizo) | - | Burma | 60-85% | 3 years |
| Dr. B | Dari | - | Afghanistan | 1% | 3 years |
| Dr. C | Dari | British | Afghanistan | 10% | 7 years or more |
| Dr. J | Urdu | - | Pakistan | 100% | 7 years or more |

² Dr. IE was the only questionnaire respondent to reply to the follow up open answer questions

Table 11. Personal details of the interviewees

| Interview data | | | | | |
|----------------|---------------------------|-------------|--------------------------------|--|-------------------------------------|
| Interviewee | First language | Nationality | Country in which PMQ was taken | Proportion of PMQ in English | Time learning English |
| Dr. Cadi | Arabic | Iraqi | Iraq | 100% | Intermittently for 12 years |
| Dr. Dafi | Arabic | Iraqi | Iraq | 100% | 15 years |
| Dr. Ali | Arabic | Sudanese | Sudan | Most subjects | Intermittently for 15 years |
| Dr. Bader | Arabic (and Zaghawa) | Sudanese | Sudan | 60% | Intermittently since high school |
| Dr. Farid | Arabic | Syrian | Syria | 0% | 2 years |
| Dr. Ghanem | Arabic | Syrian | Syria | 0% | Intermittently for 15 years |
| Dr. Hadeel | Arabic | Syrian | Syria | 0% | Intermittently since primary school |
| Dr. Jasmine | Farsi | Iran | Romania | Most of it, apart from hospital placements | Intermittently since primary school |
| Dr. Irene | Russian (and Azerbaijani) | Russia | Russia | 0% | Intermittently since primary school |

Tables 10 and 11 show information on the twenty-two participants' identities and their experiences in using English, according to the thirteen questionnaire respondents and nine interviewees. Central to the study are the first languages of the sample group. In order to represent this in both tables, the participants in each group (questionnaire respondents and interviewees) were sorted via first language, then nationality (where details were provided) and then the country in which their PMQ was taken. Any mention of an equal status L1 was added to the relevant participant details after the data were sorted. In looking at their first languages, it was revealed that fourteen of the twenty-two participants stated that their first language was Arabic, although two stated that L1 Arabic was on equal status with Zaghawa. Two stated their L1 was Burmese one having equal status with Mizo, and another two described their first language as being Dari. One of the questionnaire respondents

gave Farsi as their first language. Although the differences between Dari and Farsi can analogously be described as the same as those between American English and British English, the project aims to represent the participants as accurately as possible and therefore they have been treated as discrete languages in this study. One of the interviewees stated that their first language was Russian and one Urdu. To refer back to the literature review chapter, Crawley and Crimes' (2009) questionnaire of refugees living in Wales states that many of their respondents were from Arabic, Pashto and Farsi L1 countries and the results reflect their data. The Russian and Burmese respondents appear to be outliers in the literature but, in my experience, they are not unusual backgrounds for a small number of the clients of the WARD group.

As is evident in the tables above, five of the thirteen questionnaire respondents declined information on their nationality. Tables 11 and 12 also show us that six of the twenty-two overall participants identified themselves as Iraqi and this formed the majority of the sample. The next largest groups were Sudanese and Syrian with three participants coming from each country. Among the remaining participants who provided information on their nationality, one was Russian and one was Iranian. Three of the questionnaire respondents stated that they were European nationals with two identifying their nationality as British and another as Dutch.

Also in the review of the literature was the fact that, depending on where they took their PMQ, many doctors studied for this through the medium of English. The participants who qualified in Iraq mentioned that 90 – 100% of their qualification was taught in English, yet two of the participants who took their PMQ in Iraq stated that they had been learning English for less than two years. According to the GMC, a PMQ is defined as:

...a programme of study comprising at least 5,500 hours over a minimum period of three years, or four academic years full time equivalent study.

(GMC, 2014f)

As such, this raises questions about definitions of 'learning English'. It appears that Dr. G had separated their PMQ, the vast majority of which was in English, from explicit English language learning claiming to have learnt English for only two years. While this is perfectly understandable, it does not account for the amount of linguistic input that taking a qualification in English would afford. Proponents of CLIL (Mehisto, Marsh and Frigols, 2008; Coyle, Hood and Marsh, 2010) might argue that this is a very relevant form of language learning. Similarly, it may be seen as an exemplar of the classical concept of input hypothesis in practice (Krashen, 1982; VanPatten, 1996). This difference in perception of the meaning of 'learning English' seems to be common in the questionnaire respondents, with the only interviewee, Dr. Farid, stating that he had been learning English for just two years:

After I left school, I started to learn English in English courses in the local institutes in Damascus for two years, then I stopped learning English and it was a sufficient level for me to manage my needs in this language.

He quickly followed this up by mentioning that he had not taken a PMQ that was delivered in English and his strategies for accessing information:

Unfortunately, in Damascus University all the subjects were in Arabic and that's what they are proud of in terms of nationals and the Arabic language but in order to improve myself in the university I had to supplement I had to study English books to improve my level.

The participants who completed their qualifications in Sudan said that between 60 – 100% of their qualifications were in English. In one case, there is a similar response to the previously mentioned Iraqi doctor's on the question on time learning English, where Dr. H's PMQ was 100% delivered in English but s/he only declared learning English for two years. The remaining two Sudanese participants acknowledged a much longer period of study.

The participants with Syrian PMQs all said that none of their learning was through the medium of English. Although some of them mentioned that they supported their learning by reading English textbooks, it was stated during their interviews that this was a policy of the Syrian government. In the case of this group, their English language learning experiences were much more varied. The interviews revealed that Dr. Farid had begun English language learning as an adult learner, Dr. Ghanem had begun his learning in high school and Dr. Hadeel had spent a large part of their formative years in the UK.

The participants referred to as Dr. I and Dr. E have unusual profiles. While both state that their first language is Arabic, both are identified as European nationals: British and Dutch respectively. Dr. I undertook their PMQ in the Ukraine and stated that 80% of it was delivered in English but that they had studied English for one year. Dr. E did their PMQ in the USSR and none of it was in English yet they stated that they had studied English for more than seven years.

While one questionnaire respondent who was awarded their PMQ in Burma stated that it was delivered 100% in English, the other Burmese respondent stated that the delivery was between 60 – 85% in English. In both cases, the participants state that they had studied English for three years.

It also appears that PMQs delivered to the participants in Afghanistan used very little English. Dr. B said that they had studied English for three years, whereas Dr. C, who was identified as a British national, had studied English for more than seven years.

The final three displaced medical healthcare professionals are single cases regarding their first languages, their nationalities and the places where they took their PMQs. The Iranian doctor, Dr. Jasmine, studied most of her PMQ in English although it was taken in Romania. They all stated that they had learnt English intermittently since primary school. Dr. Irene, a Russian Azerbaijani, took her PMQ

in Russia and none of it was delivered in English. During the interviews, this was revealed as being at her discretion, as she had been given the option to take some of it in English. She had been learning English intermittently since school, but in the interviews made the distinction between learning a language as a part of the school curriculum and two years of studying the language for self-improvement. The Urdu L1 respondent who was awarded the PMQ in Pakistan said that it was 100% delivered in English and claimed to have studied English for more than seven years.

This reflects the varied experiences that the participant group have had in learning English. It also exemplifies the varied definitions that they had when providing information on the length of time they had been learning English. It seems that for some, they had a very strict definition that referred to discrete English language lessons. In some cases, it appears that they have failed to acknowledge the more holistic linguistic input they may have received, either in their daily lives in the UK or in more formal situations, for example when they were studying for their PMQs. In addition, many of the participants stated that they had learnt English intermittently. This hiatus in instruction may have meant that they have become accustomed to using non-standard forms that, in turn, may have been internally consolidated as SLEs.

4.5.1 Additional Profile Data Collected in Questionnaires

The respondents were aged between 30 and 54, with seven of them in their 30s, three in their 40s and three in their 50s. As shown later in the findings, it did not appear that age was an issue that they felt affected them negatively with their SLEs. In order to substantiate this, a comparison table of age, number of times taking the IELTS test and the respondents' maximum scores was produced.

Table 12. Statistical data on the profiles of questionnaire respondents

| Name | Age | Number of times taking IELTS | Max. score |
|-------------|------------|-------------------------------------|-------------------|
| Dr. A | 35 | 3 | 7.0 |
| Dr. B | 43 | 4 | 7.0 |
| Dr. C | 49 | 10 | 7.5 |
| Dr. D | 38 | 5 | 7.0 |
| Dr. E | 54 | 3 | 7.0 |
| Dr. IE | 50 | 3 | 7.0 |
| Dr. F | 38 | 5 | 7.0 |
| Dr. G | 33 | 3 | 7.0 |
| Dr. H | 30 | 10 | 7.0 |
| Dr. I | 42 | 6 | 6.5 |
| Dr. J | 34 | 2 | 8.0 |
| Dr. K | 51 | 3 | 7.0 |
| Dr. L | 36 | 3 | 7.0 |

As the table above shows, there is no clear pattern relating of age and number of times taking the IELTS test in this sample.

All of the questionnaire respondents stated that they were doctors, which indicates that twelve of the thirteen respondents had achieved the minimum entry requirement for entry into the GMC. However, it is not certain when they attained their scores or whether they had achieved a minimum of 7.0 in each skill.

The questionnaire also asked about the length of time the respondents had served as a doctor. The responses are detailed in figure 10 below.

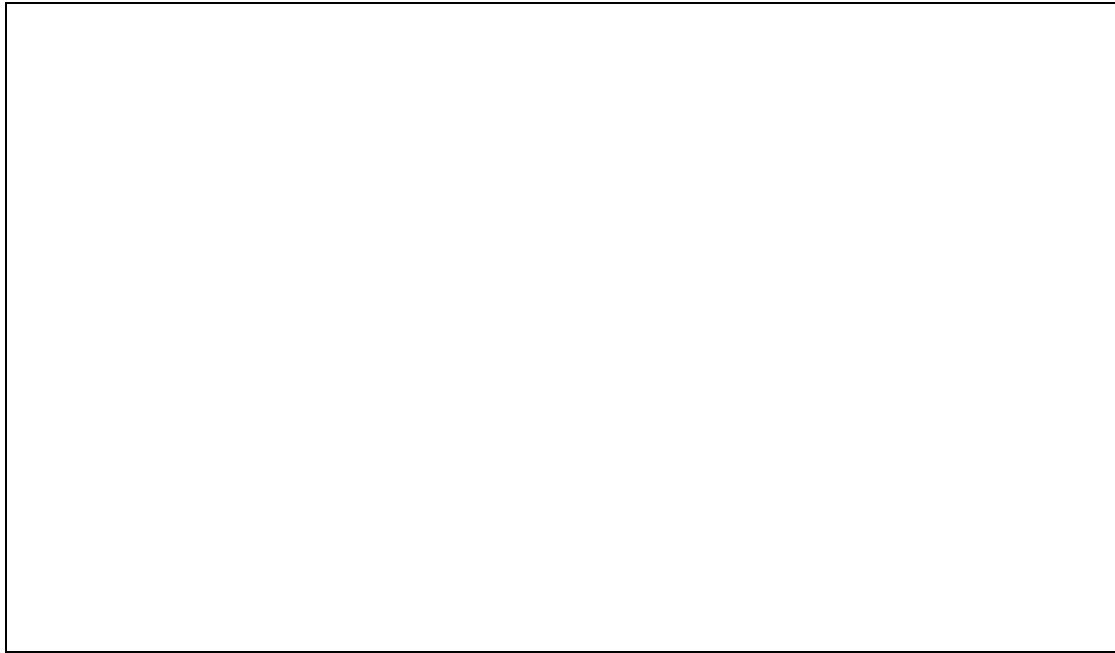


Figure 10. Length of time serving as a doctor

The questionnaire showed that eight of the doctors, over half of the group, stated that they had worked as doctors for seven years or more. Of the remaining five respondents, one, Dr. G, said that they had worked as a doctor for six years. Dr. I had worked as a doctor for five years, whereas Dr. L said that they had been in practice for four years. Two doctors, namely Dr. A and Dr. H, had worked in their professions for two years. In total, the respondents have a combined professional experience of more than seventy-five years.

In order to ascertain the hiatus in professional practice that displacement represents, the respondents were also asked about the length of time that had elapsed since they had worked as a doctor.

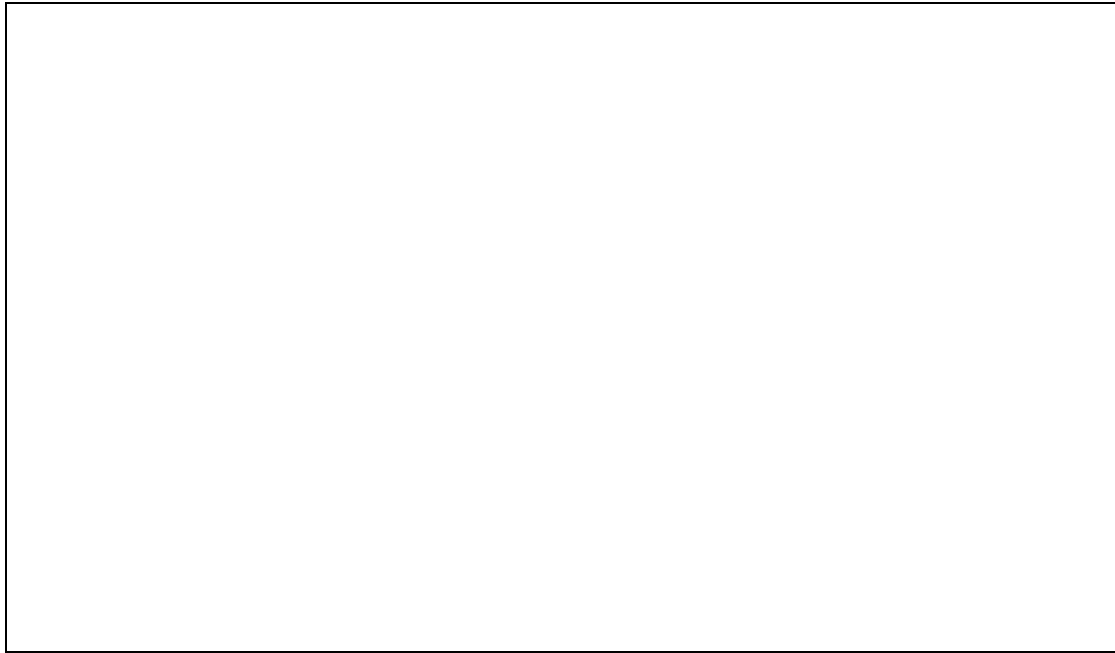


Figure 11. Length of time that had elapsed since working as a doctor

As figure 11 indicates, eight of the doctors had experienced a hiatus in their practice of four or more years, which represents a considerable break in their careers. Five respondents had not worked in their profession for seven years or more. Dr. A and Dr. I had not worked as doctors for five years, Dr. I for four years and Dr. H for two years. Four of the respondents stated that it had been less than one year that they had not worked as a doctor. The data do not explicitly indicate that these were currently working as doctors but in all four cases, the same respondents stated that they had been in an English speaking country for more than seven years, and have a maximum IELTS score of 7.0. A table comparing the length of time that the participants claim they spent learning English with the length of time they have spent in an L1 English country follows.

Table 13. Length of time in an English L1 country

| Respondent | English language learning | Length of time in an English first language country |
|-------------------|----------------------------------|--|
| Dr. A | 3 years | 7 years or more |
| Dr. B | 3 years | 3 years |
| Dr. C | 7 years or more | 7 years or more |
| Dr. D | 7 years or more | 7 years or more |
| Dr. E | 7 years or more | 4 years |
| Dr. IE | 1 year | 6 years |
| Dr. F | 7 years or more | 7 years or more |
| Dr. G | 2 years | 6 years |
| Dr. H | 2 years | 2 years |
| Dr. I | 1 year | 4 years |
| Dr. J | 7 years or more | 7 years or more |
| Dr. K | 7 years or more | 6 years |
| Dr. L | 3 years or more | 7 years |

The definition of 'English language learning' is dynamic and likely to mean different things to different people. In some cases in table 13, the length of time in an English L1 country and the length of time learning English seemed to complement each other. In other cases, for example the case of Dr. E, the respondent stated that they had been learning English for longer than they had been in an English L1 country. This was due to English language learning prior to arrival in the UK. Finally, there were instances of respondents who stated that they had been learning English for a shorter amount of time than they had been in an L1 country. Five respondents, Dr. A, Dr. IE, Dr. G, Dr. I and Dr. L all fell under this category. While it may be a case of the participants finding small pockets of their own language communities and taking up English language learning after a long period of adjustment, it should be noted that three of them had studied 100% of their PMQ in English, Dr. I 80% and Dr. L 60-85%. This indicates that these participants had a very large amount of input in terms of CLIL and immersion methods.

On the subject of input, in the literature review chapter, it was mentioned that Gillet (2013) estimated that an IELTS test taker could improve by one IELTS band score in three months of full time study. This led to a possible conclusion that a person can

increase their IELTS score from 1.0 to 7.0 in eighteen months. This seems to be a very high expectation and there are too many variables around this statement to use it as a direct form of measurement. Notwithstanding, it is the closest estimation available from the IELTS organisation, and provides us with a baseline for managing the expectations of people training for the passport test. This may serve to justify the statements of Dr. I and Dr. IE, who achieved 6.5 and 7.0 respectively in the IELTS test, yet claim to have learnt English for just one year prior to their questionnaire responses.

The last question that was featured only in the questionnaire was the one on the skills that the participants were most confident in using. In the IELTS test these are divided into four areas: Listening, Speaking, Reading and Writing.

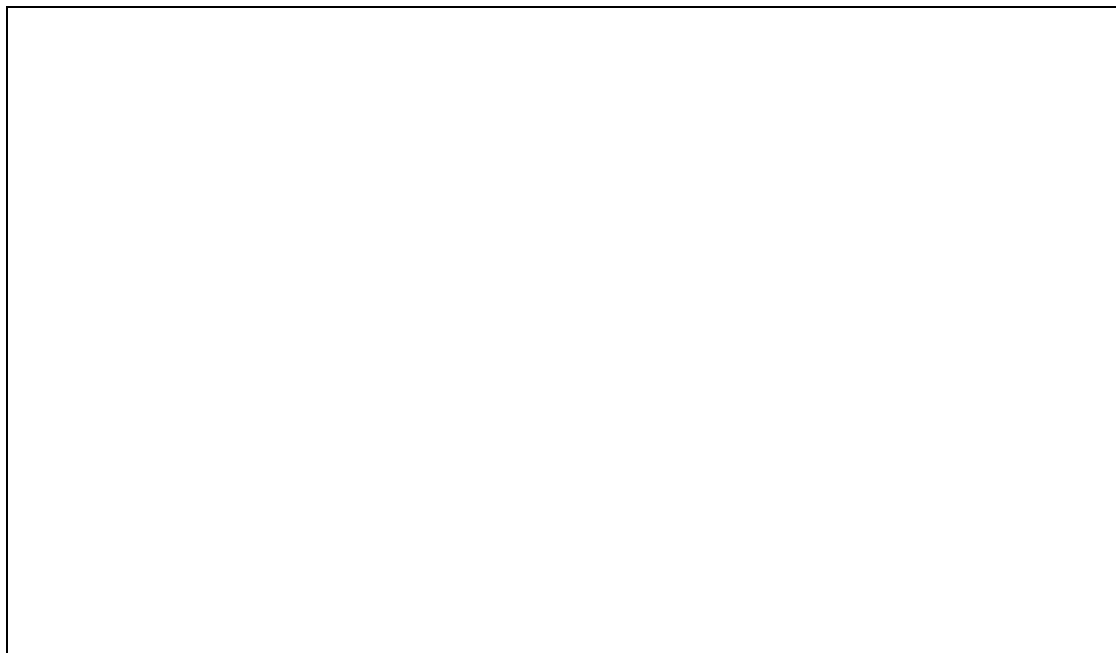


Figure 12. Skills that the participants were most confident in using

The levels of confidence in each skill in figure 12 reflect closely the overall results from the IELTS test that were discussed in the literature review chapter. English is notoriously difficult in its written form and, as mentioned in the literature review chapter, this is the weakest area for the majority of the people who take the test.

Similarly, most test takers, particularly those from the language areas that are involved in this study, succeed more highly in speaking than the other skills.

On analysis of the individual results, the data indicate that three respondents felt confident in all four skills, which would also account for the three respondents who showed that they were confident in writing in figure 12. One participant felt confident in listening, speaking and reading. Another two felt that they were confident in the receptive skills i.e. listening and reading. One respondent seemed confident in listening and speaking and another felt most confident in speaking and reading. Three respondents said that they felt confident in speaking, one in listening and one in reading. No one stated that they felt confident in just writing and none of the participants said that they did not feel confident in any of the skills.

4.5.2 Vignettes of Interviewees

As the data set is small scale and it is made up of an unusual population, displaced medical professionals, vignettes of the interviewees have been provided. The use of vignettes in recent literature is well supported by Humphries' description of reflexivity in autoethnographic vignettes:

I used narrative vignettes described by Erickson (1986) as "vivid portrayal[s] of the conduct of an event of everyday life" (p.149) to enhance the "contextual richness" (Miles and Huberman, 1994, p.83) of ethnographic research...

Humphreys (2005, p.842)

The following vignettes on each of the interviewees were compiled from the interview data, field notes and additional information that was provided by their teacher.

Dr. Ali

Dr. Ali was from Sudan and spoke Arabic as a first language. Although he was familiar with a local dialect, he did not consider himself fluent in it when he was in Sudan and felt he had since then lapsed in the skills that he had in the dialect. He enjoyed his early educational experiences and had fond recollections of a native

English teacher who taught him in school. Dr. Ali seemed to suffer from performance anxiety during the interview and was unusual in that he appeared to disagree with the results from the diagnostic language quiz. This in itself may represent Dr. Ali's main barrier to progress. He had been trying to pass the IELTS test for the five years that he had been in the UK and was still committed to his goals. Since conducting the interview, Dr. Ali passed the IELTS test on his fourth attempt. He also completed further PLAB qualifications to register with the GMC.

Dr. Bader

Dr. Bader was the only interviewee who stated that he had two first languages of equal status: Sudanese and Zaghawa. He had studied English since high school on a fairly intermittent basis. In his early years, his teachers seemed to use a grammar translation approach and delivered most of their English classes in their L1. He felt that this approach was not sufficient, particularly when he had just one or two hours of learning English each week. Roughly 60% of his Sudanese PMQ was delivered in English, particularly the examinations and the core texts that were used. At the time of the interview, Dr. Bader had been in the UK for eighteen months. Since the interview, Dr. Bader failed his sixth attempt at the IELTS test and seemingly dropped out of the classes.

Dr. Cadi

Dr. Cadi was from Iraq. At the time of his arrival to the UK, three years before the interview was conducted, there were still British troops in Iraq and he said that he had experienced serious culture shock. For the first two years, he relied on other members of the local community to conduct his affairs on his behalf, for example, helping him to arrange accommodation and purchase basic goods. This had a dual impact as he realised that this was stalling his integration into UK life, as well as reinforcing the interlanguage errors of his peers in his own language learning. He appeared to be attempting to address his learning strategies and improve his

confidence in speaking to native speakers. Dr. Cadi ceased to attend the IELTS classes after seven failed attempts.

Dr. Dafi

Dr. Dafi was an Iraqi doctor in his twenties and in the early stages of his career at the time of his displacement. He appeared to be strong-minded and determined to follow his own independent study agenda. He had been trying to pass the IELTS exam for some time and had experienced demotivation from getting substandard results. He had been in the UK for eighteen months. In relating his socio-affective experiences, he mentioned a humorous linguistic misunderstanding, in which he misinterpreted the phrase "I'm a married woman" as "I married a woman" and took it to be a cultural difference. He observed that strategies for the IELTS exam are very different from the strategies for learning English that he uses. After eight attempts, Dr. Dafi passed the IELTS test.

Dr. Farid

Dr. Farid was a pharmacist from Syria and had arrived in the UK six months prior to the interview. He was the only interviewee who had not had English lessons during his primary and secondary schooling. As an adult, he decided to learn English independently in a private school. During the interview, Dr. Farid was interested in the reasons behind the questions that I was asking him and was quite analytical in his answers. He seemed to prefer group work and practical study to intensive theoretical work. This was reflected in his apparent position within the group during the focus group interviews, as well as his attitude towards the group. He was clearly a leading member who motivated others to study in the group environment. Dr. Farid took the IELTS test twice and achieved the necessary score to enter a higher degree in his field.

Dr. Ghanem

Dr. Ghanem was a Syrian dental surgeon. Although Arabic was his first language, he felt that he was more proficient in French than in English. He studied his orthodontics degree in France in the medium of French. He was working very hard to improve his level of English and took every opportunity to practise, including attending a variety of classes in the local area. Dr. Ghanem came to the UK six months prior to the interview because his wife, Dr. Hadeel, and their children held British passports. He was also very involved in his children's schooling and saw this as a further opportunity to improve his English and to integrate more successfully. Shortly after the interviews, Dr. Ghanem passed the IELTS test with the necessary score to join the General Dental Council (GDC), which was a grade of 7.0 overall with no less than 6.5 in any skill.

Dr. Hadeel

Dr. Hadeel held a British Passport but needed IELTS for entry to the GMC due to the fact that she received her PMQ in Syria. She grew up in the UK while her father was a university student and had spoken English from a very early age. She returned to live in the UK six months before the interview. She mentioned that her listening and speaking were a lot stronger than her reading and writing and this may have led to her feeling artificially confident in her overall skills. She also felt that being in classes with people with mixed abilities at lower levels than her own, was holding her progress back. Twelve months after the interview, Dr. Hadeel passed the IELTS test on her sixth attempt and was working towards registration with the GMC.

Dr. Irene

Dr. Irene completed the questionnaire as well as participating in the interviews. She described herself as both Russian and Azerbaijani in giving her national identity and when referring to her L1. She had been in the UK for two and a half years. Although she stated that her strongest language was Russian, due to it being the language of the state, Azerbaijani was her home language. She was talkative during the

interview and reflective in her statements when discussing her attitudes towards learning English in the past. Shortly after the interviews, Dr. Irene passed the IELTS test on her first attempt.

Dr. Jasmine

Dr. Jasmine was a polyglot from Iran who studied for her Primary Medical Qualification in Romania. Apart from her native Farsi and English, she also had a degree of competence in speaking Arabic, Turkish and Romanian. She described her experience in trying to pass the IELTS test as being 'like a tree with weak roots that is expected to repeatedly produce fruit'. She was very talkative and personable at all times but declined to answer some of the more personal questions around her reasons for coming to the UK two years before the interview. Dr. Jasmine attended the IELTS classes for a considerable period of time and achieved the necessary score to join the GMC on her first attempt.

4.6 Research Question One: What are Displaced Medical Healthcare Professionals' Perceptions on their Own Common SLEs?

As discussed in the methodology chapter, the research questions were intended to foreground the views of the participants. The decision to do this was not only to provide a disempowered group with a voice, and therefore address the criticisms of fossilization studies that assumptions are made by researchers in a top down way about participants' language errors, but also to ask the participants to reflect on their own learning journeys that began long before the research project. While the questionnaire asked the participants to diagnose their own problem areas, the opportunity was taken to use my professional skills, knowledge and experience to diagnose the interviewees' problem areas in grammar, orthography and

pronunciation. This allowed an element of cross analysis in the data that was collected on their SLEs.

4.6.1 Analysis of the data on SLEs

Table 14 below is a numeric count of the problem areas in both the questionnaires and the diagnostic language quizzes that preceded the semi-structured interviews. The differences between the questionnaire data and the data from the diagnostic quiz were that the questions on the auxiliary verbs 'have and be' and problems with 'do' were separated in the questionnaire, while the questions on punctuation and spelling were grouped together. In addition, the diagnostic language quizzes included questions on pronunciation and interrogatives, which were not in the questionnaire. In order to account for this, each distinct category was entered discretely in the reporting of the data. Data provided by the only questionnaire respondent to contribute to the follow-up open answer email questions, Dr. IE, is reported under the questionnaire data here.

Table 14. The problem areas highlighted in the project

| Linguistic area | Questionnaires n=13 | Interviewees n=9 | Total n=22 |
|--|------------------------|---------------------|---------------|
| a/an/the | 3 | 0 | 3 |
| at/in/on | 5 | 5 | 10 |
| comparison & contrast | 2 | 6 | 8 |
| conditionals | 5 | 1 | 6 |
| do | 1 | 0 | 1 |
| have/be | 2 | 0 | 2 |
| infinitives & gerunds | 4 | 4 | 8 |
| interrogatives | N/A | 0 | 0 |
| it/they/them | 1 | 3 | 4 |
| modal verbs | 4 | 4 | 8 |
| passive voice | 1 | 2 | 3 |
| past and perfect verb tenses | 4 | 4 | 8 |
| prepositions w/ nouns & verbs | 4 | 0 | 4 |
| pronunciation | N/A | 4 | 4 |
| punctuation | 10 | 2 | 12 |
| spelling | 10 | 1 | 11 |
| subject/verb/object | 1 | 0 | 1 |
| superlatives | 3 | 1 | 4 |
| uncountable nouns | 3 | 3 | 6 |
| when/if/whether | 1 | 0 | 1 |
| who/which | 3 | 0 | 3 |
| TOTAL | 67 | 40 | 107 |
| Total after adjustments | 57 | 36 | 93 |
| Average number of errors identified per participant | 4.4 | 4 | 4.3 |

To gain an overview of the amount of linguistic problems the participants exhibited, the number of problem areas was totalled and divided by the number of participants in the questionnaires and interviews respectively. This overview provided an insight into how the participants in the questionnaire judged their own language problems, as opposed to how I assessed the interviewees' problem areas. Table 14 shows us that the participants who provided their own diagnosis of their language problems in the questionnaires tended to state that they had more language problems than the interviewees who took the diagnostic language quiz. The items marked as N/A were not featured in the questionnaires but were added in the diagnostic language

quizzes. After the adjustments described above, the figures were that the questionnaire respondents had an average of 4.4 errors per participant whereas the diagnostic quiz indicated that there were 4 errors per participant. The total for the questionnaires is higher by ten due to reporting of both punctuation and spelling. This was not the same for 'have', 'do' and 'be' as these categories did not come up in the diagnostic language quizzes. However, the total for the diagnostic language quizzes is higher by a count of four due to the addition of the question on pronunciation. This was not the case for the questions on interrogative as none of the participants exhibited problems with this area. This means that the total for the questionnaires is fifty-seven and the comparable total for the diagnostic language quizzes is thirty-six. This is striking as the majority of the questionnaire respondents had achieved an IELTS score of 7.0 or above, whereas the interviewees were all still studying to achieve the GMC minimum entry requirements. This may be due to the difference in asking participants to self-diagnose their errors, as in the questionnaire, rather than having the researcher analyse the errors using the diagnostic language quiz, or some other reason such as more currently active awareness of language for those participants who were actively studying for the IELTS test at the time of data collection. The potential deterioration of language awareness reflects Ross' (2007) definition of backsliding as mentioned in section 2.3.2, which describes the candidate as losing proficiency after a benchmark threshold has been achieved.

Of the nine interviewees, all agreed that there were problematic areas in their English. Four of the interviewees agreed with the SLEs that had been identified in the diagnostic quiz, three filtered out the minor problem areas to focus on the significant problem areas. One interviewee attributed the results of the diagnostic quiz to regression after a hiatus in studying. Another interviewee felt that one area that was strongly identified in the quiz as a problem was in fact negligible. Interestingly, there seemed to be a correlation between the number of problems that

were identified and the reluctance of the participants to admit that these were indeed problems. Those who appeared to have a large number of problems according to the diagnostic language quiz seemed less forthcoming in acknowledging these problem areas. This may be a simple case of the participants trying to protect their self-esteem. Alternatively, it may be that their understanding of particular grammatical areas is intact at lower levels but that they have not yet mastered those areas. To exemplify this, some of the participants told me that they knew how to use articles with vowel sounds but it seemed that there were still gaps in their knowledge of how to use them on a more advanced level.

Notwithstanding, table 14 identifies that the top problem areas were punctuation and spelling. With regard to these areas, it should be remembered that these features of the English language present problems for native speakers, as well as English L2 learners. Crystal (2002) states that 'According to some estimates, as many as 2 per cent of the population have a major, persistent handicap in spelling.' There is a similar story with punctuation. While Cook (2004) tells us that 91 per cent of English punctuation consists of commas and full stops, leading to the suggestion that mastery of these punctuation marks will suffice in most cases; many native speakers have difficulties in using advanced punctuation. In light of this, it could be claimed that the participants' SLEs, as identified in the data, begin with prepositions and verb tenses and forms. In turn, this strongly correlates with the problems highlighted by Swan and Smith (2011), many of which were detailed in table 7 in the literature review chapter.

Table 15. Instances of problem areas selected by displaced medical healthcare professionals during interviews, organised according to their language groups

| | Arabic n=16 | Burmese n=2 | Dari n=2 | Farsi n=1 | Russian n=1 | Urdu n=1 |
|--|--------------------------------|-------------|-----------|-----------|-------------|----------|
| a/an/the | 2*† | - | 1*† | - | - | - |
| at/in/on | 5*† | 2† | 2† | - | 1*† | - |
| comparison & contrast | 6† | - | 1† | - | 1*† | - |
| conditionals | 5* | - | 1* | - | - | 1*† |
| do | - | - | 1*† | - | - | - |
| have/be | 2*† | - | - | - | - | - |
| infinitives & gerunds | 6* | - | 1* | - | - | 1† |
| it/they/them | 1† | - | 1*† | 1*† | 1† | - |
| modal verbs | 6† | - | 1*† | - | 1*† | - |
| passive voice | 3* | - | - | - | - | - |
| past and perfect verb tenses | 6*† | - | 1*† | 1*† | - | - |
| prepositions w/ nouns & verbs | 1*† | 2*† | 1*† | - | - | - |
| pronunciation | 4† | - | - | - | - | - |
| punctuation | 8*† | 2*† | 1*† | 1*† | - | - |
| spelling | 8*† | 2*† | 1*† | - | - | - |
| subject/verb/object | - | - | 1* | - | - | - |
| superlatives | 3 | - | 1* | - | - | - |
| uncountable nouns | 5† | - | 1† | - | - | - |
| when/if/whether | - | - | 1† | - | - | - |
| who/which | 1* | - | 1* | - | - | 1*† |
| TOTAL INSTANCES | 72 | 8 | 18 | 3 | 4 | 3 |
| TOTAL ACCORDING TO ERROR SOURCE | 47*, 54†, 3 (neither* nor†) | 6*, 8† | 13*, 13† | 3*, 3† | 3*, 4† | 2*, 3† |

* common errors between L1 and TL † common mistakes at IELTS 7.0 or above

In table 15, the results were compared to the common errors in IELTS at level seven or above (Moore, 2007) and cross-referenced against the common errors as described by Swan and Smith (2011). The table compares the number of instances that the respondents felt that they exhibited these problem areas. Conditionals, infinitives and gerunds, passive constructions, subject-verb-object, superlatives and relative clauses with 'who' and 'which' are not common errors in IELTS; however, they are common errors for the various participants' L1s. In most instances, where there is not a common problem between their L1 and English, there is a common error in IELTS, which would suggest that it might be a particularly difficult area of English for most learners from any L1 background to master e.g. comparison and contrast. This does not seem to be the case with Arabic speakers and the use of superlative adjectives, which seems to be neither a common mistake in IELTS nor in their L1. This might be explained by individual errors, as there were only three instances of this being a problem out of sixteen Arabic speakers.

Due to the small sample size, it was more difficult to make observations about the speakers of other languages. In the case of Russian and Farsi, the participants seemed to have identified common errors for their respective languages, but it may also be that these are particularly difficult areas of the English language as they are also identified in common errors in IELTS. This is slightly different for the Dari speakers where one respondent, Dr. B, identifies problems with articles and prepositions but the other, Dr. C, selected almost every area that was mentioned in the quiz. This is interesting insofar as Dr. C achieved 7.5 in the IELTS test but this score was achieved after ten attempts, which alongside Dr. H, was the highest number of attempts indicated in the study. If we consider the positive impact of taking mock IELTS tests, this level of 'rehearsal' may have had a positive impact on the final results for Dr. C and Dr. H. Similar to the Farsi and Russian speakers, the two Burmese speakers seem to corroborate each other, most of the common errors of transfer from their L1, and the common errors in IELTS. Although Dr. J, whose L1 is Urdu, struggled in four

areas, it seems that only two of them are attributable to the common errors for Urdu speakers. They were all, however, common mistakes in IELTS at level 7.0 or above.

Overall, the matrix of participant errors in table 15 demonstrates that many of the participants exhibited common errors in transferring from their L1 to English. Many of these are also common errors in IELTS above 7.0.

4.6.2 Findings for Research Question One

The participants seemed to have varying ideas on the definition of 'learning English', which in many cases did not seem to acknowledge using English as a medium for learning medicine, or using English in an English speaking environment, which was not a formal language learning experience.

Another key finding was that the questionnaire respondents, the majority of whom had IELTS at 7.0 or above, identified more stabilized errors in their language use than the interviewees, who were tested for errors above 7.0 and common L1 errors. There are a number of possible reasons for this. One reason may be that the people who had achieved 7.0 felt that, although they had achieved the necessary requirements to join the GMC at the time of their assessments, a level of 7.0 in IELTS does not indicate native-like fluency in the language. Perhaps they were still aware of some remaining errors in their English language production and understanding. Alternatively, it may be that they had not had specific language training since passing the IELTS test and their levels had regressed slightly. It should be remembered that IELTS certificates are only valid for two years, an acknowledgement of this point. Similarly, it may also be that the interviewees had had training that is more current and were more accustomed to frequent testing and therefore performed better in the diagnostic language quizzes. The fact that the majority of the interviewees passed the IELTS test at the necessary levels soon after the interviews took place suggests that they were very close to the desired level at the time of the interviews.

Another important finding was that the common errors in IELTS appeared to be slightly more evident in the data than common errors relating to L1 interference. This suggests that the task of learning English, particularly to the higher end of the IELTS scale is a relatively equal challenge for all learners. Peculiarities of L1 forms and structures may be recognised, understood and replaced by English forms more easily than the various inherent idiosyncrasies that exist in academic English. This may be exacerbated by the nature of the IELTS academic test, which tests small chunks of text on a local/literal level in academic contexts (Moore, Moreton and Price, 2011), as mentioned in the IELTS discussion in the literature review chapter.

It was also evident that the most common problem areas, spelling and punctuation, were areas that present challenges for L1 users of English. The analysis of the data suggests that the problem areas for the participants, prepositions and verb tenses and forms correlates with the literature (Swan and Smith, 2011) on interlanguage that exists between the language groups featured in this study and English.

4.7 Research Question Two: In the Participants' Views, What is the Impact of Life Histories, Educational Histories and Other Experiences on SLEs?

The questionnaires asked participants to select from the options that were provided to them in terms of the reasons that they felt that each domain might be the causal factor of their SLEs. In the interviews, participants were asked to map the problem areas that the diagnostic language quizzes identified to the domain that they felt might be the causal factor for the particular problem. The interviewees were then asked to provide their own rationale for the choices that they made in terms of identifying the causal factors for these errors.

4.7.1 Questionnaire Data on the Causal Factors under Each Domain

In the questionnaires, the respondents were provided with more detailed information on the possible causal factors for each domain, and asked to select the causal factors that they felt applied to them. The findings for this part of the data collection are presented in the following section starting with the 'environmental' domain.

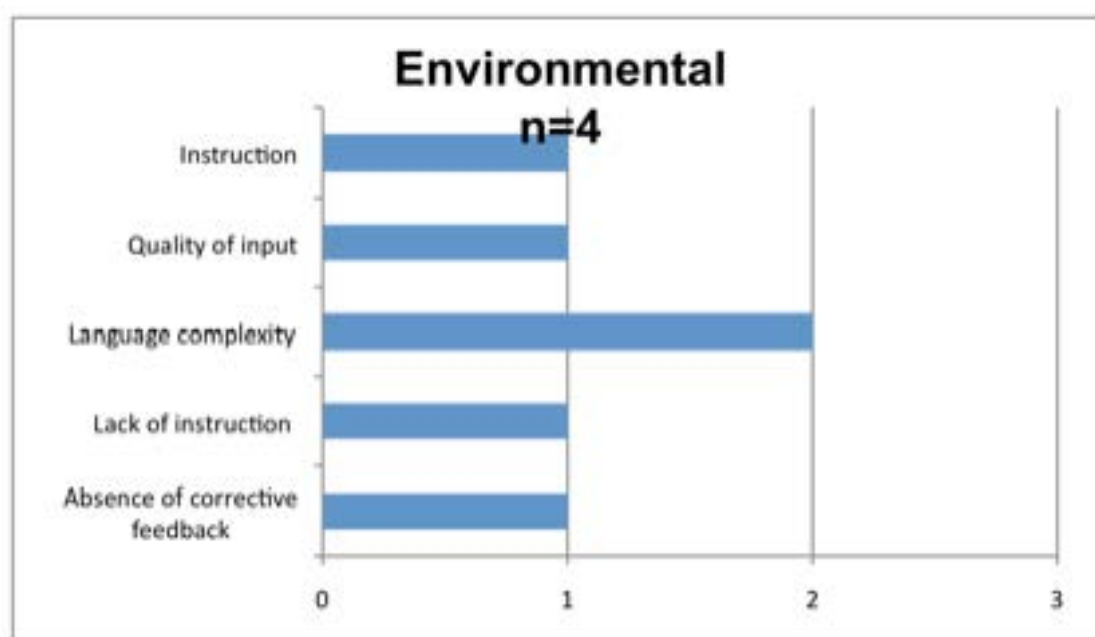


Figure 13. Questionnaire respondents' reasons for selecting the 'environmental' domain

As shown in figure 13, the four respondents who felt that their environment was a causal factor selected six answers. One answer was that that their English lessons did not help them; another was that the English that they encountered was poor. Two respondents mentioned that the English they encounter is too complicated and another answer was that the participant was not taking enough English classes. The last answer that was selected was that nobody corrected the participant when they made mistakes.

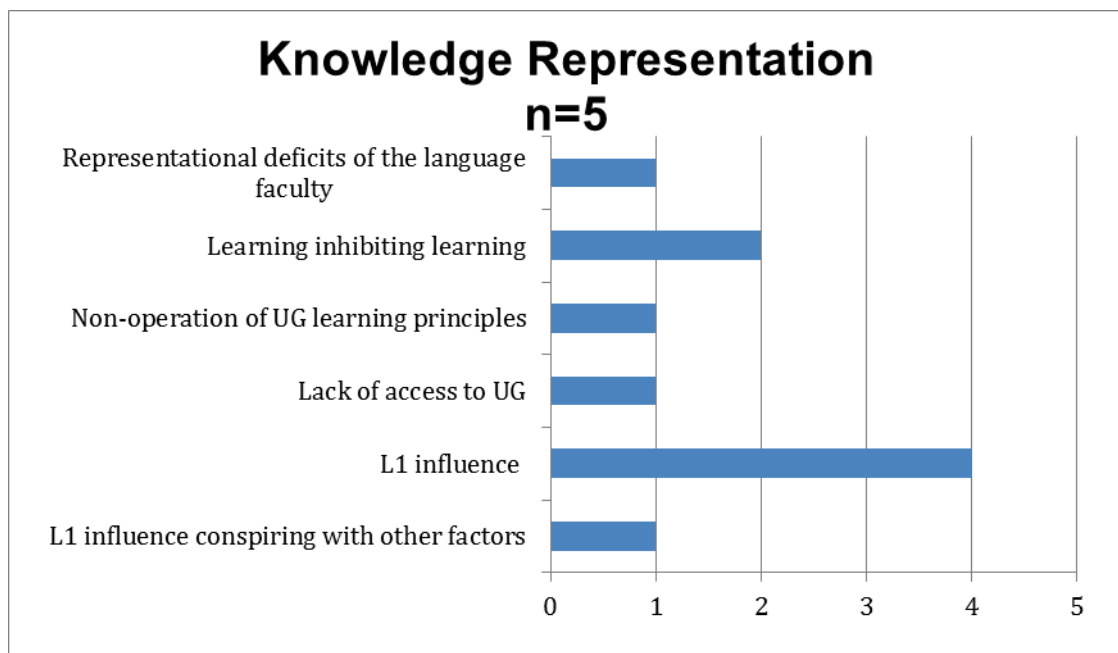


Figure 14. Questionnaire respondents' reasons for selecting the 'knowledge representation' domain

Figure 14 shows that between the five respondents who chose 'knowledge representation' as a contributing factor to their SLEs, a total of ten answers were given. The following four reasons were selected once: various problems including and beyond an overreliance on the rules of their L1, noticing the rules and patterns of English, a lack of strategy to continue to identify patterns and difficulty in identifying parts of speech. Two respondents stated that they felt that they were trying to learn too much and that they could not retain new linguistic information. The main reason that was selected by four questionnaire respondents was the overuse of the rules of their L1.

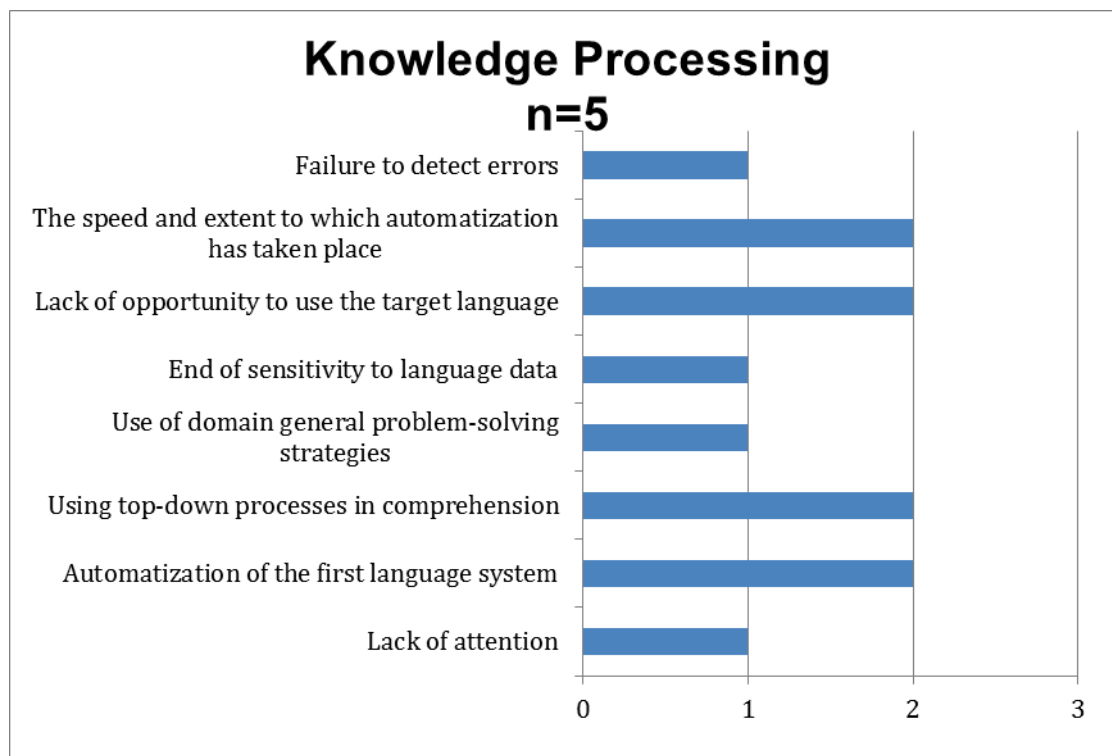


Figure 15. Questionnaire respondents' reasons for selecting the 'knowledge processing' domain

In figure 15, the information shows that the questionnaire respondents who selected 'knowledge processing' as being a causal factor gave twelve answers. Two answers were selected by four of the respondents: L1 interference, a focus on function over form, a dearth of opportunities to practise and slow automatization.

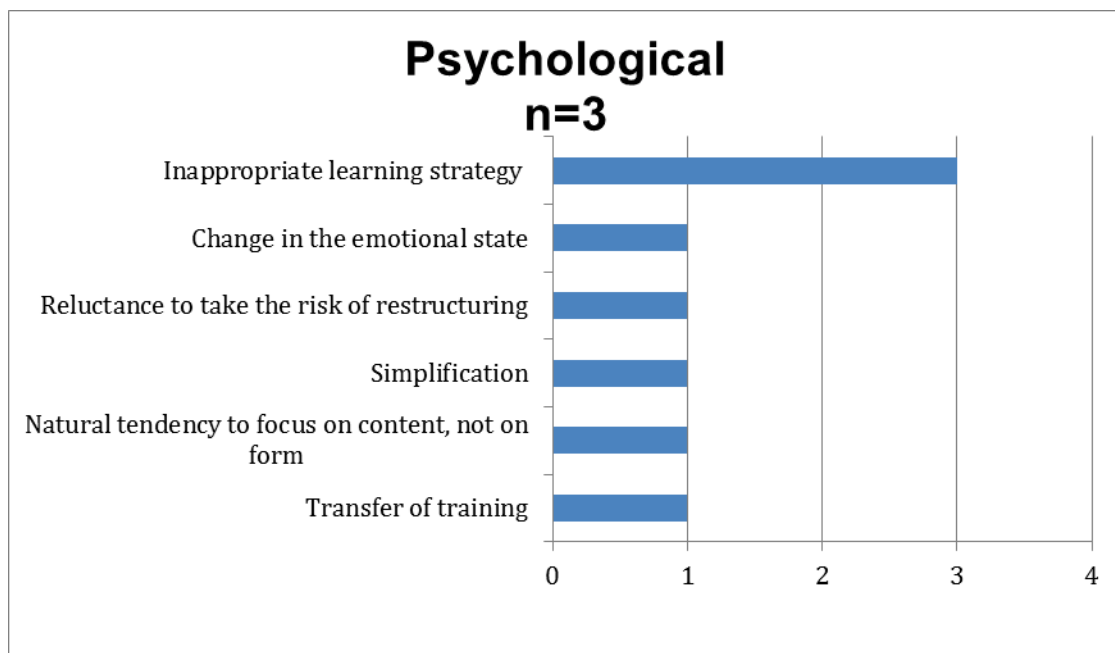


Figure 16. Questionnaire respondents' reasons for selecting the 'psychological' domain

The last domain that was selected was the 'psychological' domain. Figure 16 indicates that three questionnaire respondents provided a total of eight responses. The following causal factors received one response each: applying learning methods of L1 to the TL, focussing on general meaning when expressing oneself, over reliance on basic forms, a change in outlook that has led to a negative impact on English language acquisition, and reluctance to risk restructuring. The three questionnaire respondents felt that they were not learning English in the right way. In each case, the questionnaire respondents stress the importance of understanding colloquial English and talk about the importance of communication on a day-to-day basis, avoiding medical jargon and using forms in a more naturalistic way. Although the questionnaires did not seek information on which stage the questionnaire respondents were, the PLAB examination sets out to address the problem of avoiding medical jargon, where appropriate. Notwithstanding, the respondents may feel that their training for IELTS and subsequently PLAB did not assist them in understanding the natural forms of English that they encounter, for example slang.

The two questionnaire respondents who felt that the causal factors of SLEs did not apply to them were the only two to offer strategies and methods for overcoming linguistic problems.

In both cases, the questionnaire respondents mentioned the benefits of working in a non-medical capacity. They also said that they benefitted from using the media to help to improve their language. One cited the BBC as being helpful whereas the other mentioned reading broadsheet newspapers. In addition, one of the respondents mentioned that their classes with an experienced teacher had helped them.

Of the remaining eleven questionnaire respondents, ten stated their goals for improving their language skills. In the majority of cases, these reflected the advice of those who provided their strategies and methods for overcoming their SLEs. Questionnaire respondents mentioned using the media, the BBC and reputable newspapers, as well as placing value in interactions with L1 English speakers. Some of them mentioned the barrier that English language learning represents in their careers and most of them recognised the value of studying to achieve their goals.

4.7.2 Interview Data on the Causal Factors under Each Domain

As mentioned in the methodology chapter, the semi-structured interviews contained a mapping exercise where interviewees were asked to attribute, when possible, a minimum of three problem areas that were diagnosed in the language test to one or more of Han's (2004) domains. A thematic summary of the interviewees' selections is presented in the next section.

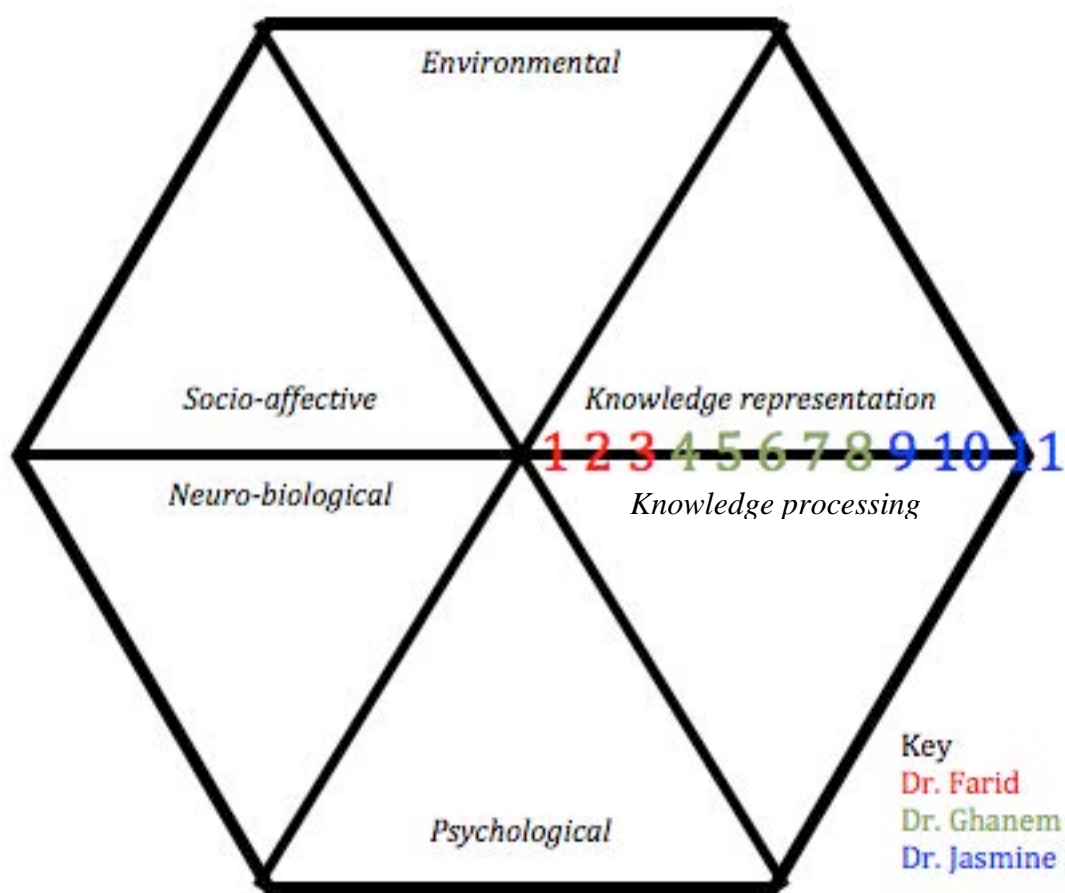


Figure 17. Hexagon mapping exercise for Dr. Farid, Dr. Ghanem and Dr. Jasmine

In figures 17, 18 and 19, the numbers refer to specific problem areas in the discussion of each figure. This first group of responses was compiled due to the commonality of interviewees' selections of Han's (2004) domains. Dr. Farid felt that problems with comparison and contrast (identified in figure 17 as 1), infinitives and gerunds (2) and subordinate clauses using 'at', 'in' and 'on' (3) were the result of a combination of the 'knowledge representation' and 'knowledge processing' domains. Similarly, Dr. Ghanem felt that these cognitive domains were responsible for all of the problem areas identified by the diagnostic language quiz, namely, problems with past & perfect verb tenses (4), pronunciation (5), uncountable nouns (6), superlatives (7) and the use of the passive voice (8). He firmly disagreed with the idea that any socio-affective barriers, as defined in the mapping exercise, were causing him problems and mentioned that he was involved in various aspects of British life, including being very involved with his children's schooling.

Similarly, Dr. Jasmine stated that problems with past & perfect verb tenses (9), punctuation (10) and uses of pronouns (11) could be mapped to the same 'cognitive' domains in equal measures. During the interview, Dr. Jasmine also discussed the barriers that a physical distance from a suitable learning environment can present, as well as other environmental factors such as the demotivating effects of a poor teacher. In addition, she mentioned the psychological barrier of shyness as a possible reason for cessation in language learning.

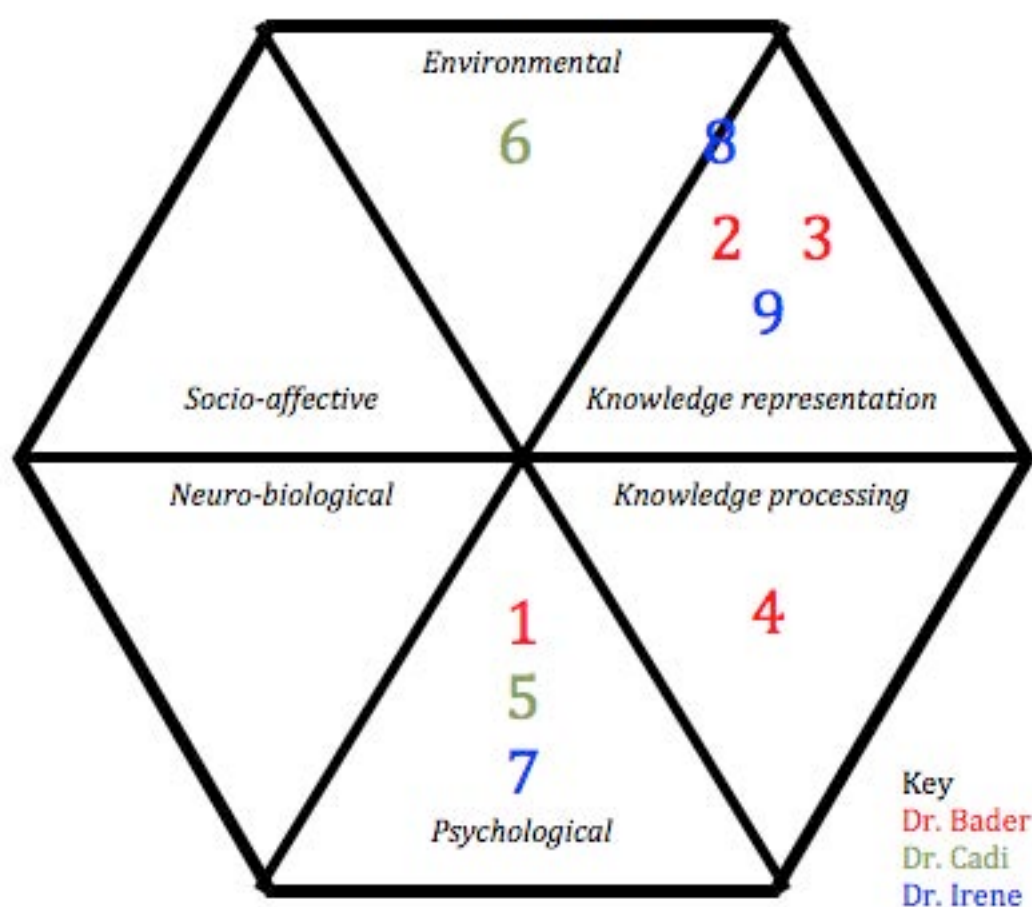


Figure 18. Hexagon mapping exercise for Dr. Bader, Dr. Cadi and Dr. Irene

This next group of responses was compiled due to the interviewees' inclusion of the 'psychological' domain. Dr. Bader mapped his problems with comparison and contrast (1) to the 'psychological' domain, as he is hesitant about taking risks in restructuring sentences. He mapped problems with past and perfect verb tenses (2) and uncountable nouns (3) to 'knowledge representation' as he felt that he was still coming to terms with the stylistic uses

of these tenses in English and was confused by the use of general nouns as opposed to abstract nouns. Subordinate clauses using 'at', 'in' and 'on' (4) were mapped to 'knowledge processing' as he felt that he conflated prepositional forms with their uses in his L1. Dr. Cadi's diagnostic test only yielded two significant problem areas for discussion: difficulties with using infinitives and gerunds (5) and problems with pronunciation (6). The psychological domain was responsible for his problems with infinitives and gerunds as he was hesitant about reformulating his sentences, and was also applying his learning experiences for his L1 to his English learning. Problems with pronunciation were mapped to the environmental domain because he said that his early English language learning experiences in his home country were marred by a faulty system for teaching pronunciation. This was later reinforced by his early experiences upon arrival in the UK when he was reliant on a fellow compatriot who aided him in his daily interactions but used inaccurate English with poor pronunciation.

While her problems with modal verbs (7) were immediately attributed to the 'psychological' domain, Dr. Irene initially chose the 'environmental' domain as being the reason for her problems with comparison and contrast (8) but then decided that, while this was true to an extent, she felt that knowledge representation was also a contributing factor to these problems. She initially stated that her difficulties with subordinate clauses using 'at', 'in' and 'on' (9) were caused by the 'socio-affective' domain but later attributed them to 'knowledge representation'.

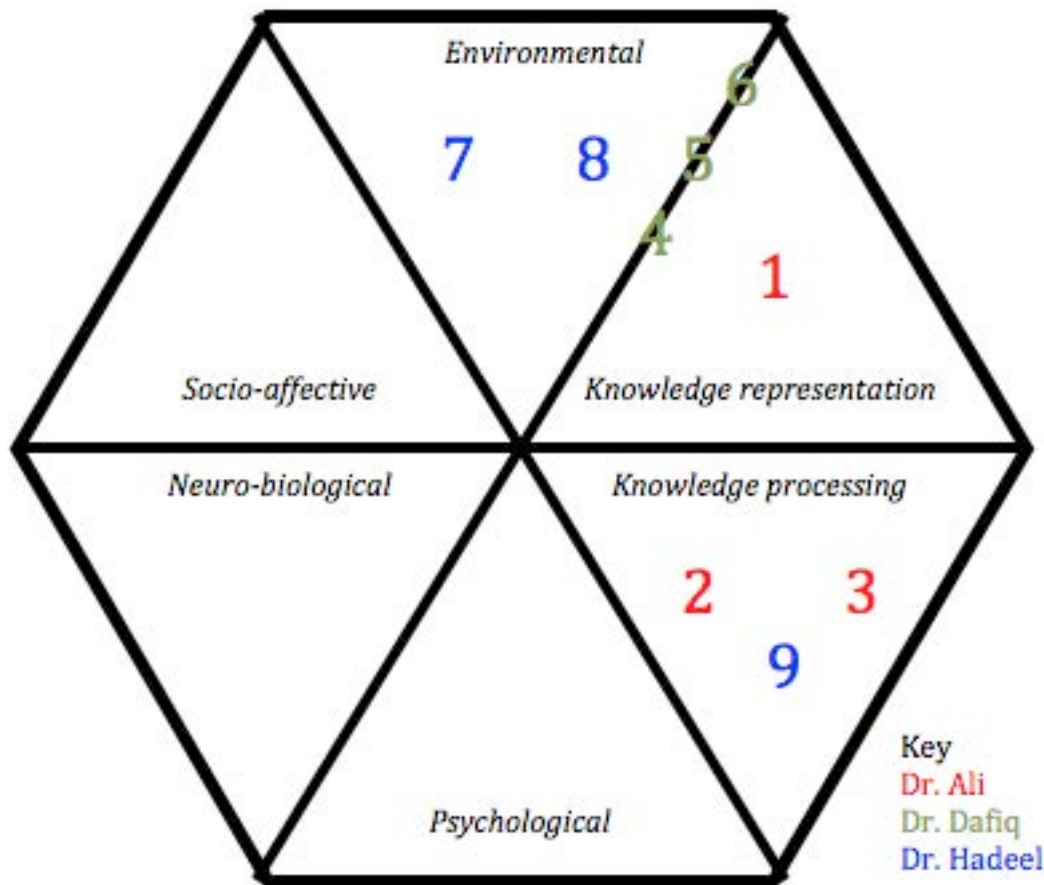


Figure 19. Hexagon mapping exercise for Dr. Ali, Dr. Dafiq and Dr. Hadeel

The remaining interviewees were grouped together based on their selections of factors represented by the first three domains. Although Dr. Ali's diagnostic test indicated that he had substantial problems with pronouns and past and perfect verb tenses, he felt that the diagnosis of pronouns as a problem area was incorrect. The test also identified six other areas as possible problem areas and he was asked to select two from this list to discuss alongside past and perfect verb tenses. As such, he mapped problems with past and perfect verb forms (1) under 'knowledge representation' as he has had problems with these structures in English sentences since his school days. The other two SLEs that he discussed were mapped against 'knowledge processing'. His problems with uncountable nouns (2) stem from his difficulties in using articles or the correct determiners as an automatized process and he felt that his L1 interfered with his use of infinitives and gerunds (3) because he used forms from his first language without thinking. The first of Dr. Dafiq's attempts to map his SLEs to the mapping hexagon showed that he felt that his problems

using uncountable nouns (4) were mapped under the 'environmental' domain. Problems with subordinate clauses with 'at/in/on' (5) and conditional forms (6) were originally mapped to 'knowledge representation'. After further consideration, he felt that these problems were attributable to both of the aforementioned domains in equal measures, and amended the chart accordingly. His reasons for this decision were that he felt that all of his problems were mainly due to difficulty in noticing his own mistakes and using a top-down strategy. He also felt that these problems were less significant in the past, but that he has experienced regression in his English language though a hiatus in his studies and slow reactivation of his language skills, due to being in a homogenous L1 Arabic group. He also described his problems using prepositions and uncountable nouns as being more general. Dr. Hadeel felt that her learning environment, in particular the low level of her classmates, was the cause of her problems with comparison and contrast (7) and the passive voice (8). She also cited a lack of L1 English speaker error correction as being a reason for her lack of progress in these areas, as well as in orthography and pronunciation. She stated that her problems with subordinate clauses using 'at', 'in' and 'on' (9) could be attributed to the 'knowledge processing' domain because she could not notice her own mistakes.

During the interviews, the interviewees alluded to other factors that they felt held back their English language learning. Although the interviewees did not select these during the mapping exercises, there were certain statements that unequivocally referred to causal factors of SLEs. These observations arose when the transcripts were thematically analysed using Han's (2004) putative causal factors of SLEs as the basis for the analysis. A summarized version of the emergent causal factors from the thematic analysis is presented in table 16 below (please see appendix 21 for the full thematic analysis).

Table 16. A summary of factors that emerged during the semi-structured interviews

| <i>Putative Causal Factor</i> | Number of instances |
|--|----------------------------|
| <i>Environmental</i> | |
| Lack of input | 1 |
| Reinforcement from linguistic environment | 6 |
| Lack of instruction | 4 |
| Language complexity | 1 |
| Quality of input | 7 |
| Instruction | 4 |
| TOTAL | 23 |
| <i>Knowledge representation</i> | |
| L1 influence conspiring with other factors | 1 |
| L1 influence | 4 |
| Failure of parameter resetting | 2 |
| Learning inhibiting learning | 6 |
| Representational deficits in the language faculty | 4 |
| TOTAL | 17 |
| <i>Knowledge processing</i> | |
| Inability to notice input-output discrepancies | 4 |
| Automatization of the first language system | 1 |
| The speed and extent to which automatization has taken place | 3 |
| Processing constraints | 1 |
| Failure to detect errors | 2 |
| Failure to resolve the inherent variation in interlanguage | 3 |
| Lack of verbal analytical skills | 1 |
| Lack of sensitivity to input | 1 |
| TOTAL | 16 |
| <i>Psychological</i> | |
| Inappropriate learning strategy | 1 |
| Change in emotional state | 1 |
| Reluctance to take the risk of restructuring | 8 |
| Natural tendency to focus on content, not on form | 1 |
| TOTAL | 11 |
| <i>Neuro-biological</i> | |
| Changes in the neural structure of the brain | 1 |
| Age | 1 |
| TOTAL | 2 |
| <i>Socio-affective</i> | |
| Satisfaction of communicative needs | 1 |
| Lack of acculturation | 3 |
| Socio-psychological barriers | 5 |
| TOTAL | 8 |

According to the emergent causal factors that came about via the results of the thematic analysis, table 16 indicates that the ‘environmental’ domain presented the interviewees with the most challenges; in particular, the quality of the input that they receive and reinforcement

from their linguistic background. For most interviewees, they felt this was due to the people in their immediate surroundings speaking in their L1 rather than in English.

The second most commonly referenced domain was 'knowledge representation' with L1 influences causing problems for some of the interviewees. Also, coping with learning different styles of English seemed to be problematic for some interviewees.

'Knowledge processing' was also a significant cause for concern to some of the interviewees. Many of the problems under this domain seemed to come from an inability to notice mistakes or variation in their developing language skills, while others were connected to automatization i.e. where the production of language forms become automatic. One possible causal factor that was not mentioned was a 'lack of opportunity to use the target language'. Some of the statements made by the interviewees may have been relevant to this category but were attributed to 'reinforcement from the linguistic environment' instead. The rationale for this attribution is that the interviewees had many opportunities to use the target language in their daily interactions. However, the linguistic environment in which they operated meant that they had friends, family and classmates speaking their L1, thus failing to model target language forms.

The most commonly referenced causal factor was a 'reluctance to take the risk of restructuring', which came under the 'psychological' domain. This is unsurprising when the context of the interviews is considered, people training for exams are often risk-averse. Another factor under this domain that was referenced once was a 'natural tendency to focus on content, not on form'.

Most of the interviewees felt strongly that age was not a problem. None selected the 'neurobiological' domain in the mapping exercises, nor in their questionnaires. Nonetheless, age was mentioned during the interview with Dr. Farid and this indicates that the interviewees may suffer from the multiple effects principle (Han, 2004; Selinker, Kim, and Bandi-Rao, 2004; Odlin, 2005) across all of the domains, as discussed in the literature review.

Although the interviewees did not select the 'socio-affective' domain during the mapping exercises, the thematic analysis found that a number of the interviewees had suffered from socio-psychological barriers, mentioning culture shock and fear of antisocial behaviour. Another socio-affective causal factor that emerged during the thematic analysis was a 'lack of acculturation'. This factor covers things like cultural barriers or a lack of affinity with the English language. In the mapping exercise this domain was summarised as 'feelings towards English speaking cultures, my ability in English and/or losing my culture' in the survey and further shortened to 'feelings towards English speaking culture'. Alongside the theoretical specificity of Han's definition of socio-affective factors, this abbreviation may have created the wrong impression to the interviewees, which led to them avoiding the domain.

In terms of the most significant causal factors of SLEs, the majority of the participants seemed to indicate that the 'knowledge representation' and 'knowledge processing' domains were the most prevalent.

4.7.3 Analysis of the Data on Causal Factors of SLEs

The questionnaire asked the participants to identify the reasons for their weaker areas according to Han's (2004) six domains: 'environmental', 'knowledge representation', 'knowledge processing', 'psychological', 'neuro-biological' and 'socio-affective'. Of the thirteen respondents, six selected two of Han's domains for further examination, another five selected just one domain and two did not feel that any of the causal factors of stabilization applied to them. Although they did not offer reasons for this within questionnaire data, the same respondents were the only two who offered strategies that helped them to overcome their problems in the open answer question towards the end of the questionnaire. However, both participants admitted that they have some problem areas of English language learning.

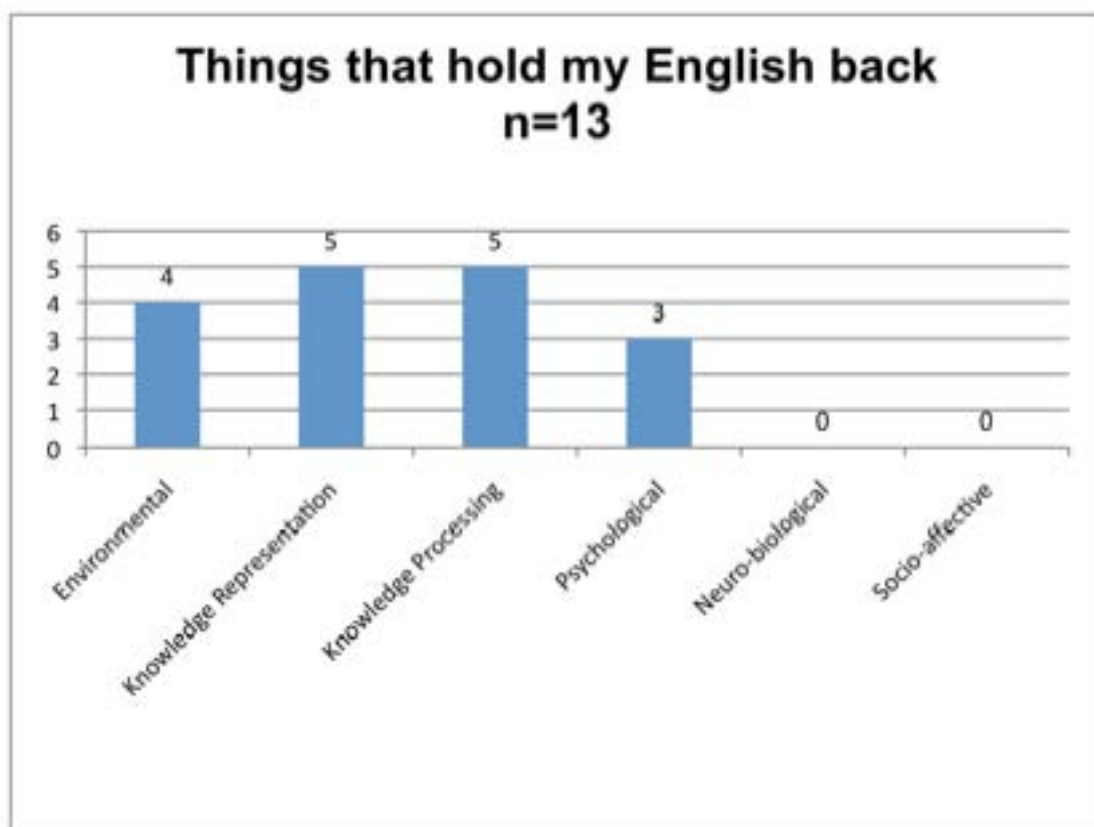


Figure 20. Questionnaire respondents' analysis of the causal factors of their SLEs

As figure 20 indicates, the eleven participants who felt that the causal factors affected them made seventeen selections between them. Four chose the 'environmental' domain, five chose the 'knowledge representation' domain, five chose the 'knowledge processing' domain and three chose the 'psychological' domain. None of the participants chose either the 'neuro-biological' or the 'socio-affective' domains.

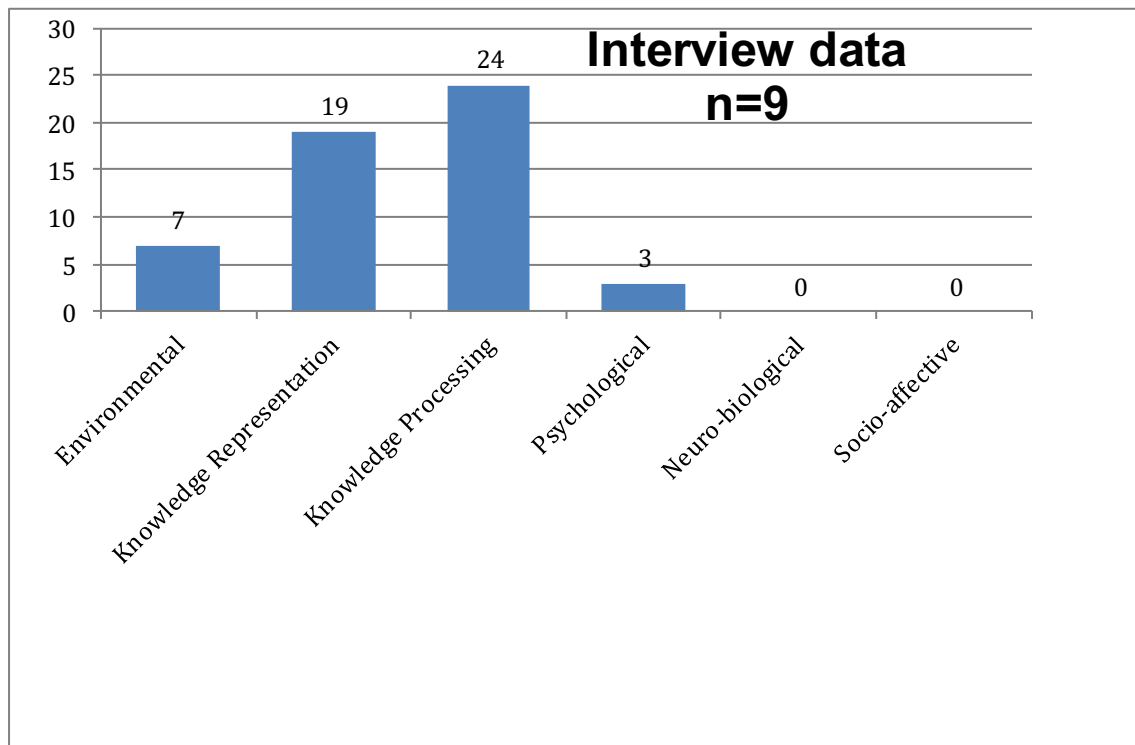


Figure 21. Causal factors of SLEs as identified by interviewees

The interviews examined the participants' feelings about the causal factors of these SLEs. Figure 21 shows the participants' responses to the exercise where they were asked to map the main significant problem areas to the causal factors. In total, the nine participants discussed thirty-eight SLEs and fifteen of these SLEs were identified as overlapping between two putative causal factors. The outcome was that a total of fifty-three significant problem areas were attributed to the six putative causal factors. About half of the nine participants felt that between them seven of their SLEs were due to environmental factors. Many of them felt that between them nineteen of their SLEs were due to 'knowledge representation', a similar number of participants felt that twenty four of their shared linguistic problems were down to 'knowledge processing' and three of the nine participants felt that three of their shared problems were due to the psychological factors.

The results of the questionnaire are mirrored in that none of the participants selected the 'neuro-biological' or 'socio-affective' domains as being causal factors of their SLEs.

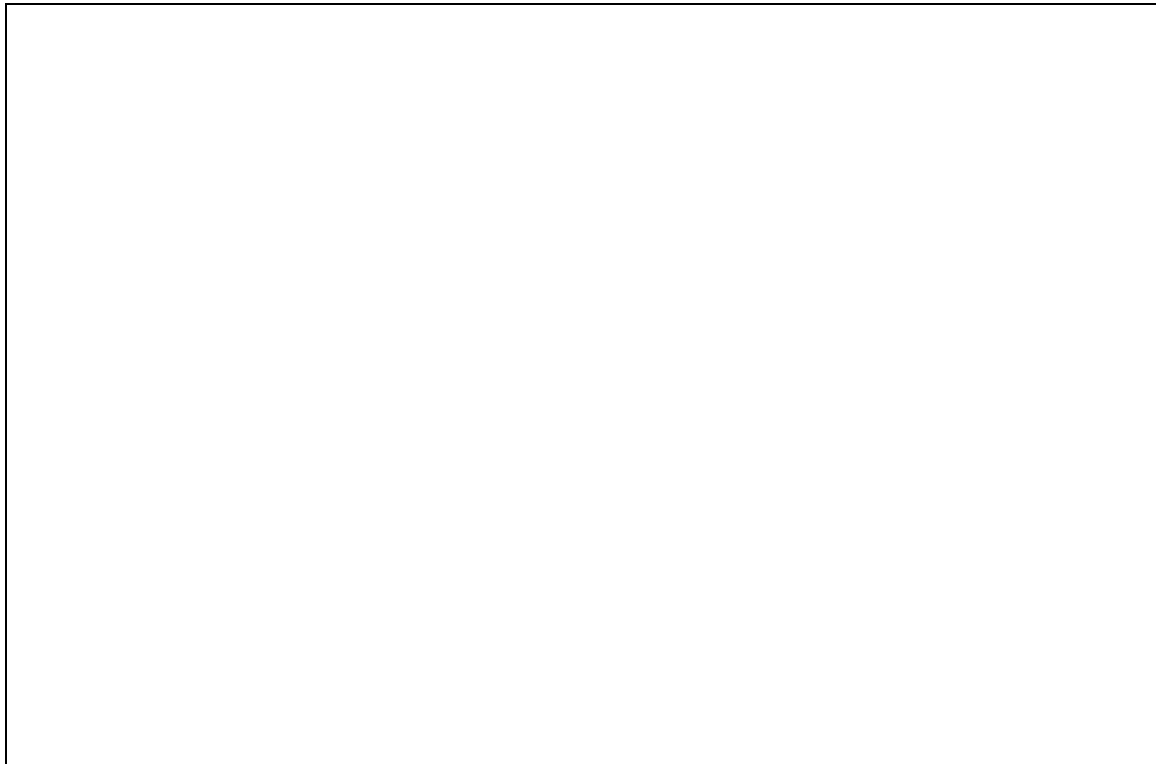


Figure 22. Comparison of causal factors between questionnaire and interviews

Figure 22 above clearly indicates a trend that came of phase one of the data collection. In the questionnaires, the mapping exercises and the semi-structured stage of the interviews, the participants all seem to attribute their SLEs to the first four domains: 'environmental', 'knowledge representation', 'knowledge processing' and 'psychological'. In most cases, the more commonly cited reasons are the cognitive domains i.e. 'knowledge representation', 'knowledge processing' and 'psychological'.

In both forms of data collection in phase one, there was little mention of the other domains: 'neuro-biological' and 'socio-affective'. This is somewhat surprising as, in the professional experience of the author, refugee healthcare professionals can suffer from neuro-biological and socio-affective problems. Some displaced medical healthcare professionals are under great pressure, both from events leading up to displacement and in trying to rebuild their lives and it is possible that this can have an impact on neuro-biological functions and socio-affective learning.

As mentioned in the literature review chapter, in this case, it seems that Han's definition of the 'socio-affective' domain encompasses only the remaining socio-affective factors that were not discussed under the preceding five domain subheadings. This approach to the socio-affective domain may be a reason that it was not cited as a causal factor of any of the participants' SLEs. Elsewhere in the literature, the term 'socio-affective' has a more general definition, which in turn would apply to several of the domains in Han's taxonomy.

4.7.4 Analysis of the Data on Impact of Life, Educational and Other Histories

Beyond the mapping exercises, the interviews afforded an opportunity to discuss the impact of life, educational and other life histories. While the thematic analysis in appendix 19 allowed emergent statements about SLEs to be collated under the six domains, there were a number of statements and observations that went beyond this, as demonstrated in table 16. This section covers areas of commonality between the participants on matters such as the effects of displacement, motivation, levels of contact with native speakers, engagement with English language learning in early years and observations on IELTS.

Half of the interviewees explicitly mentioned that they had experienced communication problems when using English in the various socio-affective contexts: survival, social and professional. Few described negative experiences with using the language in these situations, for example, trepidation in communicating with L1 English speakers or a loss of eloquence from how they spoke in their L1. Fewer still stated that they had not experienced considerable problems in using English. There was also a fifty-fifty split when the interviewees provided their views on cultural differences. While the entire group spoke very positively about their host country, half of the sample group described significant difficulties with socio-psychological factors and the differences between cultures such as the language barrier, culture shock or a loss of status. Two doctors who seemed to feel the impact of culture shock significantly were Dr. Ali and Dr. Cadi. Dr. Ali felt that:

In my opinion [the] differences [are] more than the similarities... yeah, the big difference for me, in my culture people are, I think the familiar relations... we [are] still maybe a traditional country, people still preserve most of the traditions there in my country, I think [Britain] is a modern country, people [have a] modern lifestyle I think [it's] maybe totally different than the tradition[al] lifestyle in my country.

Here, we can see the extent of the culture shock that Dr. Ali experienced and with that, there are allusions to a loss of status. In cultures that are more traditional, males are overtly given preferential treatment and doctors may be under less pressure in a country where the health service is not funded by taxation, as is the case with the National Health Service. As described in the profile for Dr. Ali in section 4.5.2, he was accustomed to operating in a bilingual society; however, his first language Arabic was a majority language in Sudan.

It appeared that Dr. Cadi was acutely sensitive to the impact of the differences between his culture and that of the UK:

...slang and informal speak could affect negatively the way of learning or also antisocial behaviour of the people here I always try to [make] contact with people to improve my speaking but the people nowadays prefer to stay indoors rather than go outdoors and contact people and this is actually the most important problem factor I face now... because I want more people to speak with them to improve my speaking... this also could affect... their learning way of English [it's] also [a] psychological problem... that was... exactly what happened with me when I first arrive in the UK... I had cultural shock.

In the case of Dr. Cadi, it is possible to see a strong correlation with the findings of the European Science Foundation project (Norton, 2013) in which a dearth of opportunities to interact and therefore practice was a main contributor to SLEs. There is also a mention of standards, both in terms of English language standards as opposed to slang forms, as well as behavioural standards. On the one hand, colloquial forms of English are not assessed in the IELTS test and therefore Dr. Cadi felt that exposure to non-standard forms may negatively affect his language production. On the other, it appears that he had some negative experiences of antisocial behaviour, which led him to avoid contact in his early days in the UK. In both cases, the differences in culture made establishing opportunities to practice his English a substantial challenge for Dr. Cadi.

With regard to a loss of status, Dr. Farid describes the frustration of not being able to communicate well and express himself more clearly:

But even in general language it's not easy to [communicate well] with others especially when you compare yourself with how you were in your society... in my own pharmacy ... I have a good reputation... I had a good reputation [within] my society in that area as I interact[ed] very well with others and I understand...quickly what others need but when I came here I think the language concept or the language learning process ...consume[s] time.

Dr. Farid, the only interviewee who had not learnt English from an early age, was not overtly affected by culture shock; however, he struggled to find opportunities to practise his language skills outside the classroom. In his profile, it was observed that he was highly sociable, and this is reflected here, yet he found it difficult to express himself with the same facility as in his first language.

It seemed clear that the interviewees were highly motivated to learn the language. The motivation to learn English to re-join their profession is instrumental, as described in Klapper (2006). In addition, it appeared that the refugee agenda of integration had provided them with a degree of integrative motivation (Klapper, 2006; Kumaravadivelu, 2006). During the interviews, four of the interviewees indicated that they were motivated instrumentally while four of them indicated that they were motivated integratively. Dr. Hadeel describes her lifelong use of English since her birth in the UK, when her father was a student:

I think so because my friends back in Syria, we studied [together at] the same level and the same books when we were in school and when we were at the university but they cannot speak the same way [that] I do because I usually come [here] on holidays and my parents [have] British friends, sometimes they came over to Syria to have a visit before the last events was started and we always... my father always encouraged me to practise speaking English even if I make any mistakes and whenever he went with the officer[s] who came from abroad he took me with him just to try to speak in English to encourage me to speak so that's why I feel that my English, my spoken English, is better than my friends 'cause they never went out of Syria or to the UK or to a country which speaks English as a first language so it affects, yes, it affects, maybe.

As stated in the participant profiles, it took Dr. Hadeel twelve months and six attempts to achieve the necessary IELTS score to join the GMC. The vignette for Dr. Hadeel also suggested that she might have felt artificially confident in her overall skills. Although she

was integratively motivated on the surface, this may have had an impact on her motivation and subsequent successes in using English in the instrumental context of meeting the IELTS requirements set by the GMC. Her confidence may have also led to an overreliance on top-down strategies.

Some of the interviewees seemed to be driven by resultative motivation from past successes. When discussing their decision to seek refuge in the UK, many of the interviewees said that their prior knowledge of English helped them to make the decision. One interviewee, Dr. Irene, stated that this was not a factor in her decision to come to the UK. Another interviewee, Dr. Ghanem, came because their family held British passports. Dr. Jasmine declined to comment on the reasons for her arrival in the UK. A few participants discussed non-motivating factors such as a lack of time or poor test results. For example, Dr. Dafeeq describes the amount of time that it has taken him to improve:

I will explain it, I think, for you, when I first uh arrived to the UK I thought that if I stay in the UK for two years then my English would [have] already improved because I'm living in [an] English speaking country and after one year I see myself [and] I haven't improved my level and I [am] confused between the English that I [am] learning and the new English in the IELTS and I find myself in, like, desire just yeah because I don't know how I can improve myself, what I can do [my teacher tried to] advise me to listen to Radio Four to do some things and I start[ed] to do that but after about one year I start[ed] to read some articles... let's say twice a week, not every day, I used to listen to Radio Four every day for half an hour... another thing, because my kids always watch cartoon[s] and it is difficult to watch TV [during the] day so I wait for the night to watch TV... I see some documentaries on either BBC One or Two that's everything and with all these things I have some uh books [of] IELTS... materials so I try to use [them to] improve my IELTS score not my English, it's good yeah.

In section 4.6.1, I discussed the potentially positive impact of rehearsal of the IELTS test on some of the participants. If the number of attempts that are taken are to be taken into consideration, another factor that led to Dr. Dafeeq successfully meeting his IELTS target may be the fact that he took the IELTS test eight times. This is not to suggest that repeated attempts at the test eclipsed Dr. Dafeeq's strategies for preparing for the test that he describes above, but it could be said that this number of attempts may have familiarised Dr. Dafeeq with the test procedures and supported his other learning strategies.

Apart from Dr. Farid, most of the interviewees began learning English in school. Although it was not expressly stated during the interviews, the field notes show that there seemed to be a consistent theme of emotional learning among the interviewees. They also spoke positively about their relationships with their teachers and some specified their preferences for certain methods that were used to teach them. Dr. Jasmine describes her sense of duty that they felt towards her teacher:

I am very emotional, yeah, personally and I wish there's nothing to distract me other than IELTS, I am very happy, very very happy with [my] teacher, sometimes he tells me the truth and I love it. I don't love it when he's strict on me [but] because they say a friend is a person who makes you cry, I like him, I really like him and maybe that's the reason. I don't know, but I feel refugees are like that because many problems [come from] how they left, what they did. I feel that away from family everything changed suddenly maybe I lose nothing if I want to take my IELTS. I want to finish it. I want to make at least my teacher and myself happy.

Some spoke quite negatively about their prior learning experiences, saying that they had experienced backsliding in their language skills, begun learning too young or were daunted by returning to a 'school' environment. All of the interviewees discussed aspects of language acquisition, including learning and teaching methods, learner strategies and course content. Dr. Irene spoke about her poor early learning experiences but describes a major turnaround in her attitudes toward English language learning:

I started to study two and half years ago...before that time, maybe I could say just my name is [Irene] and [my age], or how many brothers and sister I have, that's it and I could [not] speak at all. It is my fault, I never studied English and even at school, we had English classes maybe one hour per week and [he] was [a] terrible teacher and I just hated English, because of pronunciation [and] grammar. So, I just started [again] two and half years ago and I started to love this language and now I want to learn more and more.

The prior learning experiences that Dr. Irene describes are negative but she clearly draws a distinction between her learning as a child and her studies now. There is a clear shift in her attitude to the language, which may be attributed to a change in her situation and as a result, a change in her motivation. As discussed in the literature review chapter, integrative motivation, as described by Dr. Irene above, is perceivably the most powerful form of

motivation (Kumaravadivelu, 2006) and it was noted in the participant profiles that Dr. Irene passed the test on her first attempt.

The interviewees commented negatively on the methods that were used to teach them in their countries of origin. Two of the interviewees mentioned their previous teachers but one of them felt that their teacher's level of English was sufficient whereas the other felt that their teachers did not teach them adequately. Dr. Irene said that the current classes were good but that IELTS learning was beginning to eclipse their medical knowledge. Two interviewees felt that a hiatus in their English language studies has caused them to regress. Finally, Dr. Farid and Dr. Ghanem mentioned that they would have preferred to study for their PMQ in English and that they felt the decision by their government to teach the PMQ in Arabic was a mistake.

Two of the interviewees expressed shyness about making mistakes. Notwithstanding, they felt that it would be beneficial if native speakers pointed out their errors. Another felt that it was embarrassing when he made mistakes but said he remained unafraid of making further errors. Dr. Ghanem suggested that learners might overcome their shyness about making mistakes through prolonged contact with L1 English speakers. Many interviewees said that they were not afraid of making mistakes. Dr. Farid said that he preferred practical study to theoretical study and another believed that learning encourages further learning. Dr. Cadi reflected on physical health affecting linguistic performance and also mentioned that daily life can impinge on study opportunities. Dr Jasmine spoke of her imperviousness to making mistakes:

No, mistakes never hurt... I have crocodile skin now, I'm not afraid of making mistakes... really I learnt recently, ever since I came here feel I became stronger but it's like, I feel each mistake gives me an experience, it's like I learn from my mistakes because I [have] face[d] a lot of problems... so this three years was equivalent to thirty years and that's why I told you, now I [have] got crocodile skin

Skehan (1989) states that successful language learners are extroverted and bold in taking risks. In Dr. Jasmine's statement above, we can see a tangible example of the benefits of

these characteristics in that she refers to her learning from her mistakes. She is also clear about the patience that is required in learning a second language to the level that is required. This attitude is positive when one considers the discussion on Han's psychological factors in section 2.3.2, which indicates that avoidance of linguistic forms and an unwillingness to risk restructuring are causal factors of SLEs.

A few of the interviewees found it difficult to make contact with native speakers including one who said that he has little opportunity to build relationships beyond the L1 community. Another said that he worked in a charity outlet to increase contact with native English speakers. Some said that speakers of their L1 surrounded them but that they sought contact with native speakers either through their children or friends and neighbours. Dr. Ghanem describes his strategies for making contact with local people:

I try to do my best, especially listening [to the] radio in English, BBC four or world service BBC and I try also to speak to our neighbours. When I [am] in [the] school where my sons [are] in school I try to be really involved with school life and assisting the assembly, [asking] their teacher about their levels in the class, what the[ir] problems [are], something like that.

All of the interviewees agreed with the use of the media to increase fluency. In contrast to the rest of the group, one interviewee, Dr. Jasmine, did not mention contact with native speakers.

Finally, the interviewees, with the exception of Dr. Jasmine, reflected on their problems with the IELTS exam. Dr. Hadeel said that they felt the GMC's requirements were set too high, Dr. Bader felt that a lack of feedback on the exam held them back and Dr. Cadi felt that it was subjective in places and varied in its register too much. Three of the interviewees felt that the breadth of vocabulary and idiom was not appropriate for medical professionals. The time constraints of the exam were the main problem that five of the interviewees felt that they had. Dr Bader said of the IELTS test:

I think that it is subjective... it depend[s on] in the examiners just I think... I got seven here in Cardiff University last time, but this [most recent] exam someone give me six or six point five I don't know and [in] reading it depend[s] on the topic I think if you are

familiar [with] the topic you can get a high mark but if topic [is] about, for example anthropology or astronomy, we can't [even] pronounce the word and you struggle to read it and get many things wrong.

Although Dr. Bader says that he feels that the marking of the IELTS test is subjective, IELTS.org (2014) go to great lengths to ensure that the inevitable subjectivity of marking is minimised. In addition, they have an appeals process for test takers who feel that they were unfairly marked in the productive skills. The second point that Dr. Bader makes is reasonable when one considers the use of the test as an entry requirement to the GMC. However, the IELTS test serves as a screening test for the PLAB examination and it is within this exam that medical vocabulary and knowledge is tested.

In discussing the IELTS test, Dr. Hadeel reflected on the time constraints of the written test:

Ooh, for everybody [one hour is] a very short time to do two tasks [writing] four hundred words... I don't know why [they] are strict with the time. We might be better, we might show our skills [if we felt] more relaxed with the time... my teacher sometimes she take[s] more than twenty minutes to write down task one to describe a table or a chart, so how can we be compared, as international students, with English teachers? It's very difficult, I always tell her that it's not fair... if a teacher is writing she will get seven or seven point five how am I expected to have this uh score within a short time. It's very difficult to wait years to get this seven. My IELTS teacher said it will take you years to have this degree [of] seven in each skill... I don't know, I feel that the speaking is very important for doctors because they are going to communicate with the patients or listening is very important because they have to understand what's [being said] but for writing, seven is too much.

It should be remembered that the IELTS test is designed to assess writing skills within these constraints and it is not intended to reflect real-world writing situations. Dr. Hadeel may have been the victim of a teacher whose sympathetic nature led to a level of demotivation for the student. The reality, as stated above, is that Dr. Hadeel achieved the desired outcome in twelve months.

The interview transcripts were sent to all of the interviewees, but only Dr. Irene replied to the email to state that she agreed with the transcript.

4.7.5 Analysis of the Data on Strategies for Improving English Language Skills

In the concluding questions in both the questionnaires and the semi-structured interviews, the participants were asked to provide details on their strategies for improving their level of English. Their responses are presented in table 17 below.

Table 17. A summary of the strategies used by respondents for improving their English skills

| Strategies for questionnaire respondents (mostly >7.0 in IELTS) | |
|---|--|
| Participant | Methods for improving English |
| Dr. A | Seeking contact with native speakers, reading English books, and being unconcerned by having a unique accent. |
| Dr. B | Continuing to learn vocabulary and syntax and trying to work on writing academic sentences. |
| Dr. C | Listening to the Radio 4 and trying to read non-medical books in their spare time to avoid using medical jargon in daily interactions. Tried to automatize English as the first language of communication. |
| Dr. D | Seeking contact with native speakers as well as studying independently and in English classes. |
| Dr. E | Seeking contact with native speakers as well as sustained reading in English. |
| Dr. IE | Seeking contact with native speakers and listening to the radio and TV. |
| Dr. F | Seeking contact with native speakers. |
| Dr. G | Seeking contact with native speakers through work and listening to the BBC. |
| Dr. H | Taking English class with an experienced teacher, seeking contact with native speakers through work and reading newspapers. |
| Dr. I | Paraphrasing texts from newspapers and seeking an experienced teacher. |
| Dr. QJ | Did not offer any strategies for improving their English. |
| Dr. K | Seeking contact with native speakers, listening to Radio 4 and sustained reading in English. |
| Dr. L | Trying to notice errors and being open minded in correcting them. |
| Strategies for interviewees (mostly <7.0 in IELTS) | |
| Dr. Ali | Studied independently with grammar books; reading newspapers, listening to the radio and watching television |
| Dr. Bader | Reading magazines and newspapers and revising class notes |
| Dr. Cadi | Listening to Radio 4, reading newspapers and writing 600 words per day |
| Dr. Dafiq | Reading additional IELTS materials and journals, watching television, listening to Radio 4 and seeking contact with native speakers |
| Dr. Farid | Reviewing class notes, watching the BBC channels, listening to Radio 4 and seeking contact with native speakers |
| Dr. Ghanem | Listening to the BBC World Service and seeking contact with native speakers |
| Dr. Hadeel | Reading newspapers and seeking contact with native speakers |
| Dr. Irene | Seeking contact with native speakers, listening to the radio and watching television |
| Dr. Jasmine | Listening to the BBC, reading newspapers and novels and translating new vocabulary |

In table 17, the summary of statements shows the strong similarities between the strategies for the questionnaire respondents, the majority of who had achieved the GMC entry requirements, and the interviewees, who were still in IELTS training. While it is not clear whether they had all received the same advice from the teacher at the DPiA centre or other language classes, the general strategies seem to be very similar across the two groups. Indeed, such strategies will be familiar with most IELTS practitioners who wish to recommend methods for students to increase their exposure to the English language. Twelve of them recognised the importance of seeking contact with native speakers. These socio-affective strategies are sound, and the value of an interactionist approach to language training research is discussed by Mackey, Abbuhl and Gass (2014) as being invaluable to learners and, according to Sieloff, Magnan and Lafford (2014) immersion in the target language can lead to substantial gains for learners. One participant said that he worked in a charity outlet to increase contact with native English speakers. Four participants said that speakers of their L1 surrounded them but that they sought contact with native speakers outside their immediate environment, either through their children or friends and neighbours.

Dr. Hadeel spoke about her relationship with her neighbour:

I always try to speak to somebody who is British to help me. I have a neighbour and when she [has] time, I always ask her to just give me a ring and I will go and have cup of tea with her to have a little chat and she always correct me. She's seventy years old and she likes my kids. She's very nice, she always corrects me and she say[s] don't feel sad for that but I always assure her that I'm very happy if she corrected me.

Even seeking contact with this native speaker took an element of bravery to achieve at times. Three participants found it difficult to make contact with native speakers, with one who said that he has little opportunity to build relationships beyond the L1 community.

Although two of the interviewees mentioned that psychological factors such as shyness about making mistakes held them back, five agreed that they were unreserved in using their imperfect language as they recognised it as a part of their development. Dr. Ghanem spoke of his reticence to make mistakes:

I worry about making mistake[s] and that take[s] me time to think, for example now, before I speak to you, I have to organise all of the statement in my mind and that take[s] time and make[s] me do a lot of mistakes, because you can't control everything because the person in front you [is] wait[ing for] your reply or response and you translate from Arabic to English til it become[s] spontaneous.

In spite of this, they felt that it would be beneficial if native speakers pointed out their errors and, although Loewen (2014) is careful to acknowledge that feedback can have a negative role, it generally supports learning, particularly in lexical and phonological items. Dr. A mentioned being unafraid of having a unique accent, as long as the English was accurate; a view supported by Pickering (2014) who acknowledges the identity that accents provide. In cases like this, L1 interference is evidently present but not a debilitating factor. Another participant, Dr. Farid, felt that it was embarrassing when he made mistakes but was not inhibited from making them:

I notice my mistakes and sometimes I correct myself but many times, as you have noticed now, I don't. I worry about making mistakes, honestly it's true, especially when you reach a level of age... because of that, learning for the children [must be] much easier because they don't consider this [an] embarrassing thing.

Dr. Ghanem suggested that learners might overcome their shyness about making mistakes through prolonged contact with L1 English speakers. In all three of the above extracts from the interview data, the participants reflected Skeehan's (1989) statements on successful language learners. They were exhibiting signs of risk taking and extroversion that fed into strategies that elaborate what this means would support their active participation in their own learning. It is also worth remembering that Dr. Hadeel, Dr. Ghanem and Dr. Farid did not select the 'psychological' domain during the mapping exercise and the exclusion of psychological factors is supported in the above statements.

In terms of other strategies, many of the participants recognised the importance of quality of input and its intake, as described by Kumaravadivelu (2006). Eleven of the participants recommended either listening to the radio, watching television or both, and ten stressed the importance of continuing to read English texts. Including the participant who mentioned paraphrasing texts, three of the sample group said that they continued to practise their

writing. Another questionnaire respondent, Dr. L tried to continue to notice errors and work on correcting them. This was referred to in the literature review chapter and the act of noticing linguistic items in order to convert input and output to the aforementioned intake is referred to by Lightbown and Spada (2007) and Richards (2008) as Schmidt's 'Noticing Hypothesis'. Dr. Farid said that he preferred practical study to theoretical study. Another participant believed that learning encourages further learning. When asked about his views on the six domains of causal factors, Dr. Cadi reflected on physical health affecting linguistic performance and also mentioned that daily life can impinge on study opportunities:

Well, these points, in my opinion, could affect to certain extent some foreign learner[s] because these are fact[s] and these [are] problem[s that] anybody, any international people can face. For example in the first point uh my location, I live in Swansea [so] to attend the class I need to travel from Swansea to Cardiff and this need[s] more effort and time, you know, attending class need[s] orientation and to think about everything right, your brain need[s] high blood sugar. If your blood sugar [is] low and during travelling blood sugar become low, your orientation also decrease[s] and this, in my opinion, affect[s] negatively on the way of learning.

Here, Dr. Cadi introduces the impact of physical health on the ability to study effectively.

Birdsong (2005) acknowledges the potential for wellbeing to impact upon learners' ability to extend the upper limits of their L2 acquisition. Broadly speaking, this may be a reflection on his selection of the 'psychological' domain during the mapping exercise.

Importantly, at the time of writing this chapter, nineteen of the twenty two participants had achieved their goals of meeting the IELTS entry requirements to register with the relevant governing medical bodies and train to re-join their healthcare specialities.

In the responses to questionnaires, the principal problem areas with English were orthographic i.e. spelling and punctuation. The interviewees' main problems, as highlighted by the diagnostic language quiz were with comparison and contrast. The second most challenging area for the questionnaire respondents and the interviewees was using the prepositions 'at', 'in' and 'on'. In some areas of modern life, some of these problem areas may be considered insignificant, as most professional people use word processing software

to correct their writing; however, in medicine, accuracy is of the utmost importance and, as seen in the Ubani case that was discussed in the introduction chapter (Dreaper, 2010), can lead to matters of life and death. The participants recognised this and acknowledged the need for rigorous assessment in the form of the IELTS test. For some, this did not mitigate the frustrations that they faced in working towards the IELTS requirements of the professional bodies that they wished to register with. They remained motivated to achieve their goals and had some robust strategies to overcome their SLEs.

4.7.6 Findings for Research Question Two

The analysis revealed that 'knowledge representation' and 'knowledge processing' were the most commonly indicated sources of problems for all of the participants. The identification of the 'knowledge representation' domain reinforces the idea that, even though fewer errors were attributed to L1 interference in the answer to research question one, they still present a sizeable challenge. The identification of problems attributed to the 'knowledge processing' domain further reinforces this evidence, as well as supporting the suggestion that new forms that are peculiar to the English language, and indeed to the skills called upon in the IELTS academic test, need to be internalised by learners.

One unexpected finding in answering research question two was that none of the participants in phase one identified the 'neuro-biological' or 'socio-affective' domains. In the literature, as well as in the experience of the author, these domains play a major role in halting the progress of language learning. Indeed, with reference to the earlier discussion on neuro-biological factors in the literature review, one of the most prevalent, yet disputed, theories in language learning research is the idea that people who started learning a second language in childhood outperform those who began as adults (Chomsky, 1959; Krashen, Scarcella, and Long, 1979; Hyltenstam and Abrahamsson, 2005). The literature review also highlighted the body of research (Schuman, 1974; Corder, 1978; Johnson, 1996; Klein, 2003; Qian and Xiao, 2010) that finds 'socio-affective' factors to be the main cause of stabilization in language learning, in particular a satisfaction of communicative needs.

It may be that the participants felt that these were very negative and deeply personal factors and therefore they were reluctant to admit that advanced age, lack of talent or other 'neuro-biological' factors were holding them back in achieving their goals. Similarly, their perceptions of 'socio-affective' factors may have been influenced by the idea that these suggest a lack of affinity with their host culture and its language. On the other hand, the success of the participants in achieving the GMC entry requirements might provide evidence that these factors genuinely did not impact upon them.

One striking negative aspect that was highlighted in the interviews was the impact of culture shock on the participants and how this affected them in seeking opportunities to practise their English. This echoes the findings of the European Science Foundation project (Norton, 2013). However, many of the participants exhibited strong strategies for making contact with native speakers, such as extroversion and remaining undaunted by their own errors and attempting to learn from them.

Furthermore, the responses to questions about strategies support the fact that the participants were engaged in a variety of socio-affective strategies for learning the language, from participating in their children's school lives to engaging in voluntary work in shops. The majority of the participants agreed that, although they enjoyed learning and using English in general terms, the significance of the barrier to re-joining their careers that IELTS represented affected their on-going language learning experiences.

It should be borne in mind that the participants were asked for information on their experiences as applicable to them, and were presented with questions on linguistics, which was not their field of expertise. Alongside my own interpretation of Han's six domains, this may have led to the findings being as they are reported here. Although the domains were extremely useful as a way to engage the participants in dialogue, they did not arise from empirical work by Han and there may thus be some flexibility in their interpretation and application in this project.

4.9 Summary

In phase one, the findings showed that attempting to pass the IELTS test represented a hiatus in professional practice but that there did not seem to be a pattern within the participants between age and success in IELTS. It also seemed that a high level of motivation was able to compensate for a lack of English language learning in early life. The data also suggested that different people defined the phrase 'learning English' differently, and as such, the participants' language learning experiences needed further exploration. A further point that arose from the data was that the majority of the questionnaire respondents had achieved an IELTS score of 7.0 or above. Despite this, they identified themselves as having more problem areas in English learning than the interviewees, who had not yet achieved the required IELTS score, demonstrated in the results of the diagnostic language quiz. This was a surprising finding and, as mentioned above, this may reflect the on-going challenges that the questionnaire respondents faced post-IELTS.

The data from phase one also indicated that the number of errors that are attributable to common errors in IELTS at level 7.0 and above was slightly higher than the number of common errors between the first language and the target language for each of the language groups that made up the participant group. The data revealed that none of the participants, in either the questionnaire or the interviews, felt that the causal factors in Han's (2004) 'neuro-biological' or 'socio-affective' domains were responsible for their language problems. However, there were a number of statements made after the mapping exercise stage in the interviews, which alluded to these domains. All participants felt that the 'knowledge representation' and 'knowledge processing' were the main difficulties; however, the questionnaire respondents ranked these two problem areas slightly differently to the interviewees, who selected 'knowledge representation' as the main problem followed by 'knowledge processing'.

The impact of life histories, educational experiences and other influences was evident throughout the interviews. While being highly personalised to individual experiences, many of the interviewees felt that they had experienced some challenges in using English in social situations. Many of them based their decision to come to the UK after displacement on their English language skills but some struggled with using the English language as it is spoken in the UK, particularly informal usage. Half of them described some degree of culture shock upon arrival and this manifested itself in different ways. Many felt that their early English language lessons were not adequate but all of the interviewees felt motivated to continue attempting to pass the IELTS test. Most of the participants felt that they needed a greater degree of contact with native speakers in order to improve their language skills further.

Chapter 5. Phase Two: Methods, Analysis and Findings

5.1 Introduction

In line with the previous chapter, this chapter will describe the methods used to collect and analyse the data from phase one, before describing the findings for phase two. The second phase of the data collection was completed in order to find answers to the following research questions:

RQ3. Research question three: What are the participants' responses to the emerging findings of the study from research questions one and two?

RQ4. Research question four: What are the views of expert witnesses on the training and language skills of displaced medical healthcare professionals?

The methodology chapter details the design for collecting the data, which was carried out in the following ways:

- Participants from the IELTS classes held in the DPiA centre were invited to attend a focus group.
- Expert witnesses working in areas that apply to English language testing of displaced medical healthcare professionals were interviewed via Skype or, if these were not possible, an open answer email questionnaire.

Upon corroborating the evidence from phase one via a thematic analysis of the questionnaires and interviewees' statements, I found that the participants spoke most frequently about problems that belong more to the 'environmental' domain, followed by 'knowledge representation', then 'knowledge processing', then 'psychological'. However, I also found that mention was made of 'socio-affective' factors and a few statements indicated that there might have been some 'neuro-biological' barriers too. Finally, the findings from phase one revealed that all of the interviewees felt that the IELTS exam was not ideal for testing suitability for entry to the GMC. Although they were not asked the question in the questionnaire, it is entirely possible that the questionnaire respondents may have felt differently once they had achieved the necessary IELTS results, as many of them appeared to have done. However, in the single follow-up open answer questionnaire response that was received from someone who had passed the test, Dr. IE said 'I believe that IELTS is not

ideal assessing system for English skills especially the reading part as it is filled with a lot of extra words to make confusion for the candidate.'

The second phase sought to explore these findings through the focus group and with expert witnesses, all of latter who were engaged, one way or another, in assisting displaced medical healthcare professionals who wished to return to their medical careers.

The themes that featured in the second phase of the data collection were explored in order to gather more information on the impact of personal experiences on SLEs, particularly since the data in phase one showed little ascribing of language errors to the 'neuro-biological' and 'socio-affective' domains. This was puzzling given both my personal experience of teaching such groups and the general commentary in the literature on these areas. Having been through rigorous screening to assess their cases for receiving indefinite leave to remain in the UK, it is possible that displaced medical healthcare professionals may wish to avoid any indication of psychiatric problems or a lack of affinity with their host culture, which may be associated with the 'neuro-biological' and 'socio-affective' domains respectively. Similarly, they may harbour concerns that such declarations could affect their prospects of returning to the medical profession. It should also be remembered that in some cultures, psychiatric problems are still perceived to be a taboo subject. Additionally, many people who have been displaced from countries with oppressive political regimes may be disposed to avoid criticism of the cultures in which they live.

As described in chapter four, the overall research design sought to build on the evidence of phase one to inform development of phase two.

5.2 Methods for Phase Two

As discussed in Chapter Four, the theoretical considerations for the research design of the thesis were explored in Chapter Three. The following section will describe the practical aspects of preparing for the data collection for phase two, collecting the data and the methods of analysis that were used.

5.2.1 Preparing for the Focus Group

The focus group represents the first stage of phase two of the data collection, and as such, was reliant on the analysis of all the available data from phase one. The initial findings from the first phase informed the areas for further discussion. Although the semi-structured interviews were thorough in their coverage, there appeared to be room for more detail on the participants' life histories. Having conducted the interviews with the participants, I felt that a greater level of rapport had been established and that the participants might be willing to provide more historical information on their attitudes towards English speaking cultures and English language learning. It was also explained to the participants that it was striking that none of them had indicated any problems stemming from the 'neuro-biological' or 'socio-affective' domains, and that these would be further explored in the focus group.

The participants were asked to comment on the statements in the focus group interview schedule, which drew on certain areas from the interviews that were related to Han's taxonomy of possible causes for SLEs:

Life history.

- I enjoyed learning English as a child.
- I enjoy using English as an adult.
- There was a positive view of English-speaking cultures in my country.
- I have changed my views about English-speaking cultures since being in the UK.

Age, memory and/or any other mental changes.

- I don't have the mental capacity to learn any more.
- Getting older has made it more difficult to learn English.
- I'm too old to learn English.
- I'm not able to remember things in the way that I could before.
- My mind is 'hard-wired' to my first language.
- I'm not good at learning languages.

Feelings towards English speaking cultures, my ability in English and/or losing my culture.

- I don't need to learn more English in order to communicate my needs.
- I can't identify with English-speaking cultures.
- I don't want to lose my identity through learning English.

- My feelings towards English speaking cultures are holding me back from learning the language.

The focus group was piloted with three volunteers from the student body of a university based English language school. After informed consent was gained, the discussion lasted around twenty-one minutes. Each participant shared their views and opportunities to speak seemed equal. While some of the questions seemed less relevant to the student volunteers, largely due to their age, they all agreed that the statements that they were asked to respond to were clear. They also said that they had no concerns over voicing their opinions in relation to the statements. The recording was clear and there was no difficulty in identifying simultaneous utterances when playing it back.

5.2.2 Preparing for the Expert Witness Interviews

Once the data from the focus group were collected, they were transcribed and given a 'first pass' reading to identify themes. These observations are as follows:

- Learning English as a child was 'low risk'.
- English is useful, professionally and otherwise.
- Age is not a barrier but additional responsibilities associated with age, are.
- Socio-affective strategies (Skehan, 1989) are preferable to textbook learning.
- Computers may reduce the need for English skills e.g. word processors can check spelling, templates can be used etc.
- IELTS topics may not be appropriate for doctors.
- Time pressure in the IELTS exam may not reflect real-world situations.
- IELTS need not be a demotivating factor, but does present a hiatus in professional practice.
- EU laws concerning healthcare professionals are unfair.
- Policies should be reconsidered.
- Can provision be made for refugee doctors and displaced medical healthcare professionals to work in menial roles in the NHS before achieving 7.0 in all skills in IELTS?
- People in the UK may sometimes be less diligent than their reputation overseas would suggest.
- No fear of loss of culture but some concerns about this for their children.

As discussed in the methodology chapter, the second review of data in phase two used the same applied thematic analysis, which had been undertaken with the data in phase one.

The approach used domain and taxonomic coding to identify overarching themes from the focus group session (Saldaña, 2013). The third review of the data used a constructionist

analysis, which according to Silverman (2011), allows deeper insights into the dynamic between the participants and complements the thematic analysis of content, as discussed in the methodology chapter.

The expert witnesses for the project were selected from within my professional network. As such, they had all been approached informally prior to receiving an initial email. In the email, an overview of the project was given and informed consent was covered. The expert witnesses were reassured that they would only be referred to by their professional role and their names would not be used. The expert witnesses were also asked if they would be willing to conduct an interview via Skype or provide a written response to the questions via email. These two options were offered in order to take into account the fact that many of them did not live in the local area and some of them might not have had access to Skype or time to arrange an interview using the programme. The decision was taken to use Skype as a first option because it was the best method for replicating a face-to-face interview and therefore would provide most of the richness of data that an interview could yield. Using Skype was likely to present some unique challenges such as selecting software that would allow the Skype interviews to be recorded, as well as more common technical problems like a low Internet bandwidth. It was therefore important that the use of this technology be piloted. I had used email as a method for gathering responses to open-answered questions prior to this project and using technology in this way was not an overall concern.

The six proposed expert witnesses were broadly divided into three groups: teachers, policy makers and experts working with refugee doctors 'post-IELTS'. As such, three sets of questions were designed to be appropriate to these areas and a further set of generic questions was added to each of the three sets of specific questions in order to add cohesion to the expert witness interviews. In all cases, the questions were based on the findings from phase one, as well as the findings from the focus group. The questions that were used are featured in appendix 22.

In order to pilot using Skype, the relevant Skype recording software and the questions themselves, a colleague who works in ELT in a Higher Educational context was recruited to conduct the interview. The colleague in question has extensive experience in teaching IELTS and so the set of questions that was piloted was the one relevant to teachers. All of the software functioned as expected and the feedback on the questions was that some greater emphasis on the word 'learning' in the phrase 'English language learning' in the first of the general questions might be useful. In order to emphasise this for future interviews, the phrase was highlighted in the interview schedules that were used. The recording of the interview was saved in an appropriate format and played back very clearly.

5.3 Collection of the Data for Phase Two

The focus group provided an opportunity for participants to respond to the findings of the project to date. A convenient date for the focus group was arranged via their teacher and informed consent was sought. The focus group interview went ahead on the 14th of June 2013, at the start of one of their speaking practice classes in order to lessen possible inhibitions in participating. It was carried out in the same context as the interviews i.e. before the IELTS classes at the DPiA centre and three of the interviewees, namely Dr. Farid, Dr. Ghanem and Dr. Jasmine attended, with a fourth member, Dr. Karimah, who had re-joined the class since the interviews took place. I was the fifth member of the focus group and acted as the moderator for the session, referred to in the notes as GR (please see appendix 23 for the transcript).

Once the data from the phase one and the focus group were analysed on a preliminary basis, the expert witnesses were contacted. In practice, the use of Skype and open answer email questions to collect data from the expert witnesses worked well but two of the intended six expert witness participants declined to participate due to the timing of the interviews, which were taking place when sensitive policy changes were being implemented. The three interviews were carried out via Skype between July and August 2013 and one response to the open answer questionnaire was received in September 2013.

5.3.1 Transcription of the focus group and expert witness interviews

The transcription for the focus group was less meticulous than transcription of the interviews, choosing to focus on meaning and readability, rather than the level of accuracy that featured in the individual interview transcriptions. This decision was taken due to the fact that the majority of the participants in the focus group seminar had participated in the individual interviews so there was already a good body of data that accurately represented their speech patterns. It also reflected the aim of the third research question, which was to examine the participants' responses to the findings of phase 1 of the data collection.

5.4 Methods of Analysis for Phase Two

As stated in section 3.7 of the methodology chapter, the over-arching analytical framework is qualitative and thematic. However, different analysis instruments were used to develop a further understanding of the research questions and illuminate the findings. The details of the methods of analysis for phase two are described within this section.

5.4.1 Methods of Analysis for the Focus Group Data

A central point in this study is to provide the participants with a voice and the focus group acted as a further opportunity to explore the relevant experiences of the participants. One benefit of conducting a focus group is that the findings can be reported back to the sample group and their responses to the findings can be collected efficiently. Therefore, it was essential that all aspects of this stage be reported as fully as possible. Silverman (2011) illustrates the benefits of using thematic analysis in conjunction with constructionist methods of analysis in order to provide information on the setting of a focus group seminar. Used in tandem with a more conventional thematic analysis it was intended that the different methods of analysis would ensure that the maximum results were obtained from the transcript.

The thematic analysis differed from the analysis used for the semi-structured interviews in phase one as emergent themes that came about during the analysis were used. The analysis was based on the principles of domain and taxonomic coding (Saldaña, 2013) and looked at the overarching themes or domains in the first instance. This was then further broken down into the following more detailed groupings mainly based on Han's (2004) taxonomy, with two additional categories: 'positive factors' and 'policy and political factors' included to ensure that all of the available data were categorised:

- Positive factors
- Environmental factors
- Knowledge representational factors
- Knowledge processing factors

- Psychological factors
- Neuro-biological factors
- Socio-affective factors
- Policy and political factors

Once these categories were established, subcategories were then identified and itemised using exemplars from the transcript.

The constructionist method was also taken from Silverman (2011) and involved examining the dynamics of the group including calls for agreement, contradiction within the group, development of themes and individual dynamics within the group. This was done via a description of the dynamics of the group as witnessed by the researcher and recorded in the field notes. The recording should demonstrate:

- how focus group speakers skilfully attend to the constraints and opportunities presented by the positioning of what they say within a sequence of turns
- how we can establish participants' own understandings as displayed directly in the talk.

(Silverman, 2011, p.221)

This secondary analysis was intended to move away from the potential for the researcher to infer the participants' understanding of their situation and more to attempt to gather information on their social and psychological viewpoints. This was carried out via an examination of the discourse markers, interjections and observations of commonality between the participants' contributions to the focus group interview.

5.4.2 Methods of Analysis for the Expert Witness Interviews

The data were collected in two forms: recorded Skype interviews and email open answer questions. The data were examined and a thematic analysis was conducted with the themes being taken from all of the previous data:

- Barriers to learning;
- Socio-affective factors, such as integration or change of status;
- Learner characteristics;
- Suitability of IELTS;
- Impact of IELTS training.

The different backgrounds of the respondents at this stage were kept in mind in analysing the expert witness interviews. The areas of overlap in their professional contexts were reflected in the use of VENNY; an online Venn diagram generator (Oliveros, 2007), which allowed the codes generated during the thematic analysis of the expert witness statements to be examined for areas of overlap. The use of a Venn diagram was considered in order to allow a visual representation of the intersections between the expert witnesses and their relationships to displaced medical healthcare professionals, as well as to examine areas of intersection between their points of view on the subject.

5.5 Participant Profiles

5.5.1 Focus Group Vignettes

The three interviewees from phase one who were present in the focus group session were Dr. Farid, Dr. Ghanem and Dr. Jasmine. The fourth member of the focus group was referred to as Dr. Karimah, using the same naming convention described above.

Dr. Karimah

Dr. Karimah was from Sudan and had spent three years in the UK. Her husband was working as a surgeon in the UK at the time of the focus group. Although she had attended the IELTS classes held at the DPiA centre prior to the focus group session, she had returned to Sudan for three months during the time of the original interviews. Whilst in Sudan, she took an IELTS test and achieved 7.5 in speaking, 7.0 in listening and reading and 6.5 in writing. This meant that she was not able to join the GMC to train as a surgeon and suffered some demotivation before returning to the IELTS classes.

5.5.2 Expert Witness Profiles

The teacher had been working with doctors and teaching English language exam strategies since 2001. He began delivering IELTS classes to refugee doctors and displaced medical

healthcare professionals on behalf of the DPiA group in 2006 and has helped a large number of his students to achieve the necessary IELTS grade to progress to the next stage of re-joining their careers.

The author had been working the field for over 30 years and has written many IELTS textbooks and other ELT materials. He has worked with refugee doctors since the 1990s and has published a chapter on IELTS in a book specifically dedicated to the topic of refugee doctors.

The advisor was involved in a 2013 consultation on forming policies for assessing overseas doctors wishing to join the GMC. She authored a number of books on English language learning and assessment policies for English language learners.

The researcher recently carried out research at doctoral level, which was based on the trajectories of refugee doctors once they have passed the IELTS examination and are engaged in the latter stages of joining the GMC. He is a tutor at the Refugee and Asylum Seekers Centre for Healthcare Professionals Education (REACHE) northwest and has assisted a large number of refugee doctors in re-joining their careers. Evidently, there are some commonalities and areas of overlap between the professional contexts of the expert witnesses. Figure 23 below illustrates these in the context of this research.

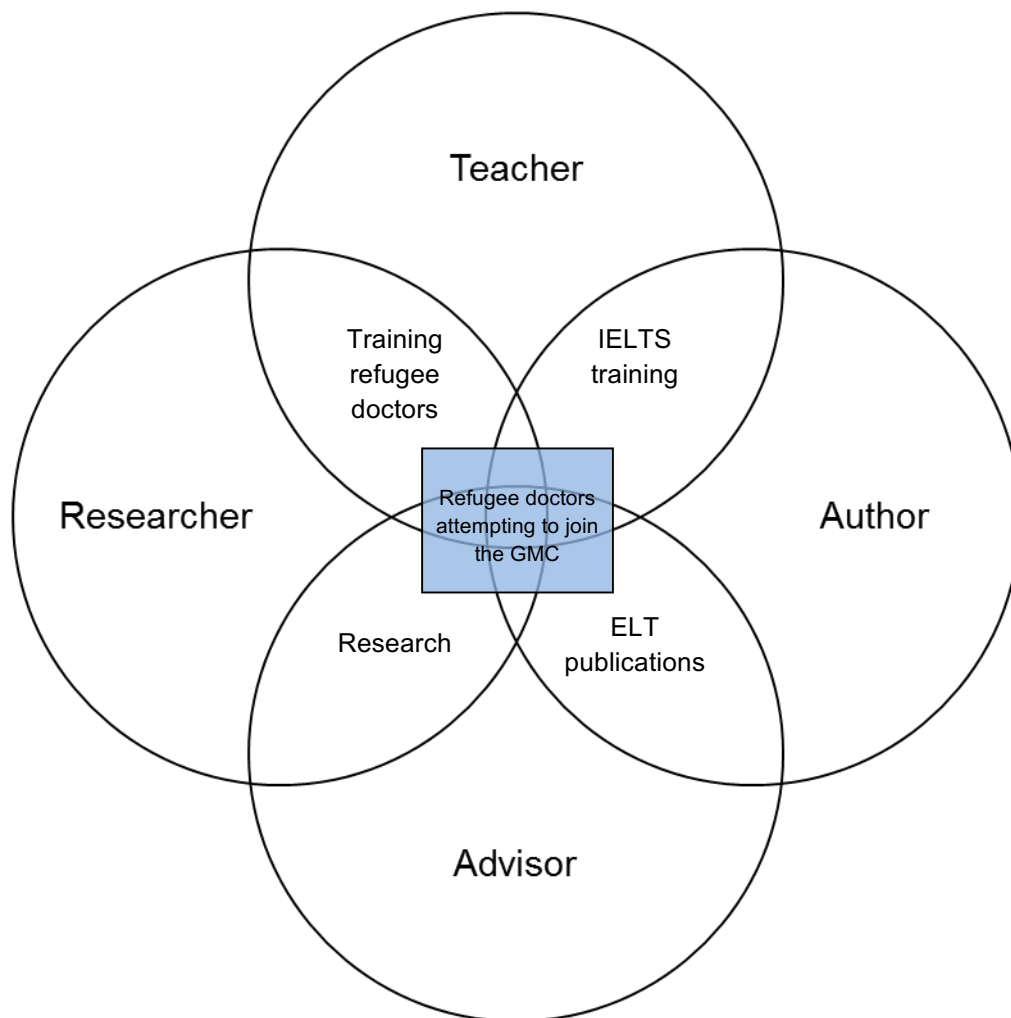


Figure 23. Expert witnesses and how their areas of expertise intersect in the context of the research

As illustrated in figure 23, the teacher and the author work regularly with refugee doctors and displaced medical healthcare professionals in preparing them for the IELTS exam. Both the author and the advisor have a number of publications on both practical ELT and policies surrounding assessment of English language skills. The common ground between the advisor who investigated the suitability of the IELTS test for the purposes of the GMC and the researcher, who examined the trajectories of refugee doctors after they had met the IELTS requirements, is research. The link between the researcher and the teacher is that they have both been involved in training refugee doctors.

5.6 Research Question Three: What Are the Participants' Responses to the Emerging Findings of the Study in Research Questions One and Two?

The focus group was intended to add further commentary the findings from the first phase of the data collection. In particular, the focus group was designed to examine the information on life and educational histories, the effects of any neuro-biological factors and socio-affective factors experienced by the participants on the SLEs. The focus group also gave space for informal responses, such as rich descriptions of personal experiences and the interviewees' views about their past and present situation. Although these responses were less focused on the SLE issue per se, they were highly relevant and shone more light on the impact of life, educational and other experiences.

Some of the findings from phase one, such as Dr. Farid's strong motivation in overcoming his lack of learning English in his formative years, were highly individual and did not feature in the interview schedule for the focus group. Another aspect was that the participants felt that the IELTS was not an ideal test for their purposes. In my experience, preparing students for the IELTS test, there is a natural tendency for many people facing a high-stakes examination, to find flaws with the assessment. This was supported by the fact that none of the questionnaire respondents, the majority of whom had achieved the desired IELTS score, mentioned this when asked about their language learning problems.

5.6.1 Analysis of Focus Group Data

The focus group transcript can be found in appendix 23. This was read several times and analysed to identify, thematically code and consider the key points that were made. The thematic codes were used to generate overarching categories relating to Han's (2004) domains for the causal factors of SLEs, as well as other observations that arose during the focus group discussion, including statements on positive aspects of language learning and

political observations on policies for registry with the GMC. Table 18 provides information on the categorisation, coding, number of instances with examples from the transcript.

Table 18 Coding of the Focus Group Interview

| Main-category (total) | Coding | No. of instances | Example |
|--|------------------------------|------------------|--|
| Positive aspects of language learning (16) | Motivation | 5 | it could be depressing for us but on the other hand it could be motivation |
| | Benefits of using English | 5 | the English language is a scientific language and also a trade language |
| | Integration | 2 | language is one of the main areas for us to become integrated with others |
| | Benefits of any L2 | 2 | Many people I know learn Russian and Turkish because of the trade relations |
| | ELF | 1 | it was the main language, like an international one |
| | Technology and globalisation | 1 | we do not see English in a bad way because most of us had satellite |
| Environmental (10) | Input | 4 | I enjoy English...when I use it in a general situation not specifically in classes |
| | Responsibilities | 4 | not age but the responsibilities and the problems that you have while you learn English |
| | Environmental | 2 | what makes learning in childhood enjoyable, the atmosphere of learning for children |
| Knowledge representation (3) | Access to UG | 1 | children find it easier to learn English, to acquire this foreign language |
| | L1 interference | 1 | first I refer to my mother tongue and there are some differences |
| | L2 interference | 1 | sometimes it became a disadvantage because you mix between the two languages |
| Knowledge processing (2) | Skills transfer from L1 | 1 | even if it was in Arabic I would never write a 250 word essay |
| | Transfer across skills | 1 | maybe I'm very good in expressing my knowledge to you by speaking |
| Psychological (4) | Psychological | 1 | The child may not feel shy if he makes a mistake |
| | Learning style (top down) | 1 | Personally speaking, I never liked the grammar part of English |
| | Usage vs. use | 1 | there should be some facilitation for waiving student for spelling mistakes or something |
| | Communicative strategies | 1 | I will explain to a person in a simpler way |
| Neuro-biological (9) | Depression | 6 | I had to stop these negative feelings, if I was haunted by them I would be in serious trouble |
| | Age | 3 | as you get older, the flexibility in your brain reduces |
| Socio-affective (29) | Deprofessionalisation | 7 | you have a feeling of losing this qualification because you do not practise |
| | 'Why should we?' | 6 | as a doctor... you have to be very good in English but we don't have to go backwards |
| | Status | 4 | when doctors are sitting in front of their computers, they will record or a secretary will write for them |
| | Culture shock | 4 | I thought people were more educated |
| | Generational loss of culture | 4 | because we had our own culture previously, we can choose what is important and beneficial for us but not for my children |
| | Loss of culture | 2 | I have my beliefs and I am holding them strictly and this will not affect my learning |
| | Spiral curriculum | 1 | it's not going to come up in our future career if they want to concentrate on... grammar |
| | Lack of acculturation | 1 | the middle East...doesn't care about the ability...to talk about something in general |
| Policies and politics (14) | Policy | 6 | the policy of dealing with professional refugees should be reconsidered |
| | Suitability of IELTS | 4 | ...what is media going to do for example for a dentist or a doctor? |
| | Politics of English | 2 | the English language imposed its necessity upon others, it's an international language |
| | Time constraints of IELTS | 1 | what I feel is unfair is the time limit... in university... for a PhD... there is not a fixed time |
| | Support | 1 | practising in a hospital will make everyone more experienced... more than studying at home |

As is evident in the coding of the focus group interview in table 18, a number of positive points were made about learning English in preparation for the IELTS test. Most of these referred to motivation, the benefits of using a second language, primarily English, as a means of cross-cultural communication, the use of English as a tool for integration and one participant, Dr. Jasmine, mentioned the benefits of using technology to broaden cross-cultural communication. Sixteen comments were made in relation to these points and they were categorised under 'positive factors'. It is encouraging to see that, in spite of the adversity that the participants had faced, they were able to draw these positive conclusions about the benefits of using English. However, the motivation that is evident in the positive statements in table 18 alludes to the use of general English, rather than the specific language that is needed for success in the IELTS academic test. In other statements in table 18, for example 'I enjoy English...when I use it in a general situation not specifically in classes' and 'as a doctor... you have to be very good in English but we don't have to go backwards' it seems that the participants resent the formality and rigour of the IELTS test.

It should be remembered that this phase of the data collection sought to further examine the participants' life and educational histories, as well as the 'neuro-biological' and 'socio-affective' domains. This may offer some explanation as to why the highest number of references made during the sessions, twenty-nine in total, was to the 'socio-affective' category. As discussed in the literature review chapter, Han's (2004) definition of 'socio-affective' was broadened to incorporate socio-psychological features ranging from social interactions to learning strategies related to a personal reflection on one's status in a community. This broadening was based on definitions found in the literature (Vandergrift, 1999; O'Malley and Chamot, 1990; Siegel, 2005; Behera and Tripathy, 2009). This may also explain why the second most mentioned domain, referred to ten items during the discussion, was the 'environmental' domain, which refers largely to matters related to educational histories. There were also frequent references to 'neuro-biological' factors, which meant that, although it was the third most frequently alluded to, it was not cited as

being as much of an obstacle as the 'socio-affective' category. Other references were made to the 'psychological' domain and these seemed to reflect attitudes that were introduced during the semi-structured interviews. For example, Dr. Farid remained consistent in his attitude towards the discomfiture that adults feel when they make mistakes in using a second language, stating in the focus group:

I think what makes learning English in childhood enjoyable, the atmosphere of learning for children, the main thing is repetition and a teacher in a children's classroom always repeats the information and the other thing is that children find it easier to learn English, to acquire this foreign language. As you said earlier one of the main factors is psychological and that one is the least. The child may not feel shy if he makes a mistake or something like that. I think these two factors: the atmosphere of the classroom of the children and the bravery of children to acquire a language and not to worry about making mistakes.

This contrast between learning English as a child and training for IELTS is understandable when the immediate goal of the participants in the focus group is to undergo a formal and high impact assessment of their English. This presents these participants with a daunting challenge and may represent their negativity towards the test itself. This is exemplified in the extracts in table 18 such as '...what is media going to do for example for a dentist or a doctor?' and 'what I feel is unfair is the time limit... in university... for a PhD... there is not a fixed time.'

While 'knowledge representation' and 'knowledge processing' were the most frequently cited reasons for SLEs in phase one, they were not discussed to a significant extent during the focus group, with only a few references to each during the discussion. As mentioned above, the final category, given the title 'policies and politics', did not feature in the research design, yet aspects connected to policies and political matters were mentioned fourteen times. This demonstrated the participants' frustration with their situation and the inequalities that they felt that they were subjected to.

In addition, a constructionist method of analysis was also conducted on the focus group transcript and field notes. As discussed in the methodology chapter, this follows the advice

of Silverman (2011) in allowing a more holistic observation of a focus group session. This adds to the thematic analysis as it provides an insight into the dynamics of the group, how they acknowledged the challenges that faced them and provided their own analysis of each other's assertions. The constructionist analysis is featured in appendix 24. Line numbers in the full analysis cross-reference those in the thematic analysis from appendix 23.

The first observation that was made on the dynamics of the group was that three of the participants, Dr. Farid, Dr. Ghanem and Dr. Jasmine, had already been involved in phase one of the data collection and may have had a greater rapport with me, the researcher, than Dr. Karimah, whom I had only met on that day. The level of rapport and trust that had been established through the semi-structured interviews was particularly evident in the participation of Dr. Farid. As discussed in the profile of Dr. Farid, he appeared to be curious about the reasons behind the interview questions during the semi-structured interviews; however, he was apparently a lot more comfortable during the focus group. This reflects Yow's (1994) suggestion that taking the time to make sure that a participant understands the reason for their involvement can lead to a greater level of trust. In this case, the group composition seemed to support Dr. Karimah, as she was familiar to the other members of the group (Barbour, 2007). This was reflected in her reluctance to provide her opinion immediately, instead waiting for the Dr. Ghanem to speak first before taking her turn.

Another dynamic that was almost immediately apparent was a 'call and response' situation between the two male members of the group, who were also both from Syria. As stated in the extract below from the analysis in appendix 24, there was an observable pattern of Dr. Ghanem speaking after Dr. Farid to support and expand upon the points that he made:

After Dr. Farid had made his point, Dr. Ghanem made a further contribution, which supported Dr. Farid's statement. This was the first instance of an apparent dynamic between these two doctors and countrymen, where they would support each other's statements throughout the interview.

Barbour (2007) describes this dynamic as Dr. Farid and, to a lesser extent Dr. Jasmine, acting as 'co-moderators' where they led the responses to the topics that were discussed.

A further aspect of the focus group that was established quite early on during the session was Dr. Jasmine's tendency to shift away from the points that were being discussed, often leading the conversation towards her own preferences and frustrations. In returning to Dr. Jasmine's profile in section 4.5, it is clear that there were some areas that she was reluctant to discuss and this may be the reason for her deviation away from the personal learning strategies that the other participants were discussing, and towards her frustrations with the IELTS test format. While her statements revolved around Han's (2004) 'psychological' domain, where she alluded to having a natural tendency to focus on content, not form, she felt that the IELTS test did not adequately accommodate this tendency. Many times, when this occurred, Dr. Farid would make an attempt to return to the initial point by providing a pragmatic counterpoint. This quickly became a point of contention between them but I made some headway in neutralising the disagreement after the first few instances as group moderator. Similar to the aforementioned 'call and response' dynamic between Dr. Farid and Dr. Ghanem, there were a number of occasions where Dr. Karima would follow Dr. Jasmine's statements with supporting points. Arguably the most neutral member of the group was Dr. Ghanem, for example when giving his views on using English as an adult but balancing it out with a statement supporting Dr. Jasmine on the pressures of performing well in the IELTS writing task under time constraints. The rest of the group agreed that generally, they enjoyed using English, for example, Dr. Karimah referred to her resultative motivation to improve, when she was in school:

It's a different language and my score was high in secondary school so that made me interested to progress and to achieve a high score all through secondary school.

After Dr. Farid had followed Dr. Karima's statement with his opinion, Dr. Ghanem spoke about the benefits of his early language learning experiences, agreeing with the general sentiments of the group:

For me, I agree also and I was really lucky because when I was young in primary school, I was in a private school which the second language was English and I think that the most important factor is the encouragement from parents, at that age and as my parents encouraged me a lot, especially because my father is a teacher in

university, he understood the importance of a second language, especially for the future, for studying or for my future career. And I was really happy to learn a new language. And I think it helped me when I did my postgraduate study, I learnt a third language, which was the French language, and on one hand it helped but on the other hand, sometimes it became a disadvantage because you mix between the two languages.

Here, Dr. Ghanem acknowledges the benefits of positive influences in his learning environment and indicates the potential for learning French inhibiting her learning English, which is described by Han (2004) as falling under the 'knowledge representation' domain.

At this point, Dr. Farid mentioned a loss of status, which prompted me to attempt sensitively to pursue the difficulties that the participants may have endured with the upheaval of displacement. Dr. Farid, who had introduced the topic, presented a balanced picture of how depression can be turned into a motivating factor. When Dr. Jasmine contributed, she quickly brought up the apparent unfairness that doctors who achieved their PMQ in an EEU country did not have to undergo the IELTS test. Again, this reflects her reluctance to discuss personal problems and to lead the discussion towards the inequity of GMC policies at the time of the data collection. In this case, it could be concluded that Dr. Jasmine had satisfied her own communicative needs (Han, 2004), but not the communicative needs imposed upon her extrinsically via the GMC IELTS requirements. She went on to make an analogy to the IELTS test being like a rock in the path of her progress, which she had to try to chip away at, little by little. Dr. Ghanem later picked up on this analogy. Although this was clearly a matter that affected the group significantly, it is a moot point as, at the time of the focus group, 7.0 in IELTS was a requirement that they all had to meet.

The opportunity to further discuss the impact of displacement had passed for the time being and I left further questioning for later in the session. Instead, I asked the group how they might feel working alongside doctors whose L1 was not English but who had not had to take the test. Dr. Jasmine's response was that it would not make a difference, as she would be able to talk to colleagues in a simplified way if necessary. Dr. Farid and Dr. Ghanem both agreed that they would be pleased to have a better command of the English language, but

that it would come at a cost in terms of time spent training and the subsequent loss of earnings. Dr. Karimah provided an example of two friends of hers, one who did not have to take the IELTS test due to her personal circumstances, and one who did. The former was able to secure work as a surgeon, whereas the latter was not, due to the amount of time spent trying to achieve the necessary IELTS score, and also age restrictions on applying for the post. Most of the participants agreed that greater support was needed for displaced medical healthcare professionals, particularly in helping them to stay involved in their professions. Support such as placing displaced medical healthcare professionals on hospital wards as porters has been explored by the WARD group but had not come into fruition at the time of writing.

In examining further socio-affective factors, the group's attitudes towards English speaking cultures were discussed. While the participants all agreed that English speaking cultures were broadly accepted in their countries of origin, Dr. Ghanem and Dr. Karimah phrased their positive responses using some pragmatically negative words (Crystal, 1997) such as 'the English language imposed its necessity upon others' and '...occupied by the English government for a long time...'. While this does not contradict the participants' statements, it may be an indication of some ambiguous cultural attitudes towards English speaking countries. When the researcher asked about any changing perspectives on English speaking cultures since arrival in the UK, the 'call and response' dynamic between the participants was, once again, very clear. The notes from the constructionist analysis state:

I then asked the participants to comment on whether their views of English speaking cultures had changed since they had arrived in the UK. Dr. Jasmine strongly disagreed with this question and Dr. Karimah supported her point of view by explaining that extended exposure to English culture back home had meant that there were no surprises for her upon arrival. Dr. Farid related a recent story of how he had been surprised at a lack of professionalism that he had encountered. Dr. Ghanem expanded on this to say that he was surprised at a lack of etiquette that he had encountered in his daily life.

Whether this represents a lack of acculturation under Han's (2004) 'socio-affective' domain, at least for Dr. Farid and Dr. Ghanem, is difficult to ascertain. On the one hand, many UK

citizens have experienced a lack of etiquette and professionalism in their dealings with others. On the other, Dr. Ghanem's statement in particular suggests that there is a level of culture shock that should be taken into account when considering the challenges that the participants faced.

Realising that the participants were pressed for time, I combined the statements on the interview schedule that covered 'neuro-biological' factors. Dr. Jasmine, Dr. Ghanem and Dr. Farid all agreed that age itself was not a barrier to their learning, but the responsibilities of age, the pressures of having family in a dangerous situation and attempting to integrate into UK life, made the task of attempting to pass the IELTS exam more difficult. This statement is important in that it is a significant socio-affective factor that, as discussed in the literature review, comes under Han's (2004) broad category of socio-psychological reasons. Dr. Ghanem also pointed out that as doctors, continuous learning was expected of them and that studying for the IELTS test was no different.

At this point, the discussion returned to the subject of depression. Dr. Jasmine spoke freely about the personal impact of depression. Dr. Karimah stated that the source of her depression was the hiatus in her career. Dr. Farid also provided a personal account of his depression but was careful to explain how he had turned it into a motivating factor. While in all of three of the cases above, the participants had managed to overcome their depression through maintaining high levels of motivation to meet the necessary IELTS requirements, something that is missing from the data is the impact of depression on those displaced medical healthcare professionals who did not succeed in meeting them. In my experience of working with refugee doctors, there were some who decided to leave the medical profession due to repeated failed attempts at progressing to the PLAB stage. Many of these former clients of the WARD group cited depression as the reason.

When asked to respond to a concluding statement about a loss of culture, Dr. Farid, Dr. Ghanem and Dr. Karimah all agreed that their sense of their own culture was robust and any

concerns about a loss of culture were focussed on their children. Dr. Jasmine stated that she did not have children but made a reconciliatory statement about the similarities between all cultures, which concluded the session.

5.6.2 Findings for Research Question Three

The focus group was intended to examine life histories, neuro-biological and socio-affective aspects that may have presented barriers to learning. The analyses of the focus group data indicate that the participants, from distinctly different backgrounds, were generally able to interact well with each other and provide a strong sense of peer support. The number of positive statements that were identified in the thematic analysis of the focus group transcript was well supported by the obvious dynamics that were witnessed in the constructionist analysis.

It was clear that the participant group agreed that the policies surrounding their situation were in need of review. Although there was some contention within the group as to why IELTS was used as an entry examination for further training in the healthcare professions, the participants recognised that it was a necessary step in their integration into the UK and their chosen professions. The participants all felt that the inequality that existed between the GMC policies for EEU doctors, as opposed to overseas doctors, was demotivating. While there was more equity in GMC requirements after changes in the regulations in 2014, there was at the same time, a rise in IELTS requirements in general. Nonetheless, a sense of fair play was generally recognised in the new requirements and displaced medical healthcare professionals felt that they were operating in a more inclusive system.

The analyses indicated that the participants did not have any resistance to learning, but felt that the pressures of training for a high-stakes examination were quite different to those of simply acquiring the language. The group was able to reflect on their changing circumstances in considerable depth. As well as examining life and educational histories,

the research design aimed to examine any further factors under the 'neuro-biological' and 'socio-affective' domains.

The majority of the group agreed that age was not a factor that had inhibited their progress in learning English. While the group all agreed that depression was a neuro-biological challenge that they had faced, the general consensus was that depression could be overcome through endeavour. The conversation quickly led to socio-affective matters, which were connected to the responsibilities of age, such as caring for family who remain in crisis zones, as well as looking after the wellbeing of younger family. As discussed in the literature review, Winkelmann-Gleed and Eversley (2004) acknowledge this, and attribute these pressures to many displaced healthcare professionals taking low-paid menial jobs rather than re-joining their professions.

It seems entirely possible to conclude that these exceptional circumstances were an important factor in stalling the language learning progress of this group, who represented a highly unusual demographic.

5.7 Research Question Four: What are the Views of Expert Witnesses on the Training and Language Skills of Displaced Medical Healthcare Professionals?

The expert witnesses who participated in the interviews were selected from my professional network, and chosen because of their various roles working with refugee and overseas doctors who were trying to achieve the IELTS requirement to continue their medical professions. Gathering their views and opinions represented the final stage of data collection and the questions that were asked of them were designed in response to the earlier stages of data collection and analysis.

5.7.1 Analysis of Expert Witness Data and Findings

The expert witness interviews were thematically analysed under the following themes, which emerged from the findings of phase one, as well as the analysis of the focus group:

- Barriers to learning;
- Socio-affective factors, such as integration or change of status;
- Learner Characteristics;
- Suitability of IELTS; and
- Impact of IELTS training.

The thematic codes were examined to highlight areas of intersection in the expert witness data. The thematic analysis was carried out through summarising the responses to the interviews with the teacher, author and advisor as well as the open answer questionnaire response from the researcher. These can be seen in appendix 25. The notes were then thematically coded into the table, presented in appendix 26. There were 27 codes in total, which covered learner strategies and attitudes, the impact of displacement and integration, policies and support mechanisms. In order to reflect the areas of intersection in the involvement of the expert witnesses in figure 23 above, the thematic codes were examined and used to compile the Venn diagram in figure 24, which highlights areas of intersection in the expert witness statements. As described in the methodology chapter, this was done using the online Venn diagram generator called VENNY (Oliveros, 2007).

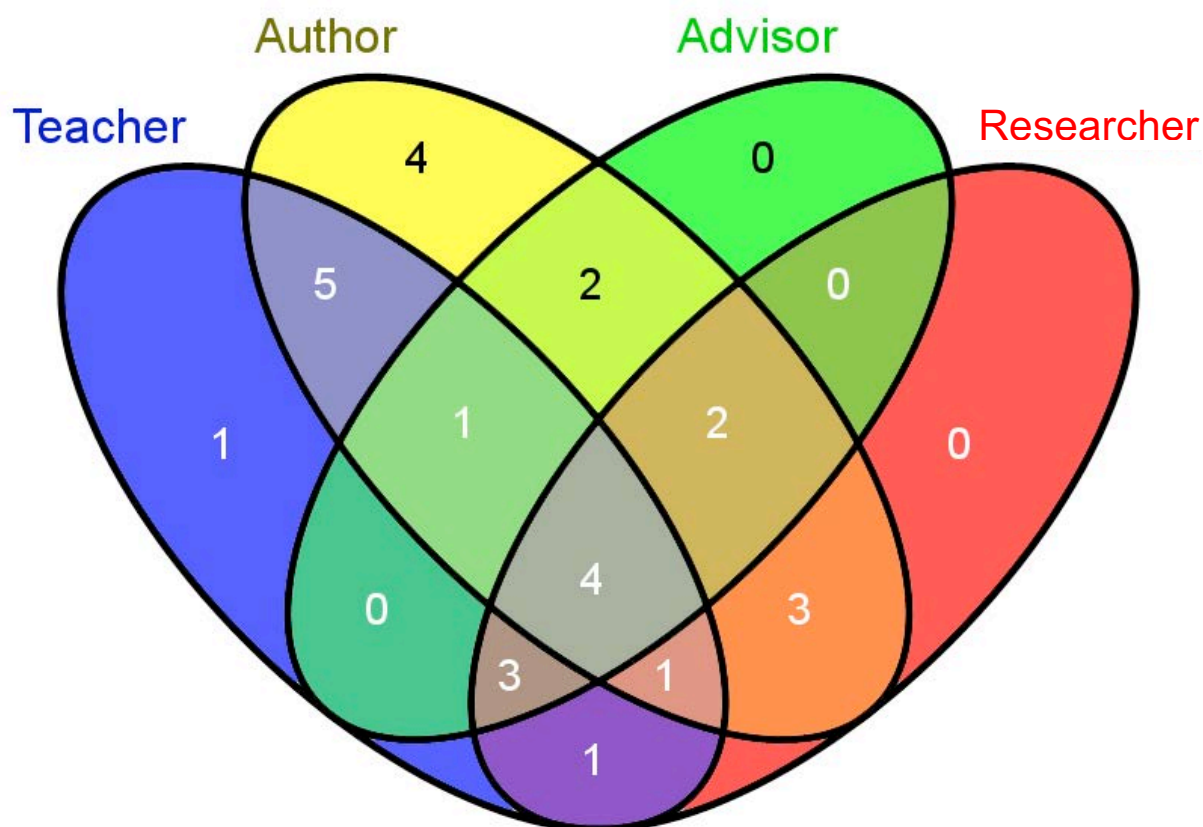


Figure 24. Areas of intersection between the expert witnesses' interviews

Figure 24 is an illustration of the areas of intersection between the coded statements from the expert witness thematic analysis, as well as the number of times they made statements that related to statements made by other expert witnesses in the group. The numbers in figure 24 indicate the number of concurrent statements that were made between the expert witnesses. For example, the teacher and the author referred to five similar areas, whereas the teacher, author and advisor only had one point of commonality in their statements.

Figure 24 shows the that there were four areas that all of the expert witnesses commented upon: flexibility in learning style, the amount of training that is required to successfully join the GMC, recognition of the barriers that faced displaced medical healthcare professionals and the suitability of the IELTS test.

All of the expert witnesses felt that displaced medical healthcare professionals needed to be flexible in their learning strategies and that this could present a challenge. The researcher exemplified this in saying that learners are prone to 'over-focussing on IELTS techniques,

rather than learning English thoroughly and comprehensively' and added that 'they also get stuck in the trap of "in book X it said I must use..." rather than applying the level of fluency that IELTS requires. As the author stated, IELTS requires candidates to reformulate and take risks with their knowledge and that if doctors apply an element of risk-taking to their professions, the results are likely to be catastrophic. However, he added that 'teaching doctors to use grammatically accurate sentences during surgery may be equally dangerous' when imperatives or the concrete nouns 'surgical tools' would suffice. All of the expert witnesses agreed that the task of meeting all of the requirements that are made of refugee healthcare professionals was a long and challenging process. They also agreed that it would be beneficial if displaced medical healthcare professionals were able to recognise their limitations and the barriers that faced them, so that they could recognise the task of overcoming them.

Regarding discussion of the suitability of IELTS, it was not surprising that all of the expert witnesses mentioned this since the research design was such that the questions that were being asked of the expert witness group were based on feedback from the previous participants in the research. One of the main themes to arise from the earlier data was about the suitability of IELTS. The general consensus between the expert witnesses was that, while IELTS is flawed, it was suitable to prepare the candidates for further professional qualifications such as the PLAB test, as well as some aspects of professional practice. The advisor stated that:

'The consensus was that IELTS was a good screening test, although there were some aspects that were not adequate; the biggest problem was listening, but the rest was good as a screening test for PLAB in terms of language proficiency and communication skills.'

This is supported by Taylor and Pill (2013) who state that the evolution of the two stage screening tests, IELTS being used to assess language and PLAB being used for medical knowledge and communication skills, were based on long-standing procedures that

originated in the 1970s. Since the introduction of the IELTS as an initial screening test, the results in the PLAB test have improved dramatically.

The teacher, the advisor and the researcher all discussed the cultural challenges that displaced medical healthcare professionals faced, both in medical practice and in the broader sense of adapting to UK culture. The researcher mentioned the gap in the understanding of medicine in a UK context and went on to say 'For overseas doctors this is different as they are coming to the UK willingly, for refugees this is often not the case and there is some reluctance to adapt to UK practice.' He also spoke of the cultural change of context:

'There are cultural issues which also need to be addressed, for example, in some cultures, domestic abuse is seen as a private matter, which is resolved in the home. However, in the UK there are legal frameworks to safeguard children and adults which the Refugee Doctors are very often unaware.'

In this sense, the impact of cultural differences may be interpreted as a lack of acculturation, which is defined in Han's (2004) framework as being a socio-affective causal factor. While the cultural differences described by the researcher above are more likely to impact on the successes of doctors at the PLAB stage, which assesses their communication skills, it does underline his earlier statement that there may be an unwillingness to adapt to UK practice. The author, advisor and researcher agreed that the task of preparing for the PLAB test was more straightforward than it had been prior to the inclusion of the IELTS test in GMC requirements.

The teacher mentioned that his students have had many problems with their adjustment to their situation, as well as the emotional toll that it took on them. Similarly, he mentioned aspects of the impact of displacement that refugee doctors and displaced medical healthcare professionals face and how this can impede their progress. The researcher exemplified this by acknowledging the severe delays that displaced medical healthcare professionals can experience in collating all the necessary documentation. Both of these statements provide reasons for many refugee doctors looking for alternative careers after

repeatedly failing to meet IELTS requirements and support the statements of the focus group about 'deprofessionalisation' (Smyth and Kum, 2010).

The author, advisor and researcher agreed on the difficulties that were presented by a loss of status for displaced medical healthcare professionals. The author spoke about the frustration that some displaced medical healthcare professionals experienced in losing their status, and the negative impact that this can have on their sense of good standing in the community. As seen in the semi-structured interviews in phase one and the focus group in phase two, this reflects the feelings of the displaced medical healthcare professionals who participated in these stages of the data collection.

The teacher, author and advisor all felt that increased research, funding and support would be beneficial to bodies aiming to assist displaced medical healthcare professionals. In defining this, the teacher mentioned the potential benefits of voluntary work in the healthcare sector, saying that 'Refugees are being thrown into UK life but running parallel, it would be beneficial if they could do some voluntary work in a medical setting, taking blood pressure, to show the expectations of a British medical centre.' but added that 'this would necessarily need strict procedures to set up, including ethical clearance and other training.' The advisor agreed that some kind of internship would be of benefit but may not be financially viable. The author and the advisor also spoke about the need for a greater understanding of the situation through further research projects.

The teacher and author also agreed with the expert witness researcher on the matter of transfer between language skills being a difficulty that overseas doctors face. As evidenced in the discussion of the literature (Selinker, 1972; Schumann, 1978; Holm, 2000; Klein, 2003; Han, 2004; Long, 2005; Birdsong, 2006), most language learners have 'spiky profiles', or profiles which are considerably stronger in some skills than others. Transferring abilities across the four skills presents a challenge to many learners, particularly in English, where there is a substantial difference between spoken English and the written word. In addition,

the author extended these problems with transfer to incorporate competence transfer, as well as emotional and situational transfer. When discussing competence transfer, the author was referring to the differences between linguistic competence and medical competence, the former requiring a degree of flexibility, which the latter would not allow. In terms of emotional and situational transfer, the author referred to the aforementioned loss of social and professional status that refugee doctors have experienced.

As explained in the methodology section for phase two, the research design was such that the questions asked of the teacher and the author, who teach refugee doctors and displaced medical healthcare professionals IELTS skills, were the same. It is therefore unsurprising that the highest number of common elements was at the intersection between them, although they did not always agree in their views. One of these differences was about the relation between age and performance. The teacher felt that mature students were more receptive to the repetitive elements of language learning than younger students. However, the author contradicted this saying that 'younger students marched through the IELTS test' and that he felt that age presented a barrier to mature students that he had instructed. It is possible that the teacher, who was working with the participants from the interview and focus group, was mirroring the positive attitudes to age that his students had.

Both of these expert witnesses agreed that capability was also a factor and felt that most refugee doctors and displaced medical healthcare professionals were capable of achieving their goals. They also agreed with the findings from the focus group on the impact of social responsibilities that displaced healthcare professionals faced. The transfer of training from medical skills training to English language and IELTS training was another point that they commented on, both highlighting the comparative rigidity of medical training. For example, the need to be precise in the administration of medicines, compared to the flexibility that IELTS training requires when students are required to restate and make circumlocutory reformulations in the speaking test. They also agreed that it was important to provide learners with strategies that are specific to language learning. Skehan (1989) advises that

training in strategies has little impact on learner successes. However, it should be considered that the author and the teacher were specifically discussing strategies for the transfer from medical training to language training.

Similarly, the author and the researcher felt that there was a disjunction between the learners' declarative knowledge, which may be an asset in medical training, and their language competence. They also mentioned the negative attitude that learners have towards the IELTS test and the fact that many of the refugee doctors and displaced medical healthcare professionals they had trained, felt frustrated at having to go through further qualifications when they had already worked in the field. The researcher observed that many refugee doctors and displaced medical healthcare professionals were not in this situation through choice, and felt the burden more acutely because of this. While this is likely to have an impact on the motivation of displaced medical healthcare professionals, the successes of the REACHE group, as well as those of the WARD group, suggest that most of their clients recognised the need to retrain and were able to succeed.

The author and the advisor mentioned alternatives to IELTS but they both agreed that, while the test is not perfect, it was the most suitable for entry into the PLAB examination at the time of the interviews. The challenges of developing an alternative test are described by Taylor and Pill:

There can be a tension between selecting an established and widely available assessment tool that is recognized and benchmarked internationally, and creating a new test, tailored to a given context or health profession group and thus immediately relevant, but potentially costly to produce and maintain.

Taylor and Pill (2014)

The author and the advisor also discussed the disparity in policies for non-EEU doctors and their EEU counterparts although, as mentioned previously, this has since been addressed by the GMC.

The teacher and the researcher agreed with the focus group on the impact of 'deprofessionalisation' (Smyth and Kum, 2010), or the loss of professional knowledge due to

a lack of sustained professional practice. They also discussed strategies for minimising the impact of this while the refugee doctors and displaced medical healthcare professionals are training for the IELTS exam. The observation of the researcher was that:

What we have observed as detrimental is “IELTS as a barrier”, a mind-set then occurs around the exam and the focus of getting back to work. If IELTS is seen as a requirement, there is less negativity around the exam and the process, as they understand that “patient safety” is the focus of the NHS.

Taylor and Pill (2014) agree that there is a need to depart from a ‘deficit model’ for language and communications assessments and suggest that a more positive approach would be to build upon the communication skills of all professionals in their context.

Additional comments were made such as those by the teacher who spoke about the high level of motivation of displaced medical healthcare professionals in comparison to other English language students he had encountered, saying that ‘[Displaced medical healthcare professionals] are far more motivated [than other English language students I have taught], it’s a pleasure teaching them but the challenge is to reassure them that you are doing enough for them.’ The author, who discussed the need for risk taking in refugee doctors, mentioned emotional learning and gender related performance.

An important statement the author made was about the need for robust IELTS teacher training and the positive impact that this could have on trainees working towards taking the IELTS exam. While there is an abundance of IELTS training materials available, there is comparatively very little specific training for IELTS teachers. Teacher training courses such as the Cert. TESOL or the CELTA, even the higher level Dip. TESOL and DELTA courses, are more general in their approaches and do not detail training for IELTS. Appendix 27 provides details of the common areas on intersection between the expert witnesses.

5.7.2 Findings for Research Question Four

In asking the expert witness group to provide their views on the findings of the first three research questions, a number of findings emerged which contributed to the knowledge

generation of this project. It seemed that all expert witnesses agreed that, while the IELTS academic test is not an ideal assessment for entry into the GMC, it is appropriate as a training mechanism that leads to the next stage of assessment in the PLAB test. The expert witnesses acknowledged that the amount of training that displaced medical healthcare professionals need to undertake is daunting, but necessary. They also recognised the unique challenges that displaced medical healthcare professionals faced. One point that had not emerged prior to the consultation of the expert witnesses was the matter of transfer. The transfer between skills had been discussed by the participants in the context of them having stronger areas in some skills than others. However, the idea that a transfer between the relatively rigid learning styles required to accumulate medical knowledge and the flexibility of training for skills required to perform well in the IELTS test had not been mentioned.

The expert witnesses agreed that more funding for research and support would be of great benefit to displaced medical healthcare professionals. They also acknowledged that the feasibility of securing such funding was in question. Similarly, the expert witnesses supported the idea of voluntary placements that the participants had suggested, but the practicality was in some doubt due to legal requirements and background checking.

The most contentious issue between expert witnesses was that of age-related performance. The teacher felt that mature students had more patience and attention to detail in learning structures and forms, whereas the expert witness author felt that, in line with the majority of the literature, age was undoubtedly a barrier for the more mature students.

5.7.3 Synthesis of the Findings from Phase Two

Table 19 indicates that there were fifteen areas that emerged from the analysis of the data from both the focus group and the expert witnesses. Within those areas, the expert witnesses agreed with nine of the points raised by the focus group, but disagreed with the remaining six. The table also indicates that there were fourteen aspects that were discussed

during the focus group session that were not explicitly addressed during the expert witness interviews. Conversely, it shows that there were eleven aspects that were discussed by the expert witnesses that did not arise with the focus group.

Table 19. Areas of agreement, disagreement and unique statements from the findings of phase two.

| Aspects discussed by both the focus group and the expert witnesses (total 15) | | Unique statements in each area of data collection for phase two (total 28) | |
|--|--|---|--|
| Areas of agreement (total 9) | Areas of disagreement (total 6) | Unique focus group statements (total 17) | Unique expert witness statements (total 11) |
| Motivation | Age | Benefits of using English | Alternatives to IELTS |
| Responsibilities | 'Why should we?' | Benefits of L2 learning | Capability |
| Transfer across skills | Status | Integration | Differences in medical cultures |
| Psychological (risk taking) | Declarative knowledge vs. competence (spiral curriculum) | English as a Lingua Franca | Emotional learning |
| Learning style | Suitability of IELTS | Technology and globalisation | Gender related performance |
| Deprofessionalisation | Negative attitude toward IELTS | Input | IELTS teacher training |
| Cultural differences | | Environmental | Impact of displacement |
| Policy | | Access to UG | Length of training for success |
| Research, funding and support | | L1 interference | Link between IELTS and PLAB |
| | | L2 interference | Medical skills to language transfer |
| | | Skills transfer from L1 | Recognition of barriers |
| | | Usage vs. Use | |
| | | Depression | |
| | | Generational loss of culture | |
| | | Loss of culture | |
| | | Lack of acculturation | |
| | | Politics of English | |

Although motivation was an area of agreement between the members of the focus group and the expert witnesses, it should be noted that this observation was made by just one of the expert witnesses. The focus group, the teacher and the author mentioned the impact of social responsibilities and all agreed that this represents a major barrier to the progress of refugee doctors and displaced medical healthcare professionals. In terms of transfer across skills, the expert witnesses outnumbered the focus group in the number of references that were made to this aspect, with only one participant talking about her preferences for using

certain skills. This was similar with the discussions on learning styles. In both cases, these aspects were more likely to be known and understood by the expert witnesses who all had expertise in language training. This is also likely to be the case with the aspects of research, funding and support, which would again be more likely to be within the expert witnesses' frames of reference. Only one member of the focus group and one expert witness referred to the psychological aspect of risk taking and, while it was mentioned on a number of occasions during the analysis of phase one, it appeared that the participants were generally unafraid of taking risks in circumlocution. The areas of deprofessionalisation and cultural aspects were equally agreed upon in both data sets. There was a lot of discussion on policy during the focus group, in particular the disparity between EEU and non-EEU doctors, where the majority of the members of the focus group felt that it was unfair. Although the expert witnesses agreed with the participants in the focus groups, there was some hesitation in their comments about this disparity. As mentioned above, the GMC's policy has been changed to make it more equal for refugee doctors and displaced medical healthcare professionals, but it has also made the entry requirements higher (GMC, 2014g).

There was some disagreement between the expert witnesses on the topic of age. The teacher felt that it was not an insurmountable barrier, whereas the author felt that it had a deeper impact. The focus group seemed to agree with the teacher's point of view, and except for a brief comment, took a more positive stance on the impact of ageing. There was a clearer difference of opinion between the members of the focus group and the expert witnesses on status, attitudes towards the IELTS test, the IELTS test requirements, training towards the IELTS test and retraining in general. The expert witnesses felt that, while these areas are challenging for displaced medical healthcare professionals, they provided the best option for the trainees, the GMC and the public and at that time, and were all necessary requirements.

In the areas that were unique to either group, it should be remembered that the research design was tailored to each audience and that the areas that were discussed were likely to

differ as a result. For example, the author towards the end of the interview briefly spoke about integration. He mentioned that many of the refugee doctors that he had worked with did not want to be regarded as 'refugee doctors', preferring to be seen as 'doctors', without the potentially stigmatising word 'refugee' attached to it. Similarly, he mentioned L2 interference anecdotally, where he was describing the impact of being a polyglot and how one student would code switch between four languages depending on his mood or the task in hand. He also talked about the difficulties of understanding slang terms and this appeared to agree with the point on 'usage' versus 'use' that was made by a member of the focus group.

The expert witness researcher mentioned a lack of acculturation when discussing medical culture, but not explicitly in reference to a general lack of acculturation, as was discussed in the focus group session. Dr. Farid alluded to the differences between medical cultures, but was talking very generally as a way of mediating Dr. Jasmine's statements on the extent of the benefits of IELTS training for medical practice. Finally, I asked about the impact of displacement but it was not discussed in the same detail by focus group participants as it was by the expert witnesses, which might relate to the acute consequences displacement represented to the focus group; as opposed to the inevitably more distanced opinions of the expert witnesses.

5.8 Summary

The findings from phase two indicate that upon deeper investigation focus group interviewees confirmed that there were some socio-affective problems that inhibited their progress. These were chiefly connected to the impact of displacement, in looking after their families and attempting to retrieve the status that they had lost at the time of displacement. These challenges were also recognised by the expert witnesses, who agreed that greater support for displaced medical healthcare professionals was needed. Both participant groups in phase two also agreed that, while IELTS may not be a perfect fit for the purposes of the

GMC, it was the best available option at that time and a necessary step towards requalification in the UK. Understandably, this situation is sometimes met with a negative attitude from those who are facing the challenge of the IELTS test, but they remain motivated to succeed. The focus group confirmed that they felt that they did not face problems categorised under the neuro-biological domain, apart from some members mentioning depression in a general sense. They also exhibited a positive attitude to overcoming this and using these difficulties as motivating factors. The expert witnesses did not agree on other neuro-biological factors such as the impact of ageing. The expert witnesses said that recognition of the barriers that displaced healthcare professionals faced was important and could be supported through further research. They also felt that the refugee doctors needed to recognise their personal barriers to learning English and integrating into UK culture: medical and social. They made the further point that, with greater flexibility in their learning styles and acknowledgement of the challenges that they face, displaced healthcare professionals stood a greater chance of success. During the focus group, Dr. Farid described an instance when he felt he was at breaking point and how he acknowledged his situation and fought against the pressures that he faced:

Yeah I faced it, very much pressure. But when I arrived at my house I paid attention to myself, I said 'no', I had to stop these negative feelings, if I was haunted by them I would be in serious trouble, so I had a shower and prayed and I promised myself to eliminate this feeling.

To summarise the three key themes that emerged from this stage of data collection and analysis:

- Depression was discussed and experienced by several members of the focus group. In spite of this, they felt that neuro-biological problems did not appear to present them with barriers to learning English.
- According to the many statements that alluded to socio-affective problems, although not initially declared, these problems appeared to be present in the lives of most of the participants of the focus group.

- The expert witnesses agreed with the focus group on a number of matters ranging from learning styles, through external influences, such as policies, the need for more research, funding and support, to internal influences such as some reluctance to take risks in language learning. Perhaps more importantly, were the areas of disagreement, which were based on the suitability of the IELTS test, the effects of maturation, the loss of status and the need to continue training to practise medicine.

Chapter 6. Conclusions and Discussion

6.1 Introduction

The NHS in the UK has suffered staffing shortages for decades. Within the same period, the UK has received thousands of displaced immigrants, many of whom are highly skilled. A subset of this demographic is displaced medical healthcare professionals, who, with the right training and support could contribute to addressing the dearth of staff in the NHS. This research project has examined the primary barriers that prevent this potential solution from taking place in the area of training and evidencing candidates' English language skills.

It is essential that necessary qualifications are in place and, as discussed in the literature review, there have been occasions where the inadequate communication skills of overseas doctors have led to catastrophes that might otherwise have been avoided. In 2014, the GMC (General Medical Council, 2014g) recognised that immigrant doctors' communication skills are as vital as medical knowledge and all applicants to the GMC whose first language is not English, are required to provide evidence of their English language via the IELTS test. However, a failure to achieve the prescribed standards in the IELTS test is holding back access in both directions: the NHS is still understaffed and there are many displaced medical healthcare professionals who are still unable to re-join their professions. The literature (British Medical Association, 2008) shows that the IELTS barrier is the main reason for the stalling of progress in displaced medical healthcare professionals joining the GMC, while subsequent stages of the process do not appear to represent such a challenge. This confirms the view of the expert witnesses that the IELTS successfully acts as a filter and supports the latter stages of GMC registration, such as the PLAB tests one and two.

This programme of research examined the problems that the participants experienced as advanced level learners of English and sought to foreground their views on what the problems were, as well as exploring how they came about. In order to ascertain the causes of their problem areas in language learning, common areas of L1 interference for the

participant groups and common errors at IELTS level 7.0 and above were used as a platform for the early stages of the project. Although the causal factors were scaffolded around Han's (2004) six domains of fossilization, the problems were not perceived to be at an end state and therefore were described as stabilized errors, rather than fossilized errors (Long, 2005).

6.1.1 Limitations of the Study

To ensure the validity of the project, an evaluation of the methodology must take place. This section will reflect on the methodological challenges that were experienced during the implementation of the project. Finally, the reflection will culminate in a critique of the research design.

The first step for this part of the research was to identify members of the potential sample group who believed that they exhibited some form of SLEs. The project focussed on a minority group in a particular profession and therefore a random population sample would not be appropriate for the study. The criteria for selection were driven by the availability of access to the sample group. I initially considered an opportunistic sample via my former IELTS students in the WARD group. It was intended that they might be able to refer me to other willing participants with similar profiles and therefore become a snowball sample. I had hoped that I might make enough connections to conduct the research project. While this has been the chosen method of selection for several excellent pieces of research into refugee issues (Stewart, 2003; Fiddian-Qasmiyeh and Qasmiyeh, 2010; Macpherson, 2010; Smyth and Kum, 2010), I was concerned that the sample that I could gather through this method would be too small to provide valuable insights. In July 2011, I met with the head of the WARD group to discuss access to their clients. They agreed to send invitations to participate to all of their 115 clients. This would still be an opportunistic sample but with a much broader one.

At this time, the method of distribution of the questionnaire needed to be considered. In a meeting with the WARD group, it had become apparent that many of their clients had been

redistributed within the UK and that others had left Wales due to employment offers within the NHS elsewhere. This meant that the questionnaires needed to be sent to respondents, either by post or via email. I had initially considered posting the questionnaires due to the possibility that the respondents may not have access to the Internet. In my professional experience, not all displaced medical healthcare professionals had convenient access to computers that were connected to the Internet. Notwithstanding, it transpired that sending questionnaires via the postal service would limit the potential sample group severely as the WARD group had the contact email addresses of their clients but did not have updated addresses on their records. Using electronic mail also brought another benefit in that I was able to produce the questionnaire electronically and would be able to distribute it easily.

Cohen, Manion and Morrison (2013) advise that although permission may be granted to access a particular sample, practicability of access may be problematic. As discussed in the literature review, refugee groups are transient and as such, difficult to meet with for any length of time. Derluyn *et al.* (2012) discussed this problem at length and found innovative ways to gather data involving collecting data for a discourse analysis from graffiti on the walls of immigration holding cells. In the case of the present study, there were a number of challenges in accessing the sample. Cohen, Manion and Morrison (2013) stress that the potential release of sensitive data might compound problems of access. Due to the sensitivity of the release of the contact list held by the WARD group, the managers sent out the questionnaire. The overall response rate to the questionnaire was 8.84% of the 115 clients of the WARD group. In using technology to disseminate the questionnaire, there were considerations around refugee groups, such as the aforementioned problem of limited access to the Internet. The last response to the questionnaire was not returned until ten months after it was sent out, which, when the peripatetic lifestyles and financial hardships of the refugee condition are considered, may suggest that some of the respondents did indeed have limited access to internet connected devices.

In addition, data collection was carried out in the form of the diagnostic language quizzes followed by the semi-structured interviews. In this case, potential participants were recruited via the IELTS classes that were delivered in the DPiA centre on behalf of the WARD group. Permission was obtained from the WARD group, the DPiA team and the participants, and the language quizzes and the semi-structured interviews took place over a three-month period from November 2012 to January 2013.

Concurrently, the questionnaire results came in very gradually and respondents who agreed to provide their email addresses to the researcher were emailed directly in April 2013 with follow-up questions. In order to maximise the return rate, second emails were sent in May 2013 to prompt potential respondents, who had not replied to the first follow up email.

In order to conduct the focus group interviews, the participants' from the semi-structured interviews were contacted via their IELTS class, and the focus group discussion was arranged to take place on the 13th of June 2013.

Lastly, a set of expert witnesses was recruited via professional network. These were selected in order to represent various perspectives on displaced medical healthcare professionals attempting to join the GMC. They included professionals who worked as IELTS tutors with displaced medical healthcare professionals, as well as policy makers who were involved in examining linguistic standards for entry to the GMC. In order to include views on the trajectories of displaced medical healthcare professionals after taking the IELTS test, other expert witnesses who worked with displaced medical healthcare professionals on more advanced stages of their journeys, such as taking either stage 1 or 2 of the PLAB exam, studying in their foundation year or practising as a doctor, were sought.

Since data were to be collected from displaced medical healthcare professionals, it was logical to include other persons who were involved in the debate around the suitability of IELTS as a GMC requirement. In the book 'Refugee Doctors: Support, Development and Integration in the NHS', Khan and Naish (2004) describe IELTS as being esoteric in its

nature. They explain that the apparent ambiguity of language testing does not always fit well with test takers, who are familiar with more scientific forms of assessment, such as in medicine. In my experience as a practitioner in the field, this is reflected in many discussions that take place among trainers, trainees and policy makers on the use of the IELTS exam as an entry point to the GMC. On occasions, it seemed that in some areas the relevance of IELTS training to displaced medical healthcare professionals was in doubt, as well as the suitability of the IELTS exam for entry into professional medical practice. During some casual discussions, and also in the data collection for phase one, this became apparent as a recurrent theme.

Although many social science researchers will estimate a response rate of between 10% and 15%, the lack of response to the questionnaires was somewhat disappointing. At the time of the data collection, the WARD group had 130 clients on their records. While the response rate reflected the aforementioned estimates, I had hoped for a greater degree of cooperation due to the nature of support that the project intended to supply. It should also be remembered that, as discussed in the literature review chapter, the nature of integration is to shed the label of refugee. In this case, it is entirely possible that people who have successfully integrated no longer engage with support groups that work with people who are at earlier stages in the integration process.

Attempts were made to improve the response rate to the questionnaire and emails were sent to the clients of the WARD group on three occasions. In addition, other similar groups around the UK were also contacted to ask if they would be happy to send the questionnaire to their clients, but all declined.

Across the two phases, the data collection stage of the project spread over seven months, from November 2012 to July 2013. The majority of this period was dedicated to collecting the data for phase one, and with the exception of an extremely late response that was received in September 2013, this took place between November 2012 and April 2013. This

extended period came about due to the low response rate as well as the low frequency of the responses that were coming in.

By contrast, the data collection for phase two was more efficient. All data for this stage were more under the control of the primary researcher and therefore the focus group and expert witness interviews took place between June and July 2013. This in itself was an interesting time as most of the participants, displaced medical healthcare professionals and expert witnesses, were aware that a reform of the GMC's IELTS requirements was in process, but at that time, no one was aware of what they would be.

The main limitation of the study was the scale. As discussed above, the response rate to the questionnaires was slightly lower than expected and this meant that there were fewer participants overall. Had the number of respondents to the questionnaires been higher, themes identified and conclusions drawn from the data might have been more representative of the experiences of displaced medical healthcare professionals who form the client base of the WARD group.

There may also have been weakness in the study in having to summarise the causal factors under the six domains into a few exemplars and without jargon. In removing the details, it is possible that the subtlety of each of the causal factors was lost. The reason for the simplification was to remove overly technical terms and allow the participants to grasp the concepts of research into language training, as well as to encourage their responses to the questions that they were being asked without being caught up in the details.

It is also possible that the participants were led to provide answers during the mapping exercise, which did not accurately represent their own issues. One example may have been the lack of a prompt for the 'socio-affective' domain, which accurately encapsulated Han's (2004) 'socio-psychological barriers' category.

While the focus group aimed to yield further results on the participants' life and educational histories, the effects of any 'neuro-biological' factors and 'socio-affective' factors, there were

inevitably some discussions on 'environmental', 'knowledge representation', 'knowledge processing' and 'psychological' factors. Although this only served to add to the data collected in the first phase, it may have limited the responses to the second phase in the limited time that was available for the focus group session. They also reiterated their frustration with the inequalities of policies that were in place for displaced medical healthcare professionals wishing to join the GMC. This did not detract from the purpose of the focus group and the participants volunteered some substantial observations on their educational experiences, life histories and in particular, 'socio-affective' factors, which were picked up in the analysis of phase two, and therefore only served to add to the richness of the data collected.

6.2 Synthesis of the Key Findings

During the course of this investigation, a number of surprising points emerged in phase one and contributed to the later stages of phase two of the data collection. Research questions one to three aimed to find out more about displaced medical healthcare professionals' views on their SLEs, the impact of their learning journeys, life histories and other experiences on their English language learning. The results of research question four sought to gain a further perspective on the findings from others who are involved in the field. The findings from the four research questions are synthesised here and highlight key issues that have emerged from the process of undertaking the research.

The first finding to emerge from research question one, was the participants' views on the definition of 'learning English'. Many of the participants perceived the definition as relating directly to formal English language learning situations in a classroom. While this definition may be appropriate, the relationship between language learning and language acquisition (Long, 2005) has been overlooked by these participants. Illustrating this relationship may allow the participants, as well as similar groups, to realise that they are making more progress in their learning than they had realised.

The finding above may account for the harsh self-criticism that the questionnaire respondents exhibited when assessing their own SLEs. The majority of the respondents had reached the required IELTS score of 7.0, which may indicate that they are no longer in formal language training. However, this does not mean that they are no longer acquiring English through their daily interactions, further training and professional practice. As illustrated in the findings for research question one, spelling and punctuation are problematic for L1 speakers, and so it is entirely understandable that these were the most prevalent in the findings. The next most frequently cited SLEs were with verb forms, verb tenses and propositions. Although these present much less of a problem for English L1 users, all of these are directly connected to L1 interference, particularly for the L1 sets that featured within the study (Swan and Smith, 2011). Under Han's (2004) taxonomy, L1 interference is cited as residing mainly in the 'knowledge representation'. In the findings from research question two, this was the second most frequently cited domain. It was also noted in table 15 that many of the problem areas that the participants exhibited were connected to inherent idiosyncrasies of English, evidenced by the greater numbers of problems areas identified as being common problems for all IELTS candidates at level 7.0 and above (Moore, 2007).

An alternative reason for the harsh self-criticism of the questionnaire respondents, as compared to the interviewees, was the possibility of their language skills lapsing after they had reached the desired IELTS outcome. Backsliding ties into a lack of corrective feedback, reinforcement from the linguistic environment and a lack of instruction, all of which come under Han's (2004) 'environmental' domain. Although the 'environmental' domain was cited in the data from phase one, it was not perceived by the participants to be as significant as the 'knowledge representation' or 'knowledge processing' domains.

The most frequently cited domain in phase one was 'knowledge processing'. This is the largest cognitive domain in Han's (2004) taxonomy and covers the receptive skills as well as the productive skills. The volume of causal factors under this domain may account for the frequency of references to 'knowledge processing', however the most frequently cited

strategy for improving English was 'seeking contact with native speakers'. Many of the participants referred to the challenges this presented and of a lack of opportunity to use the target language. These findings reflect the findings from the European Science Foundation project (Norton, 2013) which indicate that a lack of opportunities to practise a language was a major barrier to the integration of immigrant groups and one that can increase over time.

In the findings from phase one, 'socio-affective' factors were alluded to, but not specifically declared by the participants during this phase. In the finding for phase two, it was revealed that there were a number of 'socio-affective' factors that were affecting the participants that had not been explicitly identified prior to this phase. As discussed in the findings for research question one, Han's (2004) domains were not used empirically in her work and some flexibility in their interpretation was necessary in this project. For example, a lack of communicative relevance is under Han's (2004) 'environmental' domain, but in this case it may be suggested that Dr. Jasmine's focus group statements about her learning styles in phase two may come under various domains. Her learning styles not 'fitting' with IELTS may be considered a satisfaction of communicative needs, under the 'socio-affective' domain on a personal level, but a need to focus on bottom up strategies, under the 'knowledge processing' domain in the context of IELTS.

As discussed in section 5.7.3, the focus group participants and the expert witnesses agreed on nine main barriers to the progress of displaced medical healthcare professionals. On a personal level, the language learning challenges that confronted displaced medical healthcare professionals were cultural, in terms of societal differences as well as professional cultures and the difficulty in transferring from medical training to language training. There were also challenges that were connected to motivation. While the participants were highly motivated, they were concerned that other responsibilities, such as looking after their families in the UK and their home countries, would hold them back. They were concerned that spending time studying language would interfere with their currency of professional knowledge. Finally, all of the participants in phase two felt that the policy at the

time of the interviews was biased against displaced medical healthcare professionals who were from countries outside the EEU and that more research and funding would benefit the situation.

6.3 Discussion of the Key Findings

In researching the SLEs of displaced medical professionals several contributions to knowledge have been identified. In answering the research questions, phase one found that the participants who had achieved the IELTS requirements for entry to the GMC had assessed their SLEs more harshly than those who were in training and undertook the diagnostic language quiz. This returns to the question of what constitutes a stabilized language error. Any assessment of language errors can only be a snapshot of where a learner is, as well as their outlook, at a given point of time. Language is dynamic, as is language learning, and therefore statements on specific problems are ephemeral. This is regardless of how learners are assessed or who is assessing them.

Proponents of immersion learning and CLIL might suggest that those who are no longer in specific language training for IELTS are still progressing as they learn via professional contact in their day-to-day lives. On the other hand, it could be argued that such people are no longer paying so much attention to learning language forms that go beyond professional usage, resulting in the process of fossilizing their undetected errors (Klein, 2003). Worse, it may be that their language skills are regressing, as is suggested by the requirement to retry the IELTS test after two years, the duration of the IELTS certificate.

Conversely, the subsequent success rates of the participants who were in training for the test at the time of the data collection indicates that they were undoubtedly moving forward in their language learning. This also indicates the importance of Han's environmental domain and shows that, in some cases, if the environmental conditions are predisposed to learning, progress can be made. As is evident above, the participants throughout the study

recognised the importance of exposure to language in their professional, learning and social environments.

Phase one also showed that the participants felt that input and intake (Kumaravadivelu, 2006) are of primary importance. Input broadly relates to the 'knowledge representation' and intake represents the 'knowledge processing' domain. This reinforces Kumaravadivelu's (2006) observations that exposure to the target language is a necessary condition for success, but cannot operate in isolation; and the internalisation of intake is a necessary subsequent stage. To return to Han's (2014) summary of the three factors that need to be present for identifying fossilization, rather than other forms of failure to learn language: "abundant exposure to input, adequate motivation to learn and plentiful opportunity for communicative practice", it seems that phase one of the research evidenced that the majority of the participants meet these factors.

The main controversy in phase one was the absence of the 'neuro-biological' and 'socio-affective' domains. As discussed above, the participants may not have easily identified these as being contributing factors to a stalling of progress, but further exploration in phase two showed that some socio-affective problems are embodied in the challenges that this exceptional demographic face. Although it seems clear that certain neuro-biological conditions, such as diagnosed learning difficulties, may stall language-learning progress, the size of the sample led to a unanimous finding that this domain did not affect the participants who were involved in the study on an individual basis. The views of the expert witnesses neither confirmed nor denied this, as they provided arguments in favour of and against this view.

The participants also felt strongly that motivation was a key factor in overcoming many of their SLEs. They felt that the main source of demotivation was the sense of inequity in the standards for entry to the GMC between EEU doctors and those from overseas. For a group that has suffered a loss of status, a loss of context and the plethora of other life-changing

problems that displaced people typically endure, it is understandable that further inequalities would serve to demoralise and demotivate them. This inequity between EEA doctors and overseas doctors seems to have been recognised by the policy makers in the GMC and has since been addressed in their new guidelines (General Medical Council, 2014g), although, as previously observed, at the cost, perhaps, of more stringent IELTS standards for all non-UK doctors.

The expert witnesses were able to provide a more external point of view and although they were sympathetic to the participants and agreed with their views on the need for more funding, support and research, they also felt that there were some factors that only individual displaced medical healthcare professionals can address on a personal level. Some of the expert witnesses felt that the loss of status that such professionals had experienced had led to excessive negativity about the policies that governed them. These were exemplified by negativity towards the IELTS test, which, although flawed, was the best option in helping learners prepare for PLAB tests one and two.

Another attitude that was mentioned by the author and the researcher was the failure of the learners to understand why they should undergo further training after they had been fully qualified in their country of origin. While most professionals understand that on-going skills development is a part of professional life, the sense that they had to restart training for their careers at such a low entry point is likely to contribute to any sense of a loss of status. A further key point that was identified by the expert witnesses was that of the transfer of the skills needed in medical training, as opposed to the relatively more flexible skills needed in the IELTS test.

In addition, the study highlights two areas of importance in research design. These are the ethical considerations that need to be taken in researching with displaced medical healthcare professionals and practical considerations in accessing the sample. In considering the ethical implications of the project, the BERA guidelines (2011) for

educational research were consulted and clarification sought that the project complied with standards set by NRES (appendix 6). Another consideration was whether the participant group fell into the category of vulnerable adults and this was taken into account during the research design. It was also important that all participants were clear about their involvement in the project and were able to provide informed consent to participate. This presented an additional challenge to ensure the language used was suitably clear for this participant group.

Due to the difficulties in accessing such a volatile sample, a dual approach method of data collection was used in phase one. Sending electronic questionnaires to the former clients of the WARD group was complimented by contacting the displaced medical healthcare professionals who were currently attending IELTS classes, thus ensuring maximum returns. This approach also allowed a comparison between those who had moved beyond the IELTS training stage and those who were in progress of attempting to pass the test.

The collection of data in phase two was more straightforward as many of the potential participants had been contacted during the data collection for phase one. In the case of the expert witnesses, they were contacted via the researcher's professional network according to their involvement in teaching; testing and supporting displaced medical healthcare professionals.

Although this project has reached its culmination, there are a number of avenues that have opened up as a result of the work that was carried out. The discussion that follows serves to identify areas for further research that would further contribute to knowledge in the area of the language-based challenges that displaced medical healthcare professionals encounter. It also considers ways in which policy changes may better serve the participants of this project. The recommendations are perhaps more achievable and make suggestions for IELTS tutors, their trainers and for researchers looking into fossilization studies as well as displaced people in the UK.

6.4 Recommendations

Ideally, my own further research would involve maintaining an open dialogue with the participants in this project to provide a longitudinal study on their English language skills and their successes on their pathways to re-joining their careers. This would assist in identifying which, if any, of their SLEs remain and how they manifest themselves. The participants in this study undoubtedly meet Han's (2014) prerequisites for further studies in fossilization, in terms of their exposure to input, motivation and opportunities for further practice. It might also yield interesting information on how their attitudes towards the IELTS examination may have become more positive in light of their further training and professional practice.

Realistically, the challenge of accessing the sample and maintaining contact with the participants may provide a barrier to such a study. However, some of the participants have maintained contact with the researcher via the WARD group and case studies on these individuals may be feasible.

This project has provided a small-scale view of the situation of displaced medical healthcare professionals in south-east Wales. It is not the only case in the UK and many of the challenges that are described here are well known to colleagues around the UK. One such example is the REACHE centre in Salford in which excellent research that tracks refugee doctors after they have met GMC IELTS requirements has taken place. A possible way to extend this project in the future might be to engage in joint research with similar groups in the UK, such as the REACHE team, to give a fuller picture of the trajectory of displaced medical healthcare professionals, from accessing IELTS support, throughout the challenges of the PLAB exams and foundation years, to their full integration into the GMC.

In terms of policy, the development of an integrated medical competency and English language test may be of benefit. Tests of language skills combined with professional competency tests are already in place in countries with high immigrant populations such as Australia and the USA. In Australia and New Zealand these tests take the form of the Occupational English Test (OET), which is specifically based on healthcare contexts and

subsequently the Australian Medical Council (AMC) certificate. In the USA, the United States Medical Licensing Examination (USMLE) is a fully integrated single test, which all doctors must pass, regardless of their first language or nationality (Read and Wette, 2009). However, there are complications with moving from the GMC's current model, as Taylor and Pill (2013) remind us. This is a policy that would require a significant lead in and substantial funding; it may be politically difficult to justify the costs of such a specific test when the IELTS Academic test and PLAB are in place. In addition, Read and Wette's (2009) study found that although medical healthcare professionals were immediately more comfortable with the OET, they came to feel that the IELTS test had more advantages, in terms of cost effectiveness, access and breadth of IELTS training materials. On the other hand, a single test similar to the USMLE in its content and the policies surrounding it, would address the inequity in policies that exist under the current framework and provide a more progressive solution in a multi-cultural Britain.

- Motivation has played a key factor in the successes of the participant group. In the face of all of the adversity that confronts them, the hope that they will eventually rebuild their lives is a major driver. Frequent progress checking and reporting is one way of ensuring that motivation is kept at the forefront of their training. Similarly, avoiding demotivating factors such as teachers repeating and reusing materials, a failure to provide a good foundation in language learning and incomplete explanation of target language is also crucial. Encouraging learners to take risks in a safe environment can also benefit learners whose prior learning for medical studies is likely to have been prescriptive. Another motivating exercise is the tracking of learners' progress individually, allowing them to reflect on and recognise their improvements and set clear and achievable goals for further learning. This may be facilitated by IELTS tutors encouraging learners to keep learning journals as a part of their IELTS studies, maintaining a database of individual performance in practice

tests, or setting achievable targets that lie just beyond their current linguistic repertoire.

- As mentioned by the expert witness author, further training for IELTS teachers to support them in working with refugee groups would be a great benefit. A standardised approach to working with refugee professionals preparing for the IELTS test would provide teachers, often working on a voluntary basis, with a more intimate knowledge of the test and allow them to prepare lessons that are more tailored to their students than the general information offered by IELTS course books. With better teacher training, student motivation is likely to be maintained and success rates increased. An individualised approach to learner reflection, as described in the previous recommendation, can enable learners to self-identify their SLEs, further facilitating IELTS trainers and learners alike to personalise learning and teaching.
- Regarding Han's (2014) criteria for determining fossilization i.e. exposure to input, motivation and opportunities to practice, the participants adequately met the criteria. It should be remembered that these prerequisites are not always exhibited by language learners, and less frequently to the extent that the participants in this study met them. It might be beneficial to carry out further research into fossilization theory by studying a similar sample of displaced medical healthcare professionals to examine further the nature of their language errors.
- Data on displaced people in Wales are only partial, at best. With the expansion of refugee dispersal areas in Wales, a dedicated unit, similar to the Refugee Studies Centre in Oxford, would be of enormous benefit to displaced people, the Welsh government, researchers and all other stakeholders in the area. This would further enable integration for the people affected by displacement and feed into the integration as outlined by the Welsh government's Refugee Inclusion Strategy (2012).

6.5 A Final Reflection

In writing this thesis I, the researcher, have been hugely challenged in my perspectives and outlook on the situation of displaced medical healthcare professionals trying to join the NHS. In my early days of working as an IELTS trainer of refugee doctors, I had first-hand experience of the frustration and resentment that some of my trainees felt towards the IELTS test. I worked with people who had endured situations that I would not wish to imagine, let alone experience. My trainees were a proud and compelling group and, at times, it seemed that the IELTS test represented an oppressive force that was standing between these qualified doctors and their dignity. Over the course of the project, I have understood that, although there are times when individuals reflect the above points of view, this is by no means the whole story. As mentioned previously, the majority of the participants have now achieved the necessary IELTS score to continue the next stages of their registration with the GMC, the GDC and the GPC.

In conducting a survey of the literature, I have verified that the refugee condition in the UK is neither a recent phenomenon, nor is it straightforward. I have understood the way that refugees in Wales fit into the wider context of the UK and have seen that, although there is some excellent support for refugee groups, a lot more can be provided in terms of record keeping and research. I have also seen that forty years of fossilization research has led to ameliorated definitions of the term and a definitive profile that demonstrates fossilization. I have recognised displaced medical healthcare professionals within the profile that might potentially display fossilization, as described by Han in many of her publications (2004; 2011; 2014) and wondered if the linguistic shortcomings that are holding them back from the IELTS test could be matched to Han's (2004) six domains. The findings suggested that although many of them felt that certain factors within Han's six domains were applicable to them personally, they have been able to progress with their language learning to the point of success at the IELTS stage.

In order to understand more about these issues, research questions were developed, methods were chosen and ethics were considered in depth. These methodological issues

were paramount to conducting the research in a reliable, robust and meaningful way.

Another driver behind the project was the opportunity to provide this often disenfranchised group with a voice. My assumption that there would be an unusually large number of respondents to the questionnaire that was sent out by the WARD group was proven to be wrong. When the task of meeting the requirements for the various governing bodies within healthcare is considered, it is perhaps understandable that the response rate was lower than initially expected. It is also important to support refugees in the integration process and it may be that leaving the support groups that assisted them in their integration is itself an important stage in the process.

Similarly, it was disappointing to see the rate of attrition between those questionnaire respondents who had provided their email addresses for further questions and the one response that was received. In examining the results, the main challenge to my assumptions based on my working experience was the absence of the 'neuro-biological' and 'socio-affective' domains. Further analysis of the interview scripts, the focus group and the statements of the expert witnesses later counterbalanced this unforeseen result. It was also unexpected to see that the questionnaire respondents, who in the majority had achieved more than 7.0 in the IELTS test, reported more problems with SLEs than the diagnostic quiz had uncovered with the interviewees, who had not yet reached 7.0 or above. These surprises in the data provided valuable insights into the participants' reflections on both their language learning and their language skills.

In engaging with the focus group, there were opportunities to observe the support network that the participants had created amongst themselves. This also allowed the participants, within a group situation, to negotiate their feelings about the IELTS test. It appears that this kind of mutual support and open dialogue contributed to the participants' positivity and, in most cases, encourage them to reach their desired IELTS band score.

In gathering the views of the expert witnesses, it was possible to gauge their differing perspectives on the topic, as well as to analyse areas of commonality within this group. I was able to synthesise their data with the data collected during the rest of the project to produce results that represented as many stakeholders as possible. It is hoped that the findings from the project will feed into future IELTS training courses for refugee doctors, as well as to policies that surround them.

It seems that although SLEs can persist in displaced medical healthcare professionals long after they have met the desired IELTS requirements, they can be reduced and managed to a level where the governing bodies feel that they are linguistically capable to provide a safe service to their patients. Other influences are less manageable; in the words of Dr.

Ghaneim:

All of us have a high level of education, we are professionals, dentists, doctors, pharmacists, we are used to learning and not stopping at a particular age because, you know, science develops and for that reason, I don't think it is a problem to learn new things but like I said, the situation in general, depression, emotional and psychological situations are very important.

In supporting displaced medical healthcare professionals, we are supporting the NHS, the users of the service and individuals who have a great deal to contribute to their host culture, in spite of the challenges that they face.

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Appendices

Appendix 1: Provision of Training Offered by the WARD Group

The **WARD** team has developed a wide range of courses. All refugee/asylum seeker doctors should attend a minimum programme of training consisting of the following:

- **IELTS**

The 'International English Language Testing System' (IELTS) classes are provided by Bridgend College. The courses are delivered both in Bridgend and also at the Displaced People in Action (DPIA) drop-in centre in central Cardiff. In preparation for IELTS a number of textbooks have been purchased, which are located at the DPIA drop-in centre in Cardiff.

The course is structured on a four weekly rotation:

| Monday | Wednesday | Thursday | Friday |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Grammar and Vocabulary Workshop | Grammar and Vocabulary Workshop | Grammar and Vocabulary Workshop | Grammar and Vocabulary Workshop |
| Strategies for the IELTS Exam | Strategies for the IELTS Exam | Strategies for the IELTS Exam | Strategies for the IELTS Exam |
| Test Practice (reading) | Test Practice (writing) | Test Practice (speaking) | Test Practice (listening) |

The table above is the schedule for the first week of the rotation; subsequently the 'Test Practice' on a Monday would be for the writing part of the exam, the following Monday's test practice would be for the speaking part of the exam and so on. This is done in order to cover every aspect of the exam with a student who could only attend the class on a certain day of the week. Classes are not given on a Friday as many of the students are of the Islamic faith and their commitments were taken into consideration.

The 'Grammar and Vocabulary Workshop' segment of the lesson is an opportunity for students to clarify any new vocabulary and it's meanings or raise questions about any difficulties that they may have with the structure of the English language. The methodology of this section is largely a 'lockstep' situation where the learners are free to question the lecturer.

The IELTS exam is very specific in what is required to attain the requisite band score, therefore the 'Strategies for the IELTS Exam' focuses on how the learner should approach certain parts of the test e.g. 'skimming and scanning' for answers in the reading section. This phase is conducted in a classic P.P.P. (present, practice, produce) format.

Each class finishes with 'Test Practice' for each module, in order to give the student a full idea of what would be expected in the exam, as well as an opportunity to use the skills and

strategies that they have learnt to best effect. This is carried out under examination conditions in order to familiarize the students with a true test environment.

- **PLAB**

Mannequins and instruments for practice are available at the drop-in centre at DPIA.

- **PLAB Part 1**

We book members of WARD onto a PLAB 1 course, held in London which consists of a 20 days teaching course with two off days in between. The course is from 9am till 7pm with one hour lunch break.

Plabtrainer gives a short lecture on each day about a topic (eg;- CNS or Peads) and then solve all the past questions about that topic on that particular day. They try to cover all the topics required for the PLAB 1 Exam.

At the end of the course mock tests are conducted and are very similar to the GMC exam where candidates will learn about the time management as well as techniques of answering the questions.

It is strongly recommend everyone takes at least four mock tests to enhance the chances of passing the exam in the first attempt.

Typical course schedule will be as follows (each day is dedicated to a particular topic):

| | |
|----|---------------------------------------|
| 1 | Respiratory system and Blood gases |
| 2 | Cardiovascular system |
| 3 | Gastro-Enterology |
| 4 | Nephrology and Biochemistry |
| 5 | Psychiatry |
| 6 | Paediatrics |
| 7 | Trauma |
| 8 | Orthopaedics |
| 9 | Obstetrics |
| 10 | Gyneacology |
| 11 | General surgery |
| 12 | Systemic surgery |
| 13 | Endocrinology |
| 14 | ENT/Ophthalmology/Dermatology |
| 15 | Rheumatology/ Epidemiology/Toxicology |
| 16 | Central Nervous system |
| 17 | Infectious disease |
| 18 | Pharmacology / Miscellaneous topics |

- **PLAB Part 2**

The PLAB 2 course should be done ideally about 5 to 6 weeks before the GMC exam date so that the doctors will have at least 3 to 4 weeks to practice after the course as there are nearly 300 stations to practice.

Course consists of 11 days of teaching including the weekend, from 9 am to 7 pm daily.

Each day will be dedicated to a specific topic:

| | |
|----|--|
| 1 | Introduction and ATLS |
| 2 | Manikins (Part 1) |
| 3 | Remaining manikins including CPR (Part 2) and Dose calculation |
| 4 | Clinical Examination in Medicine |
| 5 | Clinical Examination in Orthopaedics and Surgery |
| 6 | History and Counselling in Medicine |
| 7 | History and Counselling in Surgery and Orthopaedics |
| 8 | History and Counselling in Obstetrics and Gyneacology |
| 9 | History and Counselling in Paediatrics |
| 10 | History and Counselling in Psychiatry |
| 11 | VIVA, Drug Prescription, Hand washing, MRSA, Telephone conversation and other miscellaneous topics |

Mock test takes about one and a half hour to two hours. There will be "Feedback" of the mock test in the evening after all the batches finishes the mock test. There will be two types of feedback. One type of feedback is "General feedback" and the other type is "Personal feedback". For the general feedback all the candidates who took the mock tests on that particular day (usually about 25 to 30 doctors take the mock test per day) will assemble in the evening and the mock test examiners will discuss all the mistakes done by all the candidates. Usually the general feedback takes about 3 hours, (usually from 4.30pm till 7.30pm). In the general feedback you will learn all the mistakes done by other candidates too. After the general feedback you can meet your mock test examiner who will give your personal feedback if you need.

Appendix 2: Han's Sample Empirical Studies of Fossilization

| <i>Researcher</i> | <i>Informants' L1</i> | <i>Informants' TL</i> | <i>Linguistic focus</i> | <i>Type of study</i> | <i>Fossilization assumed or established</i> |
|-----------------------|-----------------------|-----------------------|---|---|---|
| Schumann (1978a) | Spanish | English | Negation | One-year longitudinal case study | Established |
| Lardiere (1998a) | Chinese | English | Pronominal marking and past tense marking | Eight-year longitudinal case study | Established |
| Kellerman (1989) | Dutch | English | Hypothetical conditionals | Non-longitudinal, cross sectional study | Assumed |
| Schouten (1996) | Dutch | English | Hypothetical conditionals | Non-longitudinal, cross sectional study | Assumed |
| Hyltenstam (1998) | Finnish, Spanish | Swedish | Swedish lexical density, variation and sophistication | Non-longitudinal, group study | Assumed |
| Lennon (1991) | German | English | English adverb order; 'there is/there are'; 'have got'; 'always'; future time forms | Six-month longitudinal case study | Established |
| Thep-Ackrapong (1990) | Chinese | English | English infinitival complements and related structures | A-year-and-a-half longitudinal case study | Assumed |
| Mukattash (1986) | Arabic | English | Conflation of simple past tense with simple present; conflation of non-perfective phrases with the perfective; be-deletion; using the active voice instead of the passive | Sixteen-week longitudinal, group study | Established |
| Washburn (1991) | Miscellaneous | English | Characteristics of linguistic behaviour | Non-longitudinal, group study | Assumed |
| Han (1998) | Chinese | English | Passives; unaccusatives | Two-year longitudinal case study (2 subjects) | Established |
| Long (2002) | Japanese | English | Plural –s marking; past time marking | Sixteen-year longitudinal case study | Established |

Appendix 3: IELTS Band Descriptors for Productive Skills

| IELTS Task 1 Writing band descriptors (public version) | | | | |
|--|--|--|---|---|
| Band | Task Achievement | Coherence and Cohesion | Lexical Resource | Grammatical Range and Accuracy |
| 9 | <ul style="list-style-type: none"> fully satisfies all the requirements of the task clearly presents a fully developed response | <ul style="list-style-type: none"> uses cohesion in such a way that it attracts no attention skilfully manages paragraphing | <ul style="list-style-type: none"> uses a wide range of vocabulary with very natural and sophisticated control of lexical features; rare minor errors occur only as 'slips' | <ul style="list-style-type: none"> uses a wide range of structures with full flexibility and accuracy; rare minor errors occur only as 'slips' |
| 8 | <ul style="list-style-type: none"> covers all requirements of the task sufficiently presents, highlights and illustrates key features / bullet points clearly and appropriately | <ul style="list-style-type: none"> sequences information and ideas logically manages all aspects of cohesion well uses paragraphing sufficiently and appropriately | <ul style="list-style-type: none"> uses a wide range of vocabulary fluently and flexibly to convey precise meanings skilfully uses uncommon lexical items but there may be occasional inaccuracies in word choice and collocation produces rare errors in spelling and/or word formation | <ul style="list-style-type: none"> uses a wide range of structures the majority of sentences are error-free makes only very occasional errors or inappropriacies |
| 7 | <ul style="list-style-type: none"> covers the requirements of the task (Academic) presents a clear overview of main trends, differences or stages (General Training) presents a clear purpose, with the tone consistent and appropriate clearly presents and highlights key features / bullet points but could be more fully extended | <ul style="list-style-type: none"> logically organises information and ideas; there is clear progression throughout uses a range of cohesive devices appropriately although there may be some under-/over-use | <ul style="list-style-type: none"> uses a sufficient range of vocabulary to allow some flexibility and precision uses less common lexical items with some awareness of style and collocation may produce occasional errors in word choice, spelling and/or word formation | <ul style="list-style-type: none"> uses a variety of complex structures produces frequent error-free sentences has good control of grammar and punctuation but may make a few errors |
| 6 | <ul style="list-style-type: none"> addresses the requirements of the task (Academic) presents an overview with information appropriately selected (General Training) presents a purpose that is generally clear; there may be inconsistencies in tone presents and adequately highlights key features / bullet points but details may be irrelevant, inappropriate or inaccurate | <ul style="list-style-type: none"> arranges information and ideas coherently and there is a clear overall progression uses cohesive devices effectively, but cohesion within and/or between sentences may be faulty or mechanical may not always use referencing clearly or appropriately | <ul style="list-style-type: none"> uses an adequate range of vocabulary for the task attempts to use less common vocabulary but with some inaccuracy makes some errors in spelling and/or word formation, but they do not impede communication | <ul style="list-style-type: none"> uses a mix of simple and complex sentence forms makes some errors in grammar and punctuation but they rarely reduce communication |

| | | | | |
|---|--|---|--|---|
| 5 | <ul style="list-style-type: none"> generally addresses the task; the format may be inappropriate in places (Academic) recounts detail mechanically with no clear overview; there may be no data to support the description (General Training) may present a purpose for the letter that is unclear at times; the tone may be variable and sometimes inappropriate presents, but inadequately covers, key features / bullet points; there may be a tendency to focus on details | <ul style="list-style-type: none"> presents information with some organisation but there may be a lack of overall progression makes inadequate, inaccurate or over-use of cohesive devices may be repetitive because of lack of referencing and substitution | <ul style="list-style-type: none"> uses a limited range of vocabulary, but this is minimally adequate for the task may make noticeable errors in spelling and/or word formation that may cause some difficulty for the reader | <ul style="list-style-type: none"> uses only a limited range of structures attempts complex sentences but these tend to be less accurate than simple sentences may make frequent grammatical errors and punctuation may be faulty; errors can cause some difficulty for the reader |
| 4 | <ul style="list-style-type: none"> attempts to address the task but does not cover all key features / bullet points; the format may be inappropriate (General Training) fails to clearly explain the purpose of the letter; the tone may be inappropriate may confuse key features / bullet points with detail; parts may be unclear, irrelevant, repetitive or inaccurate | <ul style="list-style-type: none"> presents information and ideas but these are not arranged coherently and there is no clear progression in the response uses some basic cohesive devices but these may be inaccurate or repetitive | <ul style="list-style-type: none"> uses only basic vocabulary which may be used repetitively or which may be inappropriate for the task has limited control of word formation and/or spelling; <ul style="list-style-type: none"> errors may cause strain for the reader | <ul style="list-style-type: none"> uses only a very limited range of structures with only rare use of subordinate clauses some structures are accurate but errors predominate, and punctuation is often faulty |
| 3 | <ul style="list-style-type: none"> fails to address the task, which may have been completely misunderstood presents limited ideas which may be largely irrelevant/repetitive | <ul style="list-style-type: none"> does not organise ideas logically may use a very limited range of cohesive devices, and those used may not indicate a logical relationship between ideas | <ul style="list-style-type: none"> uses only a very limited range of words and expressions with very limited control of word formation and/or spelling errors may severely distort the message | <ul style="list-style-type: none"> attempts sentence forms but errors in grammar and punctuation predominate and distort the meaning |
| 2 | <ul style="list-style-type: none"> answer is barely related to the task | <ul style="list-style-type: none"> has very little control of organisational features | <ul style="list-style-type: none"> uses an extremely limited range of vocabulary; essentially no control of word formation and/or spelling | <ul style="list-style-type: none"> cannot use sentence forms except in memorised phrases |
| 1 | <ul style="list-style-type: none"> answer is completely unrelated to the task | <ul style="list-style-type: none"> fails to communicate any message | <ul style="list-style-type: none"> can only use a few isolated words | <ul style="list-style-type: none"> cannot use sentence forms at all |
| 0 | <ul style="list-style-type: none"> does not attend does not attempt the task in any way writes a totally memorised response | | | |

| IELTS Task 2 Writing band descriptors (public version) | | | | |
|--|--|---|---|---|
| Band | Task Response | Coherence and Cohesion | Lexical Resource | Grammatical Range and Accuracy |
| 9 | <ul style="list-style-type: none"> fully addresses all parts of the task presents a fully developed position in answer to the question with relevant, fully extended and well supported ideas | <ul style="list-style-type: none"> uses cohesion in such a way that it attracts no attention skilfully manages paragraphing | <ul style="list-style-type: none"> uses a wide range of vocabulary with very natural and sophisticated control of lexical features; rare minor errors occur only as 'slips' | <ul style="list-style-type: none"> uses a wide range of structures with full flexibility and accuracy; rare minor errors occur only as 'slips' |
| 8 | <ul style="list-style-type: none"> sufficiently addresses all parts of the task presents a well-developed response to the question with relevant, extended and supported ideas | <ul style="list-style-type: none"> sequences information and ideas logically manages all aspects of cohesion well uses paragraphing sufficiently and appropriately | <ul style="list-style-type: none"> uses a wide range of vocabulary fluently and flexibly to convey precise meanings skilfully uses uncommon lexical items but there may be occasional inaccuracies in word choice and collocation produces rare errors in spelling and/or word formation | <ul style="list-style-type: none"> uses a wide range of structures the majority of sentences are error-free makes only very occasional errors or inappropriacies |
| 7 | <ul style="list-style-type: none"> addresses all parts of the task presents a clear position throughout the response presents, extends and supports main ideas, but there may be a tendency to over-generalise and/or supporting ideas may lack focus | <ul style="list-style-type: none"> logically organises information and ideas; there is clear progression throughout uses a range of cohesive devices appropriately although there may be some under-/over-use presents a clear central topic within each paragraph | <ul style="list-style-type: none"> uses a sufficient range of vocabulary to allow some flexibility and precision uses less common lexical items with some awareness of style and collocation may produce occasional errors in word choice, spelling and/or word formation | <ul style="list-style-type: none"> uses a variety of complex structures produces frequent error-free sentences has good control of grammar and punctuation but may make a few errors |
| 6 | <ul style="list-style-type: none"> addresses all parts of the task although some parts may be more fully covered than others presents a relevant position although the conclusions may become unclear or repetitive presents relevant main ideas but some may be inadequately developed/unclear | <ul style="list-style-type: none"> arranges information and ideas coherently and there is a clear overall progression uses cohesive devices effectively, but cohesion within and/or between sentences may be faulty or mechanical may not always use referencing clearly or appropriately uses paragraphing, but not always logically | <ul style="list-style-type: none"> uses an adequate range of vocabulary for the task attempts to use less common vocabulary but with some inaccuracy makes some errors in spelling and/or word formation, but they do not impede communication | <ul style="list-style-type: none"> uses a mix of simple and complex sentence forms makes some errors in grammar and punctuation but they rarely reduce communication |
| 5 | <ul style="list-style-type: none"> addresses the task only partially; the format may be inappropriate in places expresses a position but the development is not always clear and there may be no | <ul style="list-style-type: none"> presents information with some organisation but there may be a lack of overall progression makes inadequate, inaccurate or over- | <ul style="list-style-type: none"> uses a limited range of vocabulary, but this is minimally adequate for the task may make noticeable errors in | <ul style="list-style-type: none"> uses only a limited range of structures attempts complex sentences but these tend to be less accurate than simple sentences |

| | | | | |
|---|--|---|---|--|
| 4 | <p>conclusions drawn</p> <ul style="list-style-type: none"> ▪ presents some main ideas but these are limited and not sufficiently developed; there may be irrelevant detail | <p>use of cohesive devices</p> <ul style="list-style-type: none"> ▪ may be repetitive because of lack of referencing and substitution ▪ may not write in paragraphs, or paragraphing may be inadequate | <p>spelling and/or word formation that may cause some difficulty for the reader</p> | <ul style="list-style-type: none"> ▪ may make frequent grammatical errors and punctuation may be faulty; errors can cause some difficulty for the reader |
| | <ul style="list-style-type: none"> ▪ responds to the task only in a minimal way or the answer is tangential; the format may be inappropriate ▪ presents a position but this is unclear ▪ presents some main ideas but these are difficult to identify and may be repetitive, irrelevant or not well supported | <ul style="list-style-type: none"> ▪ presents information and ideas but these are not arranged coherently and there is no clear progression in the response ▪ uses some basic cohesive devices but these may be inaccurate or repetitive ▪ may not write in paragraphs or their use may be confusing | <ul style="list-style-type: none"> ▪ uses only basic vocabulary which may be used repetitively or which may be inappropriate for the task ▪ has limited control of word formation and/or spelling; errors may cause strain for the reader | <ul style="list-style-type: none"> ▪ uses only a very limited range of structures with only rare use of subordinate clauses ▪ some structures are accurate but errors predominate, and punctuation is often faulty |
| 3 | <ul style="list-style-type: none"> ▪ does not adequately address any part of the task ▪ does not express a clear position ▪ presents few ideas, which are largely undeveloped or irrelevant | <ul style="list-style-type: none"> ▪ does not organise ideas logically ▪ may use a very limited range of cohesive devices, and those used may not indicate a logical relationship between ideas | <ul style="list-style-type: none"> ▪ uses only a very limited range of words and expressions with very limited control of word formation and/or spelling ▪ errors may severely distort the message | <ul style="list-style-type: none"> ▪ attempts sentence forms but errors in grammar and punctuation predominate and distort the meaning |
| 2 | <ul style="list-style-type: none"> ▪ barely responds to the task ▪ does not express a position ▪ may attempt to present one or two ideas but there is no development | <ul style="list-style-type: none"> ▪ has very little control of organisational features | <ul style="list-style-type: none"> ▪ uses an extremely limited range of vocabulary; essentially no control of word formation and/or spelling | <ul style="list-style-type: none"> ▪ cannot use sentence forms except in memorised phrases |
| 1 | <ul style="list-style-type: none"> ▪ answer is completely unrelated to the task | <ul style="list-style-type: none"> ▪ fails to communicate any message | <ul style="list-style-type: none"> ▪ can only use a few isolated words | <ul style="list-style-type: none"> ▪ cannot use sentence forms at all |
| 0 | <ul style="list-style-type: none"> ▪ does not attend ▪ does not attempt the task in any way ▪ writes a totally memorised response | | | |

IELTS Speaking band descriptors (public version)



| Band | Fluency and coherence | Lexical resource | Grammatical range and accuracy | Pronunciation |
|------|---|--|---|---|
| 9 | <ul style="list-style-type: none"> speaks fluently with only rare repetition or self-correction; any hesitation is content-related rather than to find words or grammar speaks coherently with fully appropriate cohesive features develops topics fully and appropriately | <ul style="list-style-type: none"> uses vocabulary with full flexibility and precision in all topics uses idiomatic language naturally and accurately | <ul style="list-style-type: none"> uses a full range of structures naturally and appropriately produces consistently accurate structures apart from 'slips' characteristic of native speaker speech | <ul style="list-style-type: none"> uses a full range of pronunciation features with precision and subtlety sustains flexible use of features throughout is effortless to understand |
| 8 | <ul style="list-style-type: none"> speaks fluently with only occasional repetition or self-correction; hesitation is usually content-related and only rarely to search for language develops topics coherently and appropriately | <ul style="list-style-type: none"> uses a wide vocabulary resource readily and flexibly to convey precise meaning uses less common and idiomatic vocabulary skilfully, with occasional inaccuracies uses paraphrase effectively as required | <ul style="list-style-type: none"> uses a wide range of structures flexibly produces a majority of error-free sentences with only very occasional inappropriacies or basic/non-systematic errors | <ul style="list-style-type: none"> uses a wide range of pronunciation features sustains flexible use of features, with only occasional lapses is easy to understand throughout; L1 accent has minimal effect on intelligibility |
| 7 | <ul style="list-style-type: none"> speaks at length without noticeable effort or loss of coherence may demonstrate language-related hesitation at times, or some repetition and/or self-correction uses a range of connectives and discourse markers with some flexibility | <ul style="list-style-type: none"> uses vocabulary resource flexibly to discuss a variety of topics uses some less common and idiomatic vocabulary and shows some awareness of style and collocation, with some inappropriate choices uses paraphrase effectively | <ul style="list-style-type: none"> uses a range of complex structures with some flexibility frequently produces error-free sentences, though some grammatical mistakes persist | <ul style="list-style-type: none"> shows all the positive features of Band 6 and some, but not all, of the positive features of Band 8 |
| 6 | <ul style="list-style-type: none"> is willing to speak at length, though may lose coherence at times due to occasional repetition, self-correction or hesitation uses a range of connectives and discourse markers but not always appropriately | <ul style="list-style-type: none"> has a wide enough vocabulary to discuss topics at length and make meaning clear in spite of inappropriacies generally paraphrases successfully | <ul style="list-style-type: none"> uses a mix of simple and complex structures, but with limited flexibility may make frequent mistakes with complex structures, though these rarely cause comprehension problems | <ul style="list-style-type: none"> uses a range of pronunciation features with mixed control shows some effective use of features but this is not sustained can generally be understood throughout, though mispronunciation of individual words or sounds reduces clarity at times |

Appendix 4: The Safeguarding Vulnerable Groups Act (SVGA) 2006

Definition of a Vulnerable Adult

A person is a vulnerable adult if he has attained the age of 18 and—

- (a) he is in residential accommodation,
- (b) he is in sheltered housing,
- (c) he receives domiciliary care,
- (d) he receives any form of health care,
- (e) he is detained in lawful custody,
- (f) he is by virtue of an order of a court under supervision by a person exercising functions for the purposes of Part 1 of the Criminal Justice and Court Services Act 2000 (c. 43),
- (g) he receives a welfare service of a prescribed description,
- (h) he receives any service or participates in any activity provided specifically for persons who fall within subsection (9),
- (i) payments are made to him (or to another on his behalf) in pursuance of arrangements under section 57 of the Health and Social Care Act 2001 (c. 15), or
- (j) he requires assistance in the conduct of his own affairs.

(Oliver and White, 2008)

Appendix 5: Letter to Participant Organizations

Gabriel Roberts
ELTC, Q012, Queenswood,
UWIC, Cyncoed Campus,
Cardiff .
CF23 6XD

Dear XXXX,

I hope this letter finds you very well.

As you know, I have worked with refugees and asylum seekers in the Cardiff area for many years and continue to do so. In 2010 I was involved in a project, which was shortlisted for a Times Higher Education Award in Widening Participation in Higher Education. I am currently working on my PhD and my research is based on helping refugee doctors overcome linguistic problems that remain with them in spite of exposure to language, opportunities to practice and a high degree of motivation.

As part of the project, I would like to conduct some questionnaires, interviews and case studies with clients of the Wales Asylum-seeking and Refugee Doctor (WARD) group that you manage.

My main goal is to ascertain the language learning beliefs of non-native English speaking doctors about trying to overcome habitual errors in English and increase language proficiency.

I would be delighted if you are able forward this information to any interested parties within your organisation and have enclosed consent forms and a stamped addressed envelope.

If you have any questions, please do not hesitate to contact me.

Yours sincerely,

Gabriel Roberts *Dip. TESOL*

ELTC / IFC Director UWIC

gjroberts@uwic.ac.uk

To whom it may concern,

INVITATION TO PARTICIPATE IN ENGLISH AS A SECOND LANGUAGE
RESEARCH

You are invited to participate in the above research project for a PhD study on developing English language skills beyond habitual errors. Participants have the right to withdraw from the research at any given time. There is no intention that participation in this research would be directly linked to improving your level of English.

You may be asked to:

- Participate in questionnaires intended to identify any specific English language issues you may have.
- Contribute via interviews to a confidential database of case studies about the language learning experiences of refugee doctors.
- Give feedback on the findings of the study.

No names will be used in reports of this project and information will be held securely until the research is completed, when it will be destroyed.

Dear Gabriel,

I wish to take part in this project and give my consent to the above.

Signed

Date.....

Please print your name

.....

Appendix 6: Email from NRES

Thank you for your further email enquiry. As you are aware, our leaflet “Defining Research”, explains how we differentiate research from other activities, and is published at: <http://www.nres.npsa.nhs.uk/applications/is-your-project-research/>.

Based on the information you provided, our advice is that the project is not considered to be research according to this guidance and therefore it does not require ethical review by a NHS Research Ethics Committee.

If you are undertaking the project within the NHS, you should check with the relevant NHS care organisation(s) what other review arrangements or sources of advice apply to projects of this type. Guidance may also be available from the clinical governance office.

Although ethical review by an NHS REC is not necessary in this case, all types of study involving human participants should be conducted in accordance with basic ethical principles, such as informed consent and respect for the confidentiality of participants. Also, in processing identifiable data there are legal requirements under the Data Protection Act 2000. When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation. University projects may require approval by the university ethics committee. Please refer to our guidance on student research at:

http://www.nres.npsa.nhs.uk/applications/guidance/research-guidance/?esctl1654606_entryid62=83668.

This response should not be interpreted as giving a form of ethical approval or any endorsement to your project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feel that the project should be managed as research, and/or that ethical review by an NHS REC is essential, then please write setting out your reasons and we will be pleased to consider your request further.

Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

If you have received advice on the same or a similar matter from a different source (for example directly from a Research Ethics Committee (REC) or from an NHS R&D department), it would be helpful if you could share the initial query and response received if then seeking additional advice through the NRES Queries service.

However, if you have been asked to follow a particular course of action by a REC as part of a provisional or conditional opinion, then the REC requirements are mandatory to the opinion, unless specifically revised by that REC. Should you wish

to query the REC requirements, this should either be through contacting the REC direct or, alternatively, the relevant local operational manager.

Regards

Queries Line
National Research Ethics Service
National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD

The NRES Queries Line is an email based service that provides advice from NRES senior management including operations managers based in our regional offices throughout England. Providing your query in an email helps us to quickly direct your enquiry to the most appropriate member of our team who can provide you with accurate written response. It also enables us to monitor the quality and timeliness of the advice given by NRES to ensure we can give you the best service possible, as well as use queries to continue to improve and to develop our processes.

Website: www.nres.nhs.uk

Email: queries@nres.npsa.nhs.uk

Appendix 7: Categorisation and Simplification of Han's Factors for the Questionnaire

| <i>Environmental: My classes, the people around me and/or my location.</i> | |
|---|--|
| <p>Absence of corrective feedback Lack of input</p> <p>Reinforcement from linguistic environment</p> <p>Lack of instruction Lack of communicative relevance Lack of written input Language complexity Quality of input Instruction</p> | <p>Nobody corrects me when I make mistakes. I don't have any local contact with the English Language.</p> <p>Everybody around me speaks my language, not English.</p> <p>I am not taking enough English classes. It's not important to use English in my situation. I don't have the opportunity to read English texts. The English I encounter is too complicated. The English I encounter is poor. My English lessons don't help me.</p> |
| <i>Knowledge representation: I don't notice the patterns and rules of English.</i> | |
| <p>L1 influence conspiring with other factors</p> <p>L1 influence</p> <p>Lack of access to UG Failure of parameter-resetting</p> <p>Possession of a mature cognitive system</p> <p>Non-operation of UG learning principles</p> <p>Learning inhibiting learning</p> <p>Representational deficits of the language faculty</p> | <p>I have other problems, as well as following the rules of my first language. I often try to follow the rules of my first language when using English. I can't easily identify the patterns of English. I don't understand the differences between my first language and English. Getting older has made it more difficult to understand the rules of English. I don't have a strategy to develop my English based on the patterns I have identified. I am trying to learn too much and none of it seems to stay with me. I can't easily identify things like verbs, adverbs, and clauses.</p> |
| <i>Knowledge processing: I don't use English naturally, notice my mistakes or I tend to look for a general meaning.</i> | |
| <p>Lack of attention Inability to notice input-output discrepancies</p> <p>False automatization Automatization of the first language system Using top-down processes in comprehension</p> <p>Lack of understanding</p> <p>Use of domain general problem-solving strategies</p> <p>End of sensitivity to language data Lack of opportunity to use the target language The speed and extent to which automatization has taken place Processing constraints</p> <p>Failure to detect errors Failure to resolve the inherent variation in interlanguage</p> <p>Reduction in the computational capacity of the language faculty Lack of verbal analytical skills</p> <p>Lack of sensitivity to input</p> | <p>I don't pay much attention to my errors. I don't seem to notice my own mistakes when I compare myself with other English speakers. I use the wrong forms without thinking. I use forms from my first language without thinking. I understand the general meaning rather than the details. I don't understand what I need to do to produce correct English. I try to understand the general meaning rather than the details. I can't pick up the small details of English any more. I don't get the chance to practise my English. It takes me a long time to use new English forms without thinking. I learn the rules but forget them when I want to use them later. I don't notice my own mistakes. I can't seem to notice the differences between my first language and English I don't seem to be able to use the language logically any more. I can't seem to be able to use the language logically at all. I don't notice anything new when I hear or read English.</p> |

| | |
|--|--|
| <i>Psychological: I avoid using English, worry about making mistakes and/or feel that there are other emotional reasons.</i> | |
| Inappropriate learning strategy Change in the emotional state Reluctance to take the risk of restructuring Simplification Natural tendency to focus on content, not on form Avoidance Transfer of training | I feel that I'm not learning in the right way. I feel differently about things now and this has had a negative effect on my English. I am worried that I will make a mistake if I try to make new sentences. I use basic English too much. I try to convey the general meaning rather than getting it right. I try not to use English. I remember the way that I was taught my first language and use that way for learning English. |
| <i>Neuro-biological: My age, memory and/or any other cognitive changes.</i> | |
| Changes in the neural structure of the brain Maturational constraints Age Decrease of cerebral plasticity for implicit acquisition Neural entrenchment Lack of talent | I don't have the mental capacity to learn any more. Getting older has made it more difficult to learn English. I'm too old to learn English. I'm not able to remember things in the way that I could before. My mind is 'hard-wired' to my first language. I'm not good at learning languages. |
| <i>Socio-affective: My feelings towards English speaking culture, my English is good enough and/or I don't want to lose my culture.</i> | |
| Satisfaction of communicative needs Lack of acculturation Will to maintain identity Socio-psychological barriers | I don't need to learn more English in order to communicate my needs. I can't identify with English speaking cultures. I don't want to lose my identity through learning English. My feelings towards English speaking cultures are holding me back from learning the language. |

Appendix 8: The Flesch Kincaid Readability Formula

The Flesch Reading Ease Test grades text on a 100-point scale. A text is considered easier to understand if the number. The formula for the Flesch Reading Ease score is:

$$206.835 - (1.015 \times \text{ASL}^3) - (84.6 \times \text{ASW}^4)$$

The Flesch-Kincaid Grade Level Test benchmarks text against corresponding U.S. school grade levels, e.g. a score of 6 would be easily understood by an eleven to twelve year old grade 6 student.

The formula for the Flesch-Kincaid Grade Level score is:

$$(.39 \times \text{ASL}) + (11.8 \times \text{ASW}) - 15.59$$

(Kincaid *et al.* 1975)

³ Average Sentence Length (number of words ÷ number of sentences)

⁴ Average number of Syllables per Word (number of syllables ÷ number of words)

Appendix 9: The Questionnaire Script in Full

| | |
|---|--------|
| 1. I am aware that I am able to withdraw from the project at any time. | yes/no |
| 2. I understand that no names will be used in reports of this project. | yes/no |
| 3. I understand that information will be held securely until the research is completed, when it will be destroyed. | yes/no |
| Personal Information Name (not required) Age Nationality (not required) First Language Are you qualified as a doctor? | |
| More information How long has it been since you worked as a doctor? Where did you gain your primary medical qualification? In which language did you study for your primary medical qualification? | |
| English language learning Length of time studying English Length of time in an English speaking country Number of times taking the IELTS test English skill(s) you are most confident in using: Listening Speaking Reading Writing | |
| Problem areas of English language learning <i>Please chose as many options as you feel apply to you:</i> Problems with <i>a/an/the</i> Problems with <i>have/do/be</i> Problems with <i>it/they/them</i> Problems with <i>when/if/whether</i> Problems with punctuation and spelling Problems with uncountable nouns <i>e.g. some oil/two loaves of bread</i> Problems using prepositions with nouns and verbs <i>e.g. on the internet/provide with</i> Problems showing comparison and contrast <i>e.g. compared with/in contrast to</i> Other problems (please detail) | |
| Things that hold my English back <i>Please chose as many of these reasons as you feel apply to you:</i> Language classes, the people around me and/or my location. Problems noticing the rules and patterns of English. Failing to use English naturally or notice my mistakes Looking for a general meaning. Avoiding using English, worrying about making mistakes and/or feeling that there are other emotional reasons. Age, memory and/or any other cognitive changes. Feelings towards English speaking cultures, my ability in English and/or losing my culture. | |
| My classes, the people around me and/or my location. Nobody corrects me when I make mistakes. I don't have any local contact with the English Language. Everybody around me speaks my language, not English. I am not taking enough English classes. It's not important to use English in my situation. I don't have enough opportunity to read English texts. The English I encounter is too complicated. The English I encounter is poor. My English lessons don't help me. | |

Problems noticing the rules and patterns of English

I have other problems, as well as following the rules of my first language.
I often try to follow the rules of my first language when using English.
I can't easily identify the patterns of English.
I don't understand the differences between my first language and English.
Getting older has made it more difficult to understand the rules of English.
I don't have a strategy to develop my English based on the patterns I have identified.
I am trying to learn too much and none of it seems to stay with me.
I can't easily identify things like verbs, adverbs, and clauses.

Failing to use English naturally, notice my mistakes and/or looking for a general meaning.

I don't pay much attention to my errors.
I don't seem to notice my own mistakes when I compare myself with other English speakers.
I use the wrong forms without thinking.
I use forms from my first language without thinking.
I understand the general meaning rather than the details.
I don't understand what I need to do to produce correct English.
I try to understand the general meaning rather than the details.
I can't pick up the small details of English any more.
I don't get the chance to practise my English.
It takes me a long time to use new English forms without thinking.
I learn the rules but forget them when I want to use them later.
I don't notice my own mistakes.
I can't seem to notice the differences between my first language and English
I don't seem to be able to use the language logically any more.
I can't seem to be able to use the language logically at all.
I don't notice anything new when I hear or read English.

Avoiding using English, worrying about making mistakes and/or feeling that there are other emotional reasons.

I feel that I'm not learning in the right way.
I feel differently about things now and this has had a negative effect on my English.
I am worried that I will make a mistake if I try to make new sentences.
I use basic English too much.
I try to convey the general meaning rather than getting it right.
I try not to use English.
I remember the way that I was taught my first language and use that way for learning English.

Age, memory and/or any other cognitive changes.

I don't have the mental capacity to learn any more.
Getting older has made it more difficult to learn English.
I'm too old to learn English.
I'm not able to remember things in the way that I could before.
My mind is 'hard-wired' to my first language.
I'm not good at learning languages.

Feelings towards English speaking cultures, my ability in English and/or losing my culture.

I don't need to learn more English in order to communicate my needs.
I can't identify with English speaking cultures.
I don't want to lose my identity through learning English.
My feelings towards English speaking cultures are holding me back from learning the language.

Please write about any methods or strategies that you used to overcome any language learning difficulties that you may have had.**Please write about your goals to get over your language learning problems and how you will improve your English.**

Thank you very much for your time. If you would be willing to conduct a short interview via the internet about this area of research, please enter your email address below.

Appendix 10: Language Quiz

Circle the **incorrect** answer or answers; there may be more than one incorrect answer per question.

| EXAMPLE | |
|--|----------------|
| Questions | Answers |
| 1. <i>a/an/the</i> a. Dr. Linares has referred the patient for a blood test. b. Dr. Linares has referred the patient for an blood test. c. Dr. Linares has referred the patient for the blood test. | a. b. c. |
| 2. <i>a/an/the</i> a. The results should be with us within an hour. b. A results should be with us within an hour. c. The results should be with us within a hour. | a. b. c. |

| Questions | Answers |
|---|----------------|
| 1. <i>a/an/the</i> a. Eating a balanced diet can only prevent an obesity to a certain extent. b. Eating a balanced diet can only prevent obesity to a certain extent. c. Eating a balanced diet can only prevent obesity to the certain extent. | a. b. c. |
| 2. <i>a/an/the</i> a. Smoking not only damages the lungs, but also has serious effects on the brain. b. Smoking not only damages the lungs, but also has serious effects on brain. c. Smoking not only damages lungs, but also has a serious effect on brain. | a. b. c. |
| 3. <i>have/do/be</i> a. The patient has done sick in the ward corridor. b. The patient has been sick in the ward corridor. c. The patient was sick in the ward corridor. | a. b. c. |
| 4. <i>have/do/be</i> a. Mrs. Jones' blood pressure was very high yesterday. b. Mrs. Jones' blood pressure has been very high yesterday. c. Mrs. Jones' blood pressure did be very high yesterday. | a. b. c. |
| 5. <i>it/they/them</i> a. To most people, healthy eating is about the food we eat and how we cook them. b. To most people, healthy eating is about the food we eat and how we cook it. c. To most people, healthy eating is about the food they eat and how they cook. | a. b. c. |
| 6. <i>it/they/them</i> a. Some antibiotics are not suitable for patients who may have an allergic reaction to it. b. Some antibiotics are not suitable for patients who may have an allergic reaction to them. c. Some antibiotics are not suitable for patients who they may have an allergic reaction. | a. b. c. |
| 7. <i>when/if/whether</i> a. Most patients might self-diagnose more accurately when the internet was more reliable. b. Most patients might self-diagnose more accurately whether the internet was more reliable. c. Most patients might self-diagnose more accurately if the internet was more reliable. | a. b. c. |
| 8. <i>when/if/whether</i> a. If I can register with the General Medical Council, I will move to London. b. When I can register with the General Medical Council, I will move to London. c. Whether I can register with the General Medical Council, I will move to London. | a. b. c. |
| 9. <i>punctuation</i> a. Many of the indian doctors in the UK did not take the IELTS test. b. Many of the Indian doctors in the UK did not take the IELTS test. c. Many of the Indian Doctors in the UK did not take the IELTS test. | a. b. c. |

| | |
|--|----------------|
| 10. <i>punctuation</i> a. We can look, for example, at jobs in clinics. b. We can, look for example at jobs in clinics. c. We can look for example, at jobs in clinics. | a. b. c. |
| 11. <i>spelling</i> a. Some patience can become too dependant on their GPs. b. Some patients can become too dependant on their GPs. c. Some patients can become too dependent on their GPs. | a. b. c. |
| 12. <i>spelling</i> a. Doctors make up a small part of the workforce in hospitals. b. Doctors make up a small part of the work force in hospitals. c. Doctors make-up a small part of the work force in hospitals. | a. b. c. |
| 13. <i>uncountable nouns</i> a. Medical aid is defined as treatment by a doctor or nurse. b. Medical aids are defined as treatment by a doctor or nurse. c. Medical aid is defined as treatment by doctors or nurses. | a. b. c. |
| 14. <i>uncountable nouns</i> a. Khaled has had a ten-year post as a doctor in France. b. Khaled has had ten years of experiences as a doctor in France. c. Khaled has had ten years of experience as a doctor in France. | a. b. c. |
| 15. <i>prepositions with nouns and verbs</i> a. The symptoms to meningitis are difficult to identify. b. The symptoms from meningitis are difficult to identify. c. The symptoms of meningitis are difficult to identify. | a. b. c. |
| 16. <i>prepositions with nouns and verbs</i> a. The NHS must provide support to healthcare professionals. b. The NHS must provide healthcare professionals to the support that they need. c. The NHS must provide healthcare professionals with the support that they need. | a. b. c. |
| 17. <i>comparison and contrast</i> a. The rate of diagnoses of diabetes in children rose to 18.4% comparing to 17.8% last year. b. The rate of diagnoses of diabetes in children rose to 18.4% comparing with 17.8% last year. c. The rate of diagnoses of diabetes in children rose to 18.4% compared to 17.8% last year. | a. b. c. |
| 18. <i>comparison and contrast</i> a. The NHS in Wales spent 7% of its budget on training. The NHS in Scotland, in contrast, spent 15%. b. The NHS in Wales spent 7% of its budget on training. On the contrary, the NHS in Scotland spent 15%. c. The NHS in Wales spent 7% of its budget on training. On the other hand, the NHS in Scotland spent 15%. | a. b. c. |
| 19. <i>subject-verb-object</i> a. That journal I would like to read. b. I would like to read that journal. c. I that journal would like to read. | a. b. c. |
| 20. <i>subject-verb-object</i> a. The patients the doctor treats. b. They are the patients the doctor treats. c. The doctor treats the patients. | a. b. c. |

| | |
|---|----------------|
| 21. <i>superlative forms</i> a. Dr. Cruz is the better doctor of our time. b. Dr. Cruz is the best doctor of our time. c. Dr. Cruz is the greatest doctor of our time. | a. b. c. |
| 22. <i>superlative forms</i> a. Although she likes to help people, Dr. Patrick says that attending conferences is the enjoyest part of her job. b. Although she likes to help people, Dr. Patrick says that attending conferences is the enjoyablest part of her job. c. Although she likes to help people, Dr. Patrick says that attending conferences is the most enjoyable part of her job. | a. b. c. |
| 23. <i>interrogatives</i> a. Had they your prescription? b. Did they have your prescription? c. Have they got your prescription? | a. b. c. |
| 24. <i>interrogatives</i> a. Do they still in surgery? b. Are they still in surgery? c. Do they are still in surgery? | a. b. c. |
| 25. <i>past and perfect verb tenses</i> a. Did you eat well lately? b. Have you been eating well lately? c. Have you eaten well lately? | a. b. c. |
| 26. <i>Past and perfect verb tenses</i> a. When did the patient die? b. When has the patient died? c. When the patient died? | a. b. c. |
| 27. <i>modal verbs</i> a. You could try running to improve your cardio-vascular exercise routine. b. You could have tried running to improve your cardio-vascular exercise routine. c. You could of tried running to improve your cardio-vascular exercise routine. | a. b. c. |
| 28. <i>modal verbs</i> a. Can I take a moment to ask you a few questions about your lifestyle? b. Will I take a moment to ask you a few questions about your lifestyle? c. Might I take a moment to ask you a few questions about your lifestyle? | a. b. c. |
| 29. <i>subordinate clauses using 'who' and 'which'</i> a. This is the journal which I received it yesterday. b. This is the journal which I received yesterday. c. This is the journal who I received yesterday. | a. b. c. |
| 30. <i>subordinate clauses using 'who' and 'which'</i> a. Mr. Jordan is the patient who I most sympathise with. b. Mr. Jordan is the patient with whom I most sympathise. c. Mr. Jordan is the patient which I most sympathise with him. | a. b. c. |
| 31. <i>subordinate clauses using 'at', 'in' / 'on'</i> a. Mr. Jeremy, at ward C1, has fully recovered. b. Mr. Jeremy, on ward C1, has fully recovered. c. Mr. Jeremy, in ward C1, has fully recovered. | a. b. c. |
| 32. <i>subordinate clauses using 'at', 'in' / 'on'</i> a. The test results, at times, are unreliable. b. The test results, in times, are unreliable. c. The test results, on times, are unreliable. | a. b. c. |
| 33. <i>passive voice</i> a. The diagnosis has been completed. b. The diagnosis will be completed. c. The diagnosis be completed. | a. b. c. |

| | |
|--|----------------|
| 34. <i>conditional forms</i> a. Ordinarily, if blood came into contact with oxygen, it will coagulate. b. Ordinarily, if blood comes into contact with oxygen, it coagulates. c. Ordinarily, if blood comes into contact with oxygen, it might coagulate. | a. b. c. |
| 35. <i>conditional forms</i> a. If I were an osteopath, I can be able to help you. b. If I were an osteopath, I would be able to help you. c. I was able to help you if I were an osteopath. | a. b. c. |
| 36. <i>infinitives and gerunds</i> a. Drinking alcohol is especially harmful while pregnant. b. To be drinking alcohol is especially harmful while pregnant. c. It is especially harmful to be drinking alcohol while pregnant. | a. b. c. |
| 37. <i>infinitives and gerunds</i> a. Dr Green is walking well since his recovery. b. Dr Green walking well since his recovery. c. Dr Green is walking very well since his recovery. | a. b. c. |
| 38. <i>pronunciation</i> Which word or words do not rhyme with 'drain'? a. sane b. feign c. curtain | a. b. c. |
| 39. <i>pronunciation</i> Which word or words do not rhyme with 'breathing'? a. teething b. spreading c. relieving | a. b. c. |
| 40. <i>passive voice</i> a. Acupuncture is not funded by the NHS. b. Acupuncture does not get funded by the NHS. c. Acupuncture does not funded by the NHS. | a. b. c. |

Thank you very much for taking the time to complete the quiz and interview. Your help is extremely valuable and much appreciated.

Gabriel Roberts
gjroberts@cardiffmet.ac.uk



Appendix 11: Typology of SLEs According to Errors in the CLC at IELTS Level 7.0 or Above and L1 Group

spelling

interrogatives

*past and
perfect verb
tenses*

modal verbs

*subordinate
clauses: 'who'
or 'which'*

*subordinate
clauses: 'at',
'in' / 'on'*

*infinitives
and gerunds*

*subject-
verb-object*

*passive
voice*

*conditional
forms*

it/they/them

*when/if/
whether*

a/an/the

have/do/be

punctuation

*uncountable
nouns*

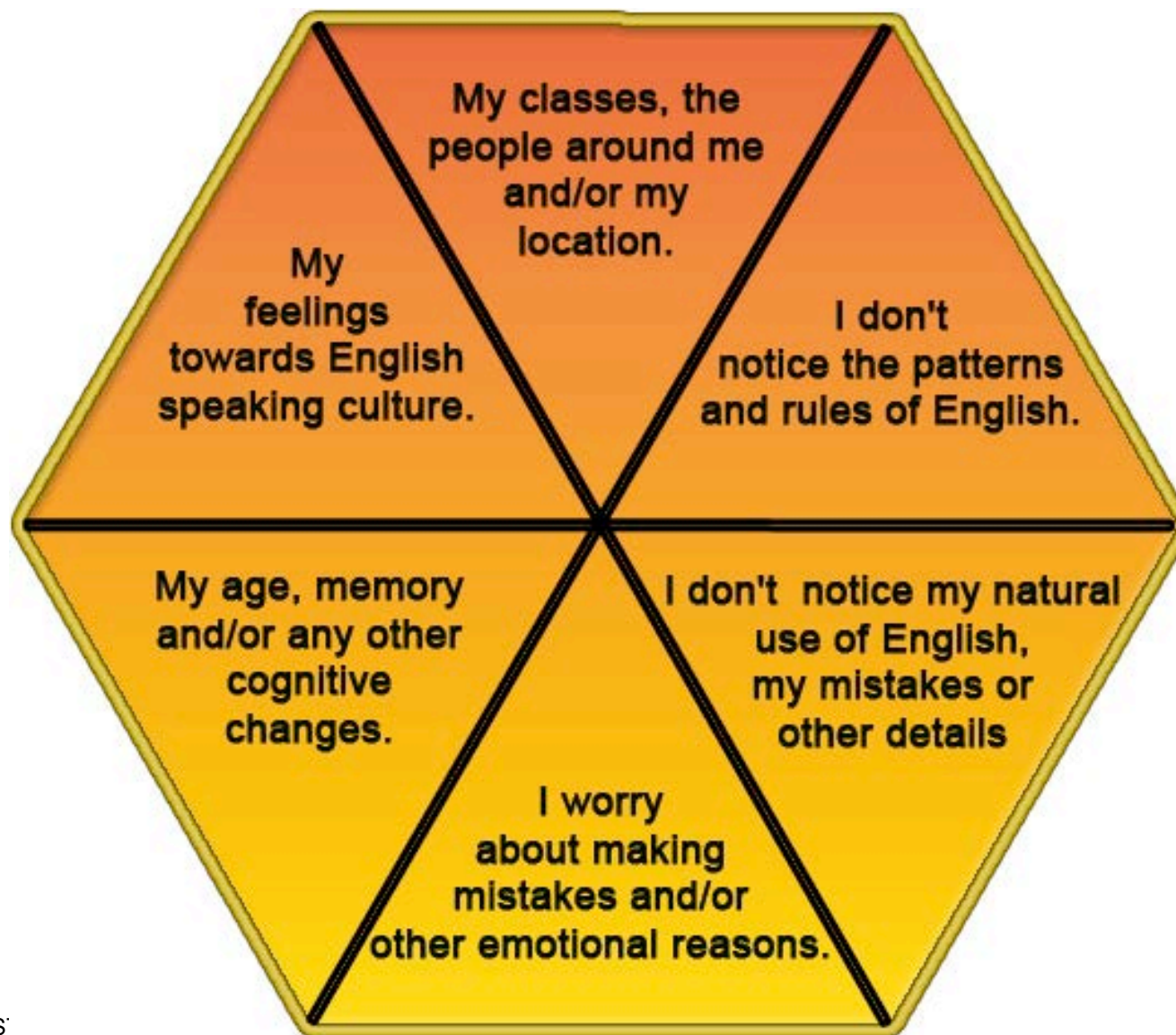
pronunciation

*superlative
forms*

*prepositions
with nouns
and verbs*

*comparison
and contrast*

Appendix 12: Adaptation of Han's (2004) Putative Causal Factors of SLEs for Mapping Exercise During the Interviews.



Appendix 13: Explanation of Putative Causal Factors

Before the interview, please think about the main reasons that can slow progress in language learning and how they may or may not apply to you. A few examples have been given for each of the six reasons but you may have other contributions that you may discuss during the interview.

My classes, the people around me and/or my location.

- Everybody around me speaks my language, not English.
- I am not taking enough English classes.
- The English I encounter is too complicated.

I don't notice the patterns and rules of English.

- I often try to follow the rules of my first language when using English.
- I can't easily identify the patterns of English.
- I can't easily identify things like verbs, adverbs, and clauses.

I don't notice my natural use of English, my mistakes or other details

- I don't seem to notice my own mistakes when I compare myself with other English speakers.
- I try to understand the general meaning rather than the details.
- It takes me a long time to use new English forms without thinking.

I worry about making mistakes and/or other emotional reasons.

- I am worried that I will make a mistake if I try to make new sentences.
- I try to convey the general meaning rather than getting it right.
- I try not to use English, if I can help it.

My age, memory and/or any other cognitive changes.

- Getting older has made it more difficult to learn English.
- I'm not able to remember things in the way that I could before.
- I'm not good at learning languages.

My feelings towards English speaking culture.

- I don't need to learn more English in order to communicate my needs.
- I can't identify with English speaking cultures.
- I don't want to lose my identity through learning English.

Appendix 14: Transcript of Pilot Interviews

Pilot transcription 18/10/12

GR: Good afternoon Mohammed, thank you very much for taking part in this pilot of an exciting new study on stabilized language errors of refugee doctors, participation is much appreciated. I have the (.) consent forms signed, I just want to ask a couple of (0.5) questions so that you know how things are going. Firstly (.) are you aware that you are able to withdraw from this project at any time and that no names will be used in the reports of this project=

MAH:= yeah, 'course yeah.

GR: Fantastic, thank you, and (.) do you understand that information will be held securely, until the research is completed, and later it will be destroyed=

MAH:= Okay, no problem

GR: (.hhh) Okay, so, um (0.8) we've identified through the language quiz that some possible problem areas that you have with English are (.) past and perfect verb tenses, um, conditional forms, and comparison and contrast, so(.) I've given you the sheet to explain a little bit more about the six (.) domains that we have here - um (0.4) and I'm going to ask you then to (.) put these cards onto the...

MAH: Yeah, 'course yeah.=

GR: =Fantastic, take your time, please think about it, don't worry about (.) um (0.5) y'know, if you've got any questions please let me know.

MAH: Okay (5.1) okay, I'm ready.

GR: Okay great, just before you map them to the board, um (0.5) I will be taking a picture of the board as well, just for my own records.
((interviewer takes photo))



GR: Um, in the three areas that you've identified, past and perfect verb tenses, conditional, were you aware that you had these problems, or that you may have these problems=

MAH: =Actually, uh, I had them since I started learning English.

GR: Really.

MAH: Yeah.

GR: (1.1) That doesn't surprise me because a lot of them are mapped to particular languages and Arabic is one of the languages I have identified here, so (.) they are difficult problems (0.8) okay, um, (.) and how long have you been learning English.

MAH: Um, I have been (0.7) learning English for about fi, four year now?

GR: Four [years]

MAH: [yeah], and, uh, I also have been learning, I, uh (0.3) uh, back in Saudi but the education wasn't that really good in English.

GR: Can you tell me a bit about your education in Saudi?

MAH: Uh, Education overall, or just in English?

GR: The English, how long were you there? We'll go into more detail [when we do the exercise.]

MAH: [Uh, once, uh, the student], uh, uh, get the age of twelve (.) maybe twelve or eleven, uh, he needs to learn English and there is, um, um, a private subject for the English language (0.3) uh, there is also, uh four lessons a week (0.4) for the English language but it's uh, it's not, uh, really good actually.

GR: We'll talk about that in a moment, so for you, you've been learning in Saudi for (0.8) how many years [before.]

MAH: [okay] uh, maybe three years?

GR: Three years, and then four years in the UK, is that right? Brilliant, ok, so, um (0.7) I'm going to ask you to map them to [the board] provided please.

MAH: [yeah] Okay, uh, (.) the first thing, uh, I have linked (0.9) the past and perfect verb tenses (0.5) with, uh, my classes, the people around me and/ or my education?

GR: Okay, so, tell me a bit about why you [think you have...]

MAH: [Actually the paddern], the pattern of the (0.8) Arabic, um, education is away different from the English uh, so it's, uh, so it's, um, a major problem for most of the students who're, who are learning English as a second language, especially for the people who're, um, who are, their first language is Arabic (0.5) yeah. The, um (1.8) uh, also they encounter the education they receive, it's not really good. Yeah, so it helps, uh, a lot to, uh, increase the number of the people who, uh, who are facing this problem.

GR: I see, and so is, did you find that there was a very different form of education, in language in the UK when you arrived?

MAH: Yeah, of course. The (0.5) the teachers themselves are not good as here, of course, yeah, but, um, they don't really show interest where, while teaching English, maybe? and also the, uh, the book itself, it's not, um (.) interact in, or m... motivating the students to interact with the teacher and to also learn the English language.

GR: Okay, thank [you for...]

MAH: [Um I'd like] to map conditional forms.

GR: Mmmhmm.

MAH: Um (1.8) I could link also with the same (0.7) with the same thing as, as, um perfect, uh (.) verb tenses? Uh (.) that's because (.) it's also relating to the (.) uh, uh, Arabic language, that's because the (0.8) the, uh, the, um (1.4) the way they speak is different than English so, uh, it's a (.) big problem facing the, uh, Arabic students.

GR: Can I just ask then, is that about, um, the way that the language is or the way which English classes are §?

MAH: Both of them actually.

GR: Both of them, I think that would probably go in between... ..I don't notice the rules and patterns of English.

MAH: Yeah.

GR: Interesting, okay (.hhh) um, and so (0.9) that's the same thing, d- do you have conditional forms, if clauses and things like that, if I was rich, I would buy you a present, do you have things like that in Arabic language structures?

MAH: Uh, maybe but it's not hard as the (0.4) as in English language, so yeah, it's a really big problem.

GR: It proba[bly is] ((laughs))

MAH: [yeah] ((laughs))

GR: Okay, lovely, and, uh, for the last one, comparison and contrast.

MAH: Uh (0.6) I could link it with a different one now, uh, maybe I could, uh, link it with I don't notice the (.) patterns and rules of English?

GR: Okay.

MAH: The paddern, the pattern of the (0.4) Arabic language is away different than English so (1.1) and also the organising the words in the sentence i-is different so it's, um (0.4) it's a hard to organise (0.4) the words to make, um (0.8) uh (0.8) a good sentence.

GR: Mmmhmm, okay, and so (0.5) do you fins that you hear people using correct structures in English but you don't find that you use the, in the same way, is that right?

MAH: Yeah, also, uh (1.0) it is hard, uh, is sometimes confuses a person who study in the English language? Um, maybe, maybe it's the way of English, actually.

GR: Yes.

MAH: Yeah, it's the rule of English.

GR: I think so, I think it's very much, y'know, English, as I always say, is a very difficult language. Okay Mohammed, thank you ver much for than, that's really in formative and useful. I hope it can be useful to you as well, to have this chance to reflect, um, I've got to ask now, have you taken an IELTS test?

MAH: Yes, I have had, uh, uh, four months ago actually?

GR: Mmmhmm.

MAH: That was in June (0.7) and I had the s- overall score of six.

GR: Very good.

MAH: And it was uh, it was good, yeah.

GR: Of course, you wanted to get [nine, I'm sure.]

MAH: [Of course] yeah. ((laughs))

GR: Can I just ask, um, do you think that these ((gestures towards mapping exercise)) had and kind of (0.4) um, influence or effect on your IELTS scores.

MAH: Uh, (1.7) maybe the conditional forms, yeah, I've had, uh (0.4) trouble with writing, so yeah (1.4) it is hard.

GR: Okay, um, are there any other things that you think might effect your, or other people's IELTS scores?

MAH: Maybe, um (2.0) maybe the listening, yeah (0.5) it might be the listening or the, uh, or the speaking that's because it have, it has a different patterns (.) between the two languages Arabic and English?

GR: Tell me about listening.

MAH: Um (0.4) for example, um, back in Saudi, uh, we don't really listen to English, we just learn English, uh, English in a books.

GR: Right.

MAH: So, uh (0.6) yeah, i-it's a book, it's a problem with, um, actually, um, I remember once I came here to Britain, the first year I couldn't understand any words (0.6) it was all complicated, uh, I didn't even know what they say (1.1) um, uh, so, uh (1.2) yeah, it is really hard actually to, uh, to understand, especially for the um, stu- um, especially for the person who had never gone to a foreign country that speaks English (1.7) it was a (.) good experience too.

GR: Right ((both laugh)) I'm glad to hear it. And, um, you said speaking as well, tell me about that.

MAH: It can... we don't really speak, uh, much of the time we do readings.

GR: Mmm.

MAH: Yeah, that's because it's not interactive, we just, just read and that's the lesson, so yeah.

GR: Fantastic, thank you, so there seems to be a link speaking and listening.

MAH: Yeah.

GR: Okay. Lovely, thank you very much for participating in this, um, it's very much appreciated.

MAH: Okay, thank you.

GR: Thank you.

END OF RECORDING

Pilot transcription 21/11/12

GR: Good afternoon Rawdah, Thank you very much for taking part in this=

RAZ: =Not at all=

GR: =um (0.6) pilot interview (.hhh) um (0.7) earlier today I provided you with a sheet with a number of, um, different classifications, these are generally the reasons why, um, people might struggle with taking on more language learning.

RAZ: Yeah

GR: So, um (1.2) have you had a chance to have a look at that sheet?

RAZ: Yes, I have yeah.

GR: Okay [so]

RAZ: [during the break.]

GR: Mmm hmm, okay, thank you, um, can you just tell me about, um, any of the things that you think may apply to you.

RAZ: (3.8) umm (5.5) maybe this one? (0.4) 'I did notice that uh, butterns and rules of English'.

GR: Mmm Hmm.

RAZ: For me I can't easily identify, uh, things like verbs and, um (1.9) adverbs and clauses.

GR: (1.0) Why do you think that is?

RAZ: (2.4) because, um (0.9) for me sometimes, um, difficult, uh because not all the adjective, uh, end ind, the end of it, um, uhh, will be -E-D or -I-N-G, some of them like um, -T-I-V-E (0.6) so a little bit it's com, completed.

GR: (1.4) So it is thing like (.) different endings=

RAZ: =Yeah=

GR: =Different styles of words (0.6) okay, um, (1.5) is there anything else under noticing the patterns and rules of English, um, do you think (1.6) maybe it's difficult to hear any mistakes that you make or anything like that?

RAZ: (2.1) Um (1.4) can you say that word again please?

GR: I'm just wondering under, under this category 'I don't notice the patterns and rules of English', you say that it's hard to identify the parts of speech, the verbs and and adverbs and things.

RAZ: It's not too hard but sometimes difficult to identify it actually.

GR: Mmm hmm.

RAZ: Yeah.

GR: (2.0) And your first language is Arabic.

RAZ: Yes, yeah of course.

GR: And does that have any similar kind of rules to it?

RAZ: (0.8) um (4.9) yeah I think we have uh the passive in English I think we have in Arabic also, uh passive grammar.

GR: I see.

RAZ: Yeah.

GR: (0.6) I've heard that. (.hhh) okay, are there any other things on the sheets that you feel

might (0.9) [cause] you some [difficulty?]

RAZ: [Mmm] [yeah] here - 'I worry about making a mistake, um (0.7) or other emotional, uh, reasons', uh for me I try to convey, uh, uh, the general meaning rather than getting it, uh right (0.5) so I, I don't care if I say, if I make a mistake when I, um, when I speak, when I am speaking but I try, uh, to, um, deliver the, the idea or the meaning the, the uh, general meaning of the um, speech.

GR: (1.5) Okay and (0.6) how do you find that works here in the UK?

RAZ: (2.0) uh what do you mean?

GR: Can you get by with that strategy?

RAZ: (1.7) Umm (0.9) you mean I find it easily or...

GR: (1.3) Yes, um, what I'm trying to say is um (0.5) does that (0.4) does that mean that y-you can be understood and you can communicate easily?

RAZ: Yes, yeah of course, yeah, I can understand the people who are, uh, speaking to me but when I went to, uh, speaking to them I found it a little bit difficult.

GR: Mmm hmm.

RAZ: So I tried um, hardly to, uh, to, differ the idea what I am saying.

GR: Mmm hmm. I think we've all been there with language learning. Um (0.4) is there any

difference (0.4) where you say 'I worry about making mistakes' is there any difference if you're in a large group or if you're in a mixed group or, uh, just with a friend or...

RAZ: Mmm (2.8) maybe, if I, uh were between, if I am between large gro-group, I find it really difficult, I want um, i don't want to uh, ma-make mistakes, so, um (1.0) I was really um, in this uh, in this uh, in this class (0.4) and we are mixed uh before so I found it really difficult when i want to speak I re- I am really shy.

GR: Mmm hmm.

RAZ: Because a lot of student and they (0.8) anything to me so I, I don't want to make mistakes uh but when I move to another uh class I find it um, uh, a little bit easy, easier yeah, [than] before.

GR: [Okay] Okay, are there any other on this sheet that I've given you that you feel might (2.1) have any [effect]?

RAZ: [Mmm] (3.2) [Mmm] (4.2) Uh (0.7) Affect uh, the English language do you mean?

GR: Yeah.

RAZ: Yeah uh, 'everybody around me speaks my language'

GR: Mmm.

RAZ: No English (0.6) specially in um, uh at class (0.8) uh, my friends sometime made uh, mistakes, so they speak in En- in Arabic so I try to talk to them and uh, we have to, we came here to learn Uh, English and we have to be uh, strict with that so we don't want to speak Arabic any more in this class until we get out so if we get out the class no problem.

GR: Mmm yeah.

RAZ: Yeah.

GR: It's a difficult thing to do.

RAZ: Yeah, yeah, I know that (.hhh)

GR: Okay, thank you very much and, and any more on this sheet at all that you felt...

RAZ: No, I don't think so, that's it.

GR: Okay, that's great um (0.8) can I ask how long you have studied English?

RAZ: Yeah, maybe (0.7) uh one year?

GR: One year.

RAZ: Yes, yeah, one year.

GR: Very good.

RAZ: Um, it's not exactly one year, may eleven months but maybe...

GR: Right.

RAZ: Yeah eleven months, yeah.

GR: You've done very well, excellent. (.hhh) okay um (0.4) for the next part I've taken the quiz that you've um, completed and I identified some areas, I think there were twenty different areas in total, and I've identified three as maybe being ones from at least the quiz results, that you might have some problems with?

RAZ: Mmm.

GR: Um, the three areas that I've got are conditional forms.

RAZ: Mm

GR: Uncountable nouns and pronunciation (4.1) are you (0.4) aware of having any problems with these?

RAZ: (1.5) Mmm (1.7) I don't think so I have problem with conditional farms.

GR: Mmm hmm.

RAZ: Um (0.9) maybe this one panci- brownunciation (0.8) um (1.2) I don't have problem also with this unaccountable uh nouns.

GR: Right okay, I think that there was certainly there were some areas where you were stonger on, I have to say, the quiz results were very good overall but I'm not assessing=

RAZ:=Yeah of course.

GR: Um ((looks at quiz results)) (4.9) pronunciation, conditional forms (0.9) yeah, I think the one that seemed to be most identified was uncountable nouns but um, I was just wondering, i'm going to show you this (0.8) hexagon here.

RAZ: Mmm hmm.

GR: And you may already have noticed that it's the same as the sheet that I've given to you.

RAZ: Yeah.

GR: The classes, the patterns and rules, the natural use of English (.hhh) it's the same so I was wondering if you could possibly identify (1.4) and of these an- and maybe place them somewhere on the hexagon, just to say (2.9) where these problems may have come from. (4.8) Do you want me to explain again?

RAZ: Yeah.

GR: ((laughs)) yeah, no problem (.hhh) um (0.5) for example, I think that you said that uh, the people around me speak my language and so possibly that may be why your pronunciation (0.8) [needs] a bit of work.

RAZ: [Oh] I see, mmm hmm.

GR: Or (0.9) possibly you don't, you know, you worry about making mistakes and so you don't get the chance to use English pronunciation.

RAZ: Yeah, because I don't practise enough so I- I might be make a mistakes with pronunciation.

GR: Maybe, so could I ask you to put these three onto the board somewhere.

RAZ: Mmm hmm.

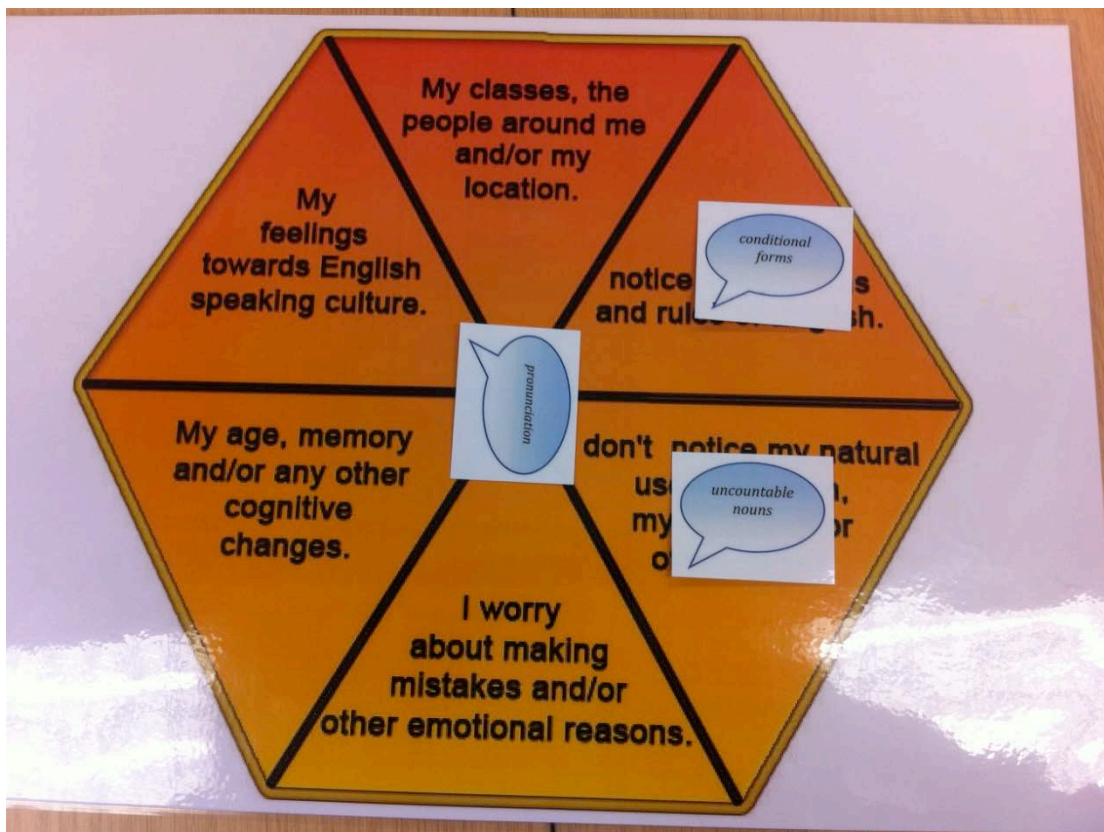
GR: You can use this ((gestures towards the board)), take your time.
(3:39.4)

GR: Okay, are you happy?

RAZ: Yeah.

GR: Alright. I'm just going to take a picture of the board okay, I won't take a picture of you, it's just for records.

((interviewer takes photo))



(19.4)

GR: Okay so, just to confirm you've put pronunciation as being across two there, which is interesting, um, my classes, the people around me and my location and I worry about making mistakes and other emotional reasons?

RAZ: Yeah.

GR: And then the conditional forms you've mapped to I don't notice the patterns and rules of English and uncountable nouns you've mapped to I don't notice my natural use of English.

RAZ: Yes, yeah.

GR: Brilliant, okay um, well let's start with I guess the bigger one, pronunciation, can you tell me why you've put it onto both of those?

RAZ: (2.4) Um ((coughs)) because this pronunciation need um more practice for uh, uh, um, um, person who want to learn another language and if they uh, learn it uh, very correctly or um, in a perfect way so they can contact with another people and uh the native speakers can um understand them uh when they, when they are talking so I put it to uh here, here.

GR: Okay, thanks very much, what about um, conditional forms with I don't notice the patterns and rules?

RAZ: Uh because I thinking uh, conditional forms uh contain to uh um, come under the grammar so um (2.7) um (1.3) so because, because that I put it under th-this um, section.

GR: (2.9) Okay.

RAZ: Mmm.

GR: And the last one uncountable nouns with I don't notice my natural use of English or don't notice my mistakes.

RAZ: (2.2) Yeah because um (3.7) mmm what I think, yeah (2.0) yeah, I don't seem to notice my own mistakes when I compare it uh, when I compare myself to other uh, English speakers (0.5) yeah I'm, maybe I um I don't notice if I say um this noun countable or not countable ba when I tal- um when someone talk to me I can understand uh his mistakes, so, or her mistakes so I said no, he said this wro- uh, in wrong way so he has uh to say it like this, you know? Because that I put it under this section.

GR: (0.8) Great, okay thank you, just a couple more questions um, you've taken an IELTS test, is that right?

RAZ: Yes, yeah of course.

GR: Yeah, and do you think that any of these problems may affect your IELTS score?

RAZ: Mmm (3.0) I think uh pronunciation, affect my IELTS score uh um score in uh speaking (0.9) uh, because when i was speaking I can uh notice that uh the woman who uh the examiner um, you know looking at me and when I say something really difficult to take in uh pronounc- I know I, I, I know my pronunciation is diff- uh is uh um uh is wrong ba I- I can know from uh her eyes (0.7) so I (1.8) uh ((laughs)) I don't know even how to say uh, um (2.1) so I am really nervous in this situation.

GR: Mmm Hmm.

RAZ: Um If I can't uh say the pronunciation in correct way (0.9) so I think this is um, erm um the problem affect my um I uh IELTS speaking.

GR: (1.0) And how was your speaking score compared to the other skills?

RAZ: (1.1) Uh (2.1) I ju- I (.hhh) people said to me that's good your score but I- I um I'm not sati- uh satisfised uh about it (1.4) so uh my IELTS score was uh I- I have done this exam for three times so five, five, five point five uh in just uh IELTS speaking.

GR: Mmm Hmm.

RAZ: So I wanted more than five point five ((laughs)) so I am trying actually these days uh, and I will take this exam in March maybe or January and uh I want to see how uh, if I improved or not, on my language.

GR: Yeah, are there any other things that you think might affect your IELTS scores?

RAZ: Um, you mean in uh speaking sections or different writing reading?

GR: In general.

RAZ: (.hhh) Okay (0.4) maybe reading (0.7) because I really find it really difficult uh the reading (.hhh) uh because um, I want to understand every word in the text ((laughs)) so uh uh um everyone said to me that you- you can't understand every wor- uh every word in foreign language is not like your uh uh uh first language so try just to understand the meaning of the, of the text or uh baragraph or whatever. So I'm trying actually (0.7) and um when I ta- when I took the um um tutorial with uh Christine um after tutorial we have uh a long discussion and I try to uh buy a magazine um a Guardian news- newspaper so when I reading uh I think now um I feel my reading improve slowly, step by step.

GR: Brilliant.

RAZ: Yeah.

GR: Okay, well, I think that pretty much concludes the interview so thank you [very much] for helping me to pilot it.

RAZ: [You're welcome].

END OF RECORDING

Pilot transcription 25/10/12

GR: Okay Paras, Thank you very much for being part of this research project and agreeing to take the pilot interview with me (.hhh) Um (0.6) I've already through the quiz the, um, possible problem areas that you may have with language learning and you've had a look at the board with the (.) possible causes for those, and some of the explanations there (1.3) Okay, so I'm just going to ask a few organisational questions first of all (.) are you aware that you are able to withdraw from this project at any time and that no names will be used in the reports [of the project]?

PM: [Yes.]

GR: Thank you, do you understand that the information will be held securely until the research is completed and later it will be destroyed?

PM: Yes sir.

GR: Brilliant, okay so, those are the (1.0) ethics questions out of the way, (.hhh) um (.) how long have you studied English?

PM: Um, back in India, hum (.) we started English from very (0.5) basic=

GR: =Mmm hmm=

PM: =so pretty much from the starting.

GR: From the start of your education?

PM: Yes, uh, from pre-school.

GR: How many years would that be?

PM: More than ten.

GR: More than ten years.

PM: Yes.

GR: And (0.3) so is that (1.1) you started in pre-school and now it's ten years up 'til now?

PM: More than ten years.

GR: More than ten years, so how, how long, how many years?

PM: Uh, umm (1.6) fourteen years.

GR: Fourteen (0.9) that's great, okay, umm (2.1) and how long have you been in the UK?

PM: Um, it's been twenty days, twenty odd days.

GR: Right, okay (0.8) thank you very much (0.6) okay (2.3) how long have you known of the possible problem areas that we've identified here? (0.7) Have you been aware that they were possibly problems for you?

PM: (1.5) Uh, yes.

GR: And how long do you think you've (.) struggled with these parts?

PM: Uhh, maybe since the high school.

GR: Since high school.

PM: I was never good at the grammar.

GR: Right, okay, thank you (1.0) um (0.9) now I'm going to ask you to put each one onto the board, take your time. ((participant maps SLEs to board)) (2:46.2) Happy?

PM: Yes

GR: Okay, just one moment while I take a photo, not of you, just the board ((interviewer takes photo))



(17.5) thank you very much (2.1) okay (2.2) so, um, I think the first one that you mapped was comparison and contrast, um, and you've mapped it to worrying about making mistakes or other emotional reasons, can you tell me a little bit about that?

PM: (1.9) Um ((laughs)) yeah I'm get a little (0.4) nervous (.) uh (0.6) maybe a little embarrassed with my wrong English (.) mmm hmm.

GR: And (1.3) what effect does that have?

PM: (1.2) Uh, not much, but just a little embarrassment, that's it.

GR: Okay (1.7) um, okay, and the second one I think that you mapped was, um (0.3) infinitives and gerunds, 'to do' and 'doing' (.) um and you've said that that's 'I don't notice natural use of English', your mistakes or other things, can you explain a bit about that?

PM: Well speaking, I don't really, you know, uh, understand what I'm, what mistakes I'm making, but b-by writing, 'cause i have to recheck it, so, probably sometime I gets- get to know what, um, what mistakes I am making.

GR: And why is that? What's the difference between speaking and writing?

PM: Um, you don't think while speaking, I-actually I don't ((laughs)) so whatever comes into my mind I just speak out and I don't try to correct it.

GR: Right, and writing=

PM: =yeah I have to correct it=

GR: Why?

PM: Uh, maybe it would help me, you know, for the future, (2.0) [uh it] makes that kind of mistakes again.

GR: [Okay so...] Is that for all writing?

PM: (1.4) No (0.8) academic.

GR: Academic writing, so for [emails...] [...go ahead...]

PM: [yes of course] [yes, yes of course.]

GR: Okay, that's interesting, thank you very much. Okay and the last one that you've mapped were, um, the possible problem area of the confusion between 'it, they and them' and you've said that that's, um, the classes, people around you or your, um (0.4) location, can you tell me about that?

PM: Yeah, its a little, you know, kind of small problems that maybe ever, uh, any other person wouldn't notice, so that's, that's why.

GR: (0.8) Yes, it's, i- I mean all of your, your, quiz results were very good and it's difficult to say (.hhh) um (1.7) perhaps you could (.) maybe (1.9) tell me about (0.4) the (0.4) you learnt in India (0.7) and the style of English there, is it very different?

PM: It is.

GR: How?

PM: The teachers aren't that (.) friendly or, you know (0.7) if they know a guy is, guy or a woman is uh, a good at studying (.) so they will probably focus more on them and maybe left out the other ones, yeah that's happened to me ((laughs))

GR: Really?

PM: Yes, so, 'cause, uh, we have about forty people in one class.

GR: Mmm hmm.

PM: So it's probably hard to (0.3) manage, uh, talking to every kind of, every student.

GR: Are the teachers judged on the performance of the students?

PM: Yes, they do, very much.

GR: Right, (0.4) okay that's really good, thank you very much (.hhh) um (0.3) do you think that any of these problems might affect your IELTS scores?

PM: Uh, yes (0.4) yes.

GR: Any reason why?

PM: Um, by reading skills ((laughs)) I get pretty bored when I'm reading.

GR: Okay, and i-is that when you face challenging texts with, for example comparison and contrast work=

PM: =uh yes, yeah, uh a l-little- I get a little confused (0.5) yeah, so it's kind of hard reading all the time, mmm, yeah, so I (1.1) s- kinda stopped reading and just scanning it, uh, kept taking my guesses.

GR: Mmm hmm.

PM: That's what I do.

GR: If it's any help, I'll say this on record, I don't think I've ever got more than thirty eight out of forty for that.

PM: ((laughs))

GR: Okay, are there any other things that might affect your IELTS scores, do you think?

PM: (1.3) Uh, my presentation skills, speaking, yeah ((laughs)) I get pretty nervous, because I have to, uh, you know, I don't have much time to (.) prepare it.

GR: Mmm.

PM: I don't think I do (0.5) ((laughs)) you know it takes a little time taking notes and preparing my thoughts.

GR: Mmm. So speaking part two.

PM: Yes ((laughs)) not much but (0.6) yeah, ver-a, a little.

GR: Okay. Well that concludes the interview thank you very much for your help.














END OF RECORDING

Appendix 15: Transcription Conventions Adapted from Edley and Litosseliti (2010) and Mackey and Gass (2005)













| | |
|----------------|--|
| (1.0) | Timed pause (in tenths of seconds) |
| (.) | Micropause (i.e. too short to time) |
| No= =gap | Indicates the absence of a discernable gap between the end of one Speakers utterance and the beginning of the next |
| Wh[en] [No] | Marks overlap between speakers. The left bracket indicates the beginning of the overlap while the right bracket indicates the end. |
| No::w | One or more colons indicates the extension of the previous sound |
| > < | Indicate talk produced more quickly than surrounding talk |
| <i>text</i> | Word(s) emphasized |
| CAPITAL | Noticeably louder talk |
| *hush* | Noticeably quieter talk |
| ? | Rising intonation or question |
| . | Falling intonation or end of speech |
| , | “Nonfinal intonation” (usually a slight rise) |
| y- | A hyphen after a sound indicates a false start |
| ((laugh)) | Nonlinguistic occurrences such as laughter or paralinguistic gestures |
| (hh) | Indicates an audible out breath (the more ‘h’s’ the longer the breath |
| (.hh) | Indicates an audible intake of breath (the more ‘h’s’ the longer the breath |

Appendix 16: Analysis of the Questionnaire Data














Age (13 Responses)

|  | 35 |
|---|----|
|  | 43 |
|  | 49 |
|  | 38 |
|  | 54 |
|  | 50 |
|  | 38 |
|  | 33 |
|  | 30 |
|  | 42 |
|  | 34 |
|  | 51 |
|  | 36 |

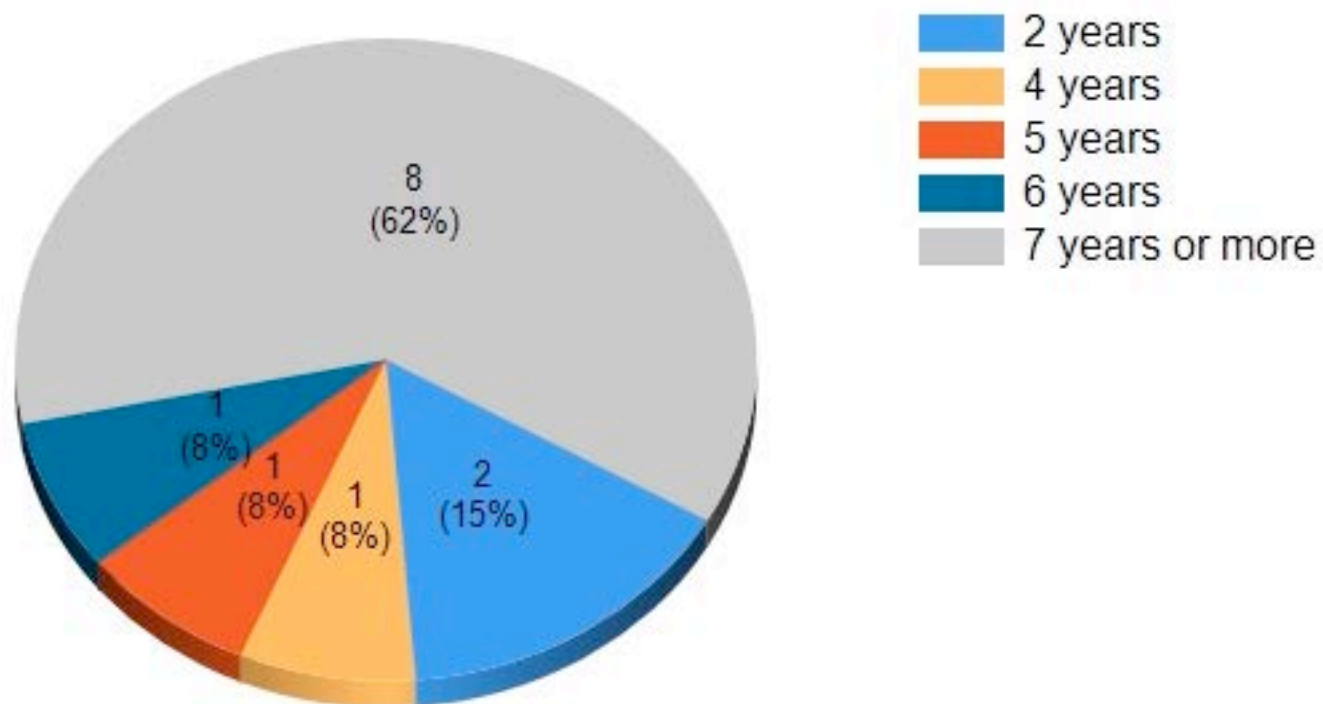
Nationality (13 Responses)

| | |
|---|----------|
| | |
|  | |
|  | |
|  | British |
|  | iraqi |
|  | dutch |
|  | Iraqi |
|  | iraqi |
|  | Iraqi |
|  | Sudanese |
|  | British |
|  | |
|  | |
|  | |

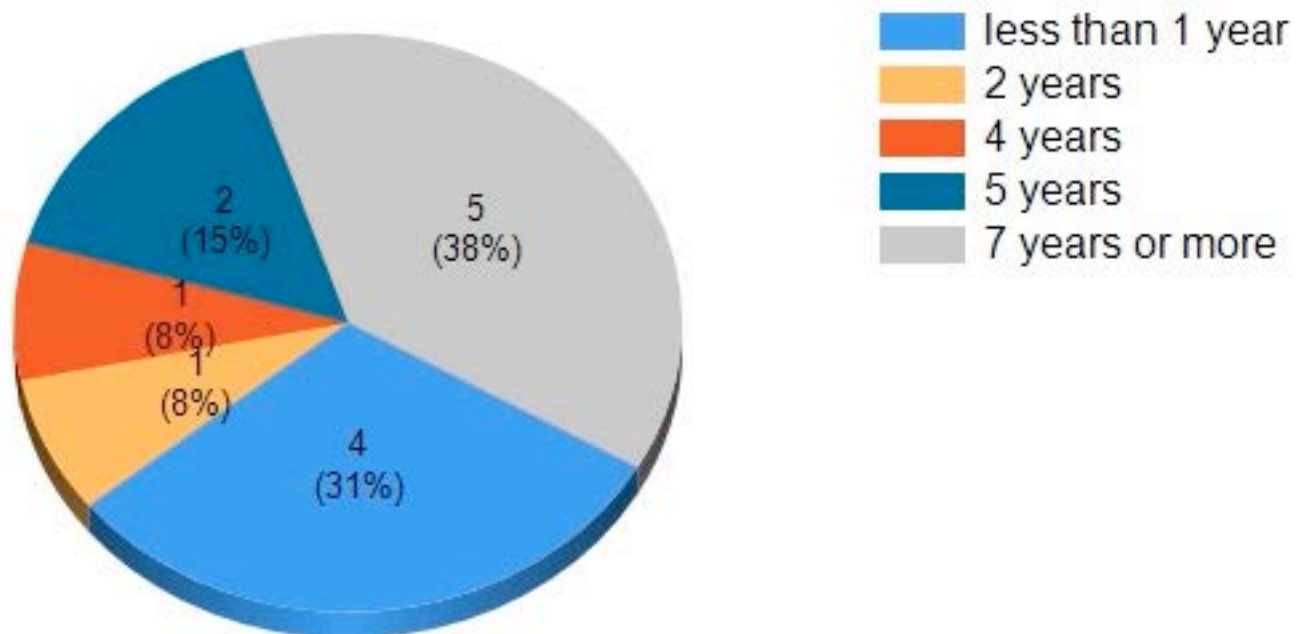
**First language
(13 Responses)**

| | |
|---|-------------------|
| | |
|  | Burmese |
|  | Dari |
|  | Deri/persion |
|  | Arabic |
|  | Arabic |
|  | Arabic |
|  | arabic |
|  | Arabic |
|  | Zagawa and Arabic |
|  | Arabic |
|  | URDU |
|  | Arabic |
|  | Burmese and Mizo |














How long have you worked as a doctor? (13 Responses)
















How long has it been since you worked as a doctor? (13 Responses)



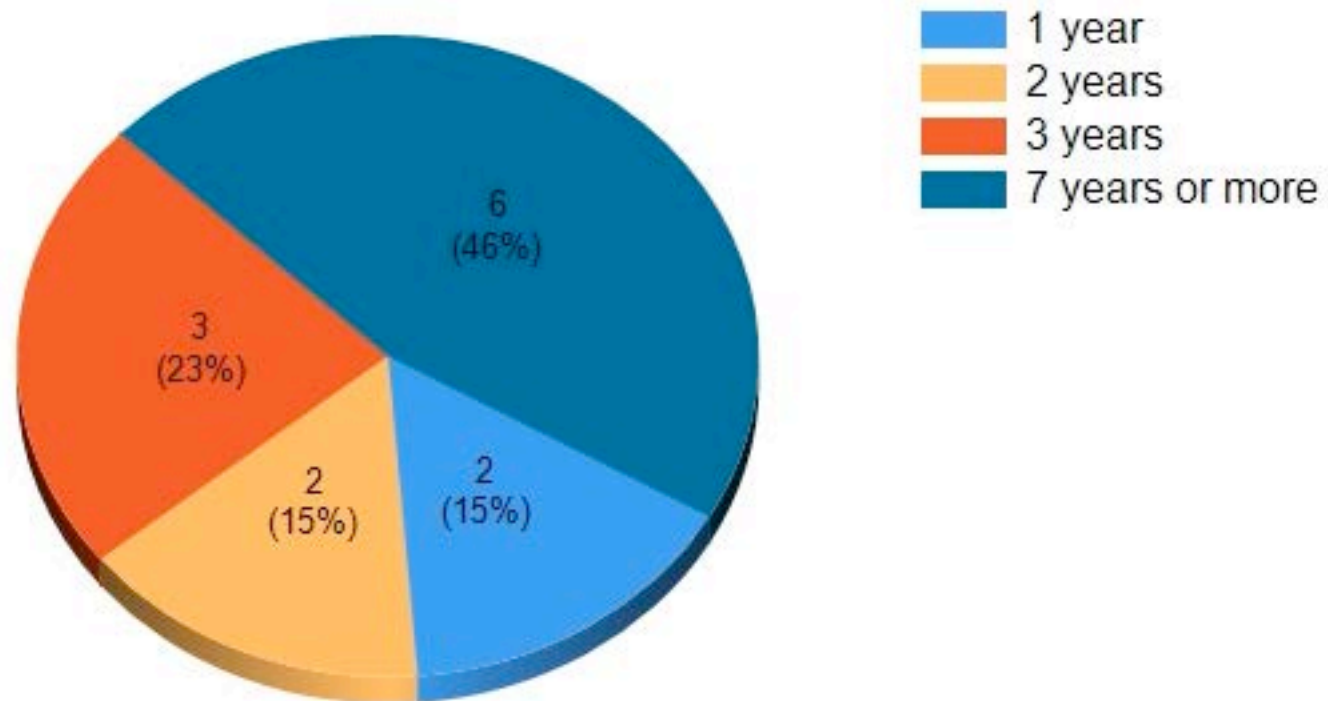
**In which country did you gain your primary medical qualification?
(13 Responses)**

| | |
|---|-------------|
| | |
|  | Burma |
|  | Afghanistan |
|  | Afghanistan |
|  | Iraq |
|  | USSR |
|  | IRAQ |
|  | iraq |
|  | Iraq |
|  | Sudan |
|  | Ukraine |
|  | PAKISTAN |
|  | Iraq |
|  | Burma |

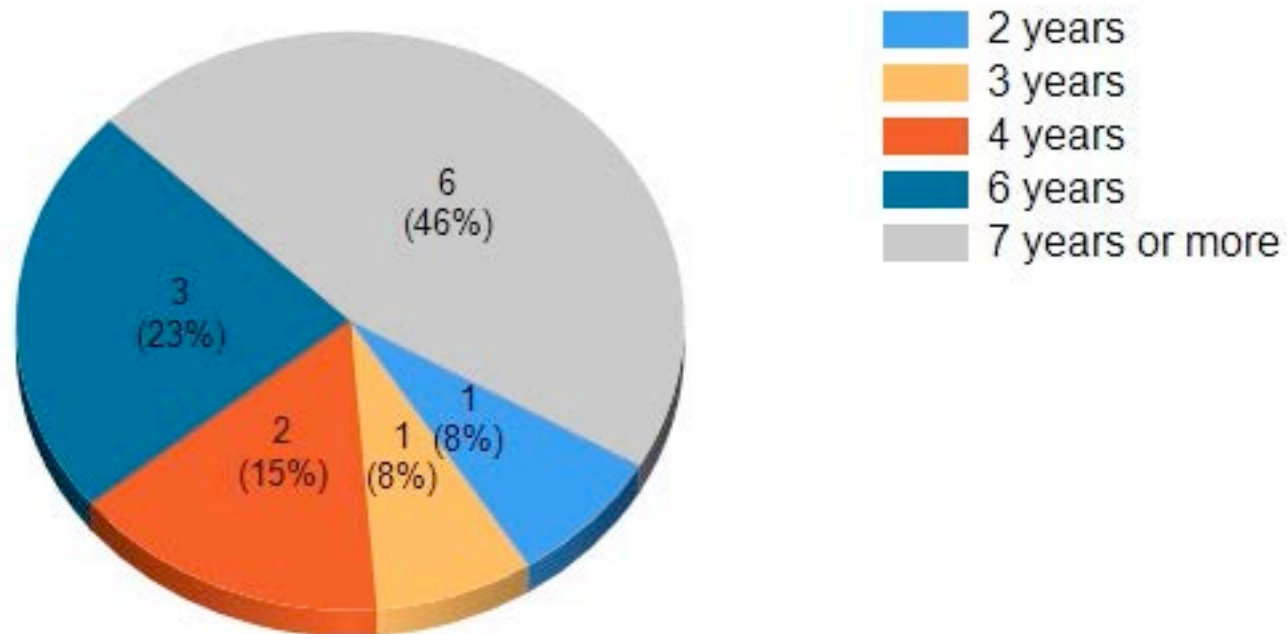
**What percentage of your primary medical qualification was in English?
(13 Responses)**

| | |
|---|--------------|
| | |
|  | 100 |
|  | 1% |
|  | 10% |
|  | 100% |
|  | 0% |
|  | 100% |
|  | 100% |
|  | 99% |
|  | 100% |
|  | 80 |
|  | 100 |
|  | 90% |
|  | about 60-85% |

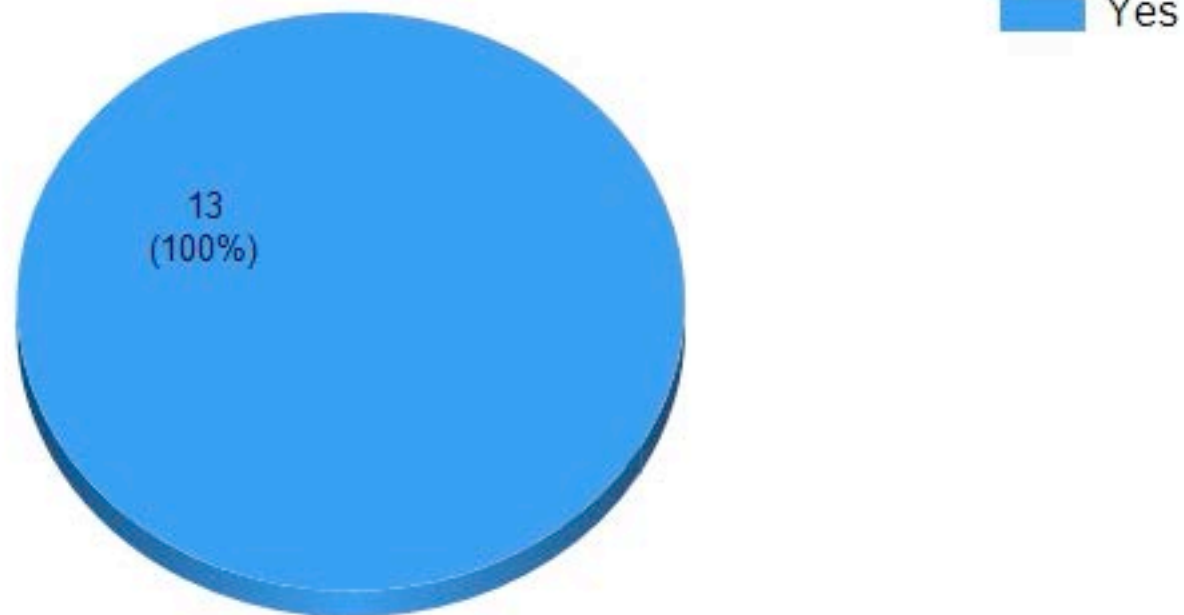
English language learning (13 Responses)
















Length of time in an English first language country (13 Responses)
















**Are you still in an English first language
country?
(13 Responses)**



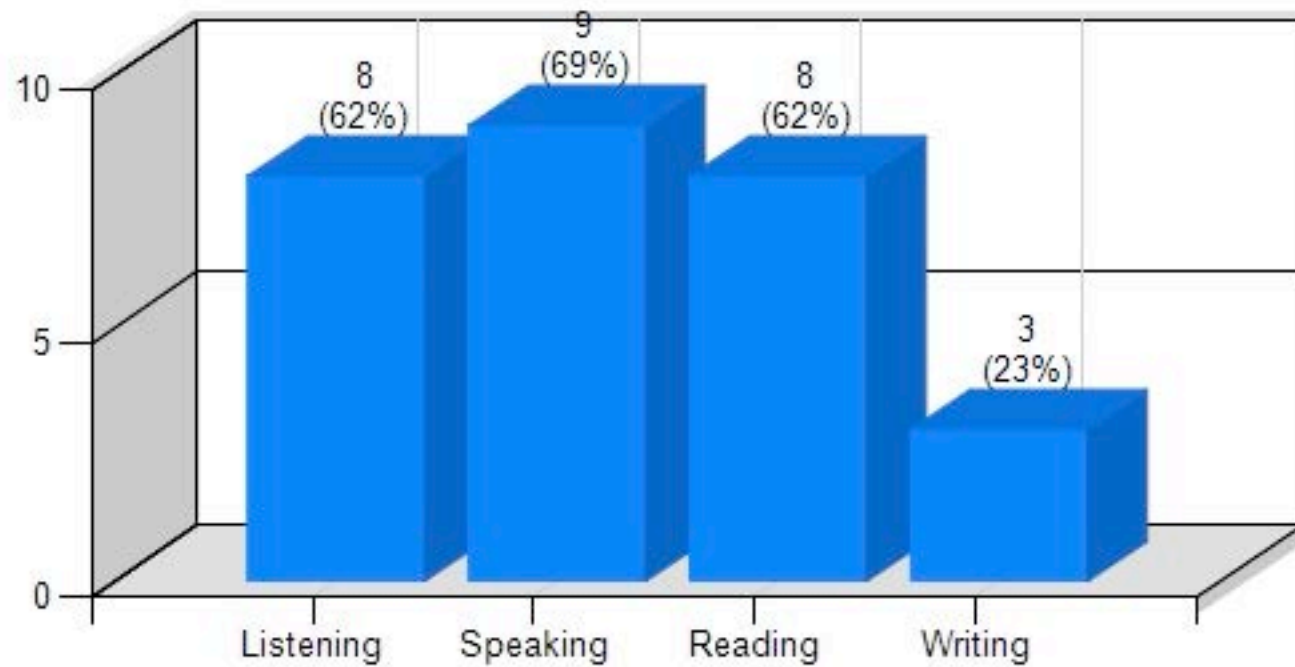
**Maximum overall score from the IELTS test (if no IELTS test was taken please put 0)
(13 Responses)**

| | |
|---|-----|
| | |
|  | 7 |
|  | 7 |
|  | 7.5 |
|  | 7.0 |
|  | 07 |
|  | 7.0 |
|  | 7.0 |
|  | 7 |
|  | 7 |
|  | 6.5 |
|  | 8 |
|  | 7.0 |
|  | 7 |

**Number of times taking the IELTS test
(13 Responses)**

| | |
|--|------|
| | |
|  | 3.00 |
|  | 4 |
|  | 10 |
|  | 5 |
|  | 3 |
|  | 3 |
|  | 5 |
|  | 3 |
|  | 10 |
|  | 6 |
|  | 2 |
|  | 3 |
|  | 3 |

English skill(s) you are most confident in using (13 Responses)

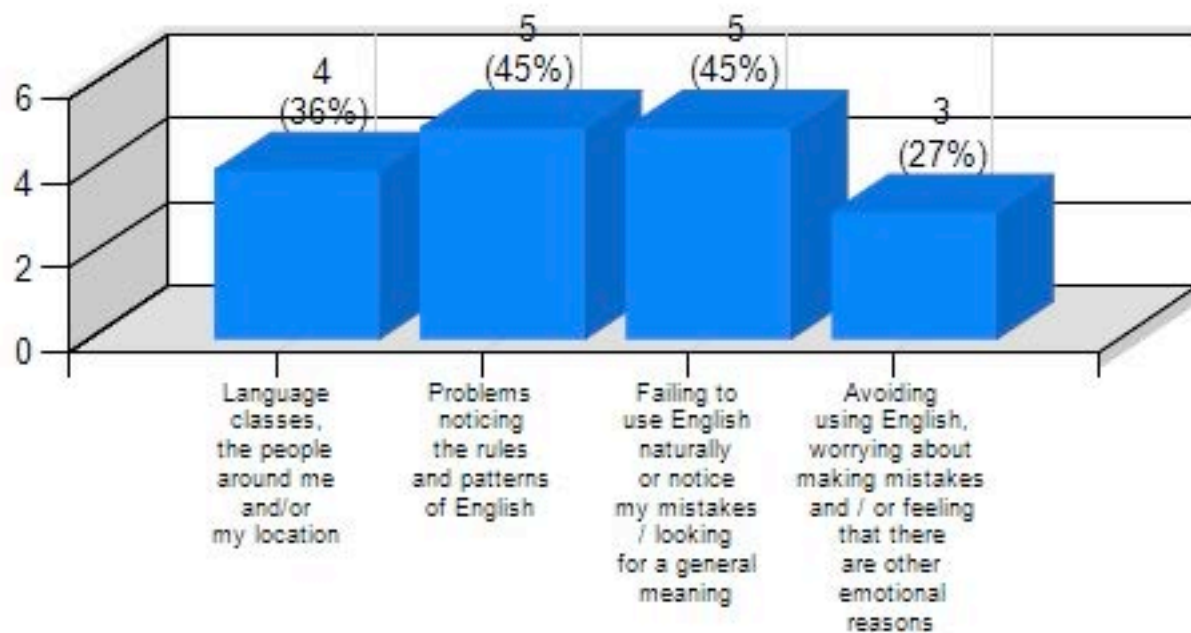


**Problem areas of English language learning
(13 Responses)**

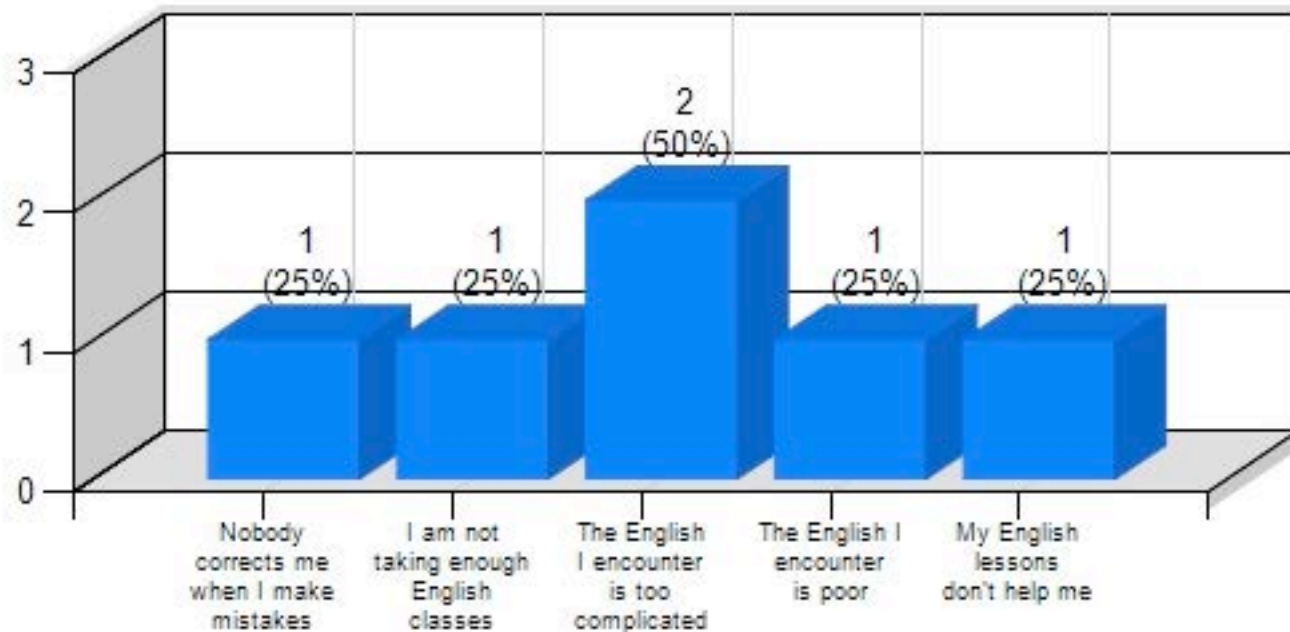
| Option | Count | Percent |
|--|-------|---------|
| problems with a / an / the | 3 | 23.1 |
| problems with have / be | 2 | 15.4 |
| problems with do | 1 | 7.7 |
| problems with it / they / them | 1 | 7.7 |
| problems with when / if / whether | 1 | 7.7 |
| problems with punctuation and spelling | 10 | 76.9 |
| problems with uncountable nouns e.g. some oil / two loaves of bread | 3 | 23.1 |
| problems using prepositions with nouns and verbs e.g. on the internet / provide with | 4 | 30.8 |
| problems showing comparison and contrast e.g. compared with / in contrast to | 2 | 15.4 |
| problems with past and perfect verb tenses e.g. did/ have done | 4 | 30.8 |
| problems with modal verbs e.g. will do/ would do/ can do/ could do/ must do /should do | 4 | 30.8 |
| problems with subordinate clauses e.g. using 'who' or 'which' to add information | 3 | 23.1 |
| problems with subordinate clauses e.g. using 'at', 'in' / 'on' to add information | 6 | 46.2 |
| problems using the passive voice e.g. 'the food was eaten / the computer has been broken | 1 | 7.7 |
| problems with conditional forms e.g. if I were rich, I would buy a Porsche | 5 | 38.5 |
| problems with using infinitives and gerunds e.g. I don't want to eating/ she is eat | 5 | 38.5 |
| problems with subject-verb-object e.g. I television watch / That car I would like to drive | 1 | 7.7 |
| problems with superlative forms e.g. the better in the world / The more hottest | 3 | 23.1 |
| Total: | 59 | 100.0 |

Things that hold my English back

(11 Responses)

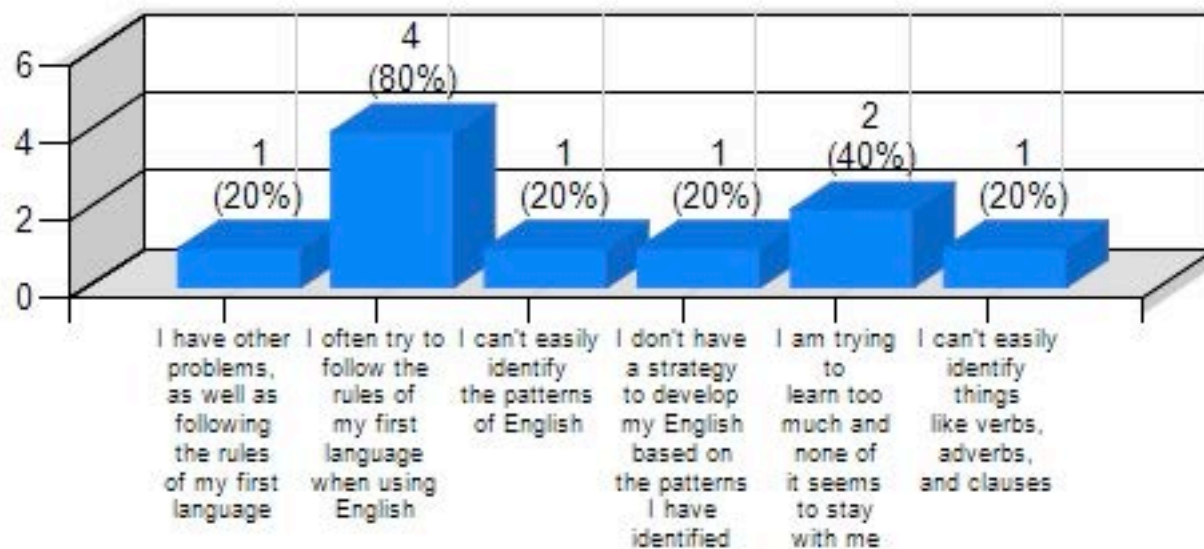


Language classes, the people around me and/or my location. (4 Responses)



Problems noticing the rules and patterns of English

(5 Responses)



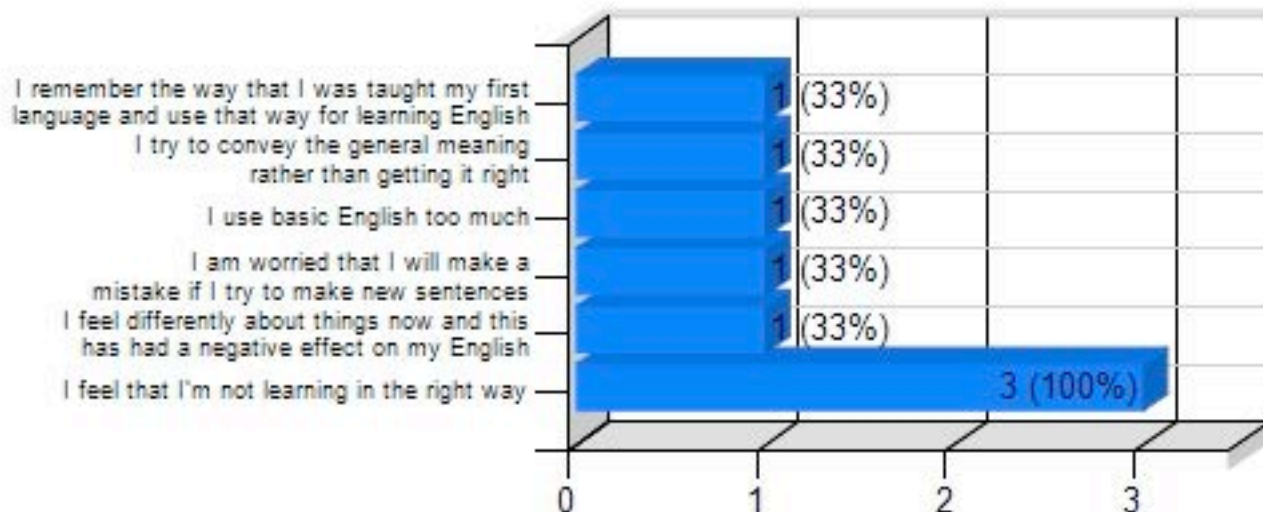
Failing to use English naturally, notice my mistakes / looking for a general meaning.

(5 Responses)



| Option | Count | Percent |
|---|-------|---------|
| I don't pay much attention to my errors | 1 | 20.0 |
| I use forms from my first language without thinking | 2 | 40.0 |
| I understand the general meaning rather than the details | 2 | 40.0 |
| I try to understand the general meaning rather than the details | 1 | 20.0 |
| I can't pick up the small details of English any more | 1 | 20.0 |
| I don't get the chance to practise my English | 2 | 40.0 |
| It takes me a long time to use new English forms without thinking | 2 | 40.0 |
| I don't notice my own mistakes | 1 | 20.0 |
| Total: | 12 | 100.0 |

Avoiding using English, worrying about making mistakes and/or feeling that there are other emotional reasons.












(3 Responses)



Please write about any methods or strategies that you used to overcome any language learning difficulties that you may have had.
(2 Responses)

| | |
|---|--|
| | |
|  | Working as a receptionist helped me in improving my speaking and listening skills. Listening to BBC. Also work gave me the confidence to speak in English. |
|  | Taking English class with an experienced teacher and working as a volunteer in charity shops to practice spoken English with native speakers can be extremely useful to improve speaking ,listening and writing , while reading newspapers such as the economist , the guardian and the independent has helped me a lot to improve my reading skills . |

**Please write about your goals to get over your language learning problems and how you will improve your English.
(11 Responses)**

| | |
|---|--|
| | |
|  | Hoping one day I will be able to speak English as if my mother tongue (I don't mind my unique accent). By learning more and more , socialising with the native people of the UK, and reading English books. |
|  | I am trying to learn on a daily basis but the most difficult part of the language is a wide range of words and making complex sentences. I also found it difficult to write academically in English language. |
|  | I usually listen to the radio 4 and I try to read more non medical books in English in my spare time. In addition to the previous measure I have tried my best to avoid medical Jargon during my consultation with the patients and their family. Finally I have put a great effort to think in English and avoid thinking in my first language. |
|  | practice and learning from native speakers. self study and learning from native speaker teachers. |
|  | more reading, more communicating with english people will definitely improve my English |
|  | Regarding my experience with english language, I feel that language barrier was the hardest one I faced in the UK. To start with, my English is not bad and I can interact with others without difficulty directly or over the phone. However, I feel the language is a barrier to feel completely engaged. As I mentioned, my previous study was in English and my standard in academic language is high and I got Distinction score in my Msc degree, but still I feel the street language is difficult. I think that more listening to radio and TV as well as talking with native English will be of great importance to improve the standard of language. |
|  | practice everyday language with native speakers. |
|  | I have problems in writing. I am trying to write more and often, using text from newspaper and magazine. But this was not enough, because I need someone to guide me through my writing journey. |
|  | |
|  | I am listen more for BBC4 programmes. Read as much as I can. However, most of the reading is academic one which helps little in general language. The difficult part is the layout language which is very difficult to improve. I believe that without interaction with native people, it is difficult to improve language. |
|  | Language problem can be a big barrier in our careers. For this, having a strategy to overcome language learning problems is very important for me and one of my plans is, " recognising my weak points and correcting them until my English as good as the native speakers". Keen to learn with open minded is a stepping stone for me to improve my English. |

Thank you very much for your time. If you would be willing to conduct a short interview via the internet about this area of research, please enter your email address below.
(13 Responses)

| | |
|---|-------------------------|
| | |
|  | |
|  | |
|  | imam@doctors.org.uk |
|  | |
|  | mahak63@hotmail.com |
|  | drahmedkhalid@yahoo.com |
|  | |
|  | lalfattal@yahoo.com |
|  | tammony1@hotmail.com |
|  | dralsanosi@live.co.uk |
|  | |
|  | |
|  | nuteidlk@yahoo.co.uk |

Appendix 17: Questionnaire Results CSV

| Name | Age | Nationality | First language | Are you qualified as a doctor? | How long have you worked as a doctor? | How long has it been since you worked as a doctor? | In which country did you gain your primary medical qualification? | What percentage of your primary medical qualification was in English? | English language learning | Length of time in an English first language country | Are you still in an English first language country? |
|-----------|-----|-------------|-------------------|--------------------------------|---------------------------------------|--|---|---|---------------------------|---|---|
| Dr. QA | 35 | | Burmese | Yes | 2 years | 5 years | Burma | 100 | 3 years | 7 years or more | Yes |
| Dr. Irene | 31 | Azerbaijani | Russian | Yes | 1 year | 5 years | Russia | 0 | 3 years | 3 years | Yes |
| Dr. QB | 43 | | Dari | Yes | 7 years or more | 7 years or more | Afghanistan | 1% | 3 years | 3 years | Yes |
| Dr. QC | 49 | British | Deri/persion | Yes | 7 years or more | less than 1 year | Afghanistan | 10% | 7 years or more | 7 years or more | Yes |
| Dr. QD | 38 | iraqi | Arabic | Yes | 7 years or more | less than 1 year | Iraq | 100% | 7 years or more | 7 years or more | Yes |
| Dr. QE | 54 | dutch | Arabic | Yes | 7 years or more | 7 years or more | USSR | 0% | 7 years or more | 4 years | Yes |
| Dr. QIE | 50 | Iraqi | Arabic | Yes | 7 years or more | 7 years or more | IRAQ | 100% | 1 year | 6 years | Yes |
| Dr. QF | 38 | iraqi | arabic | Yes | 7 years or more | less than 1 year | iraq | 100% | 7 years or more | 7 years or more | Yes |
| Dr. QG | 33 | Iraqi | Arabic | Yes | 6 years | 7 years or more | Iraq | 99% | 2 years | 6 years | Yes |
| Dr. QH | 30 | Sudanese | Zagawa and Arabic | Yes | 2 years | 2 years | Sudan | 100% | 2 years | 2 years | Yes |
| Dr. QI | 42 | British | Arabic | Yes | 7 years or more | 4 years | Ukraine | 80 | 1 year | 4 years | Yes |
| Dr. QJ | 34 | | URDU | Yes | 5 years | 5 years | PAKISTAN | 100 | 7 years or more | 7 years or more | Yes |
| Dr. QK | 51 | | Arabic | Yes | 7 years or more | 7 years or more | Iraq | 90% | 7 years or more | 6 years | Yes |
| Dr. QL | 36 | | Burmese and Mizo | Yes | 4 years | less than 1 year | Burma | about 60-85% | 3 years | 7 years or more | Yes |

| Maximum overall score from the IELTS test | Number of times taking the IELTS test | English skill(s) you are most confident in using | Problem areas of English language learning | Things that hold my English back |
|---|---------------------------------------|--|--|--|
| 7 | 3 | Speaking | problems with punctuation and spelling, problems using prepositions with nouns and verbs e.g. on the internet / provide with, problems with subordinate clauses e.g. using 'at', 'in' / 'on' to add information | Problems noticing the rules and patterns of English |
| 0 | 0 | Reading, Listening | problems with subordinate clauses e.g. using 'at', 'in' / 'on' to add information , problems with past and perfect verb tenses e.g. did/ have done, problems using prepositions with nouns and verbs e.g. on the internet / provide with, problems with a / an / the | Avoiding using English, worrying about making mistakes and / or feeling that there are other emotional reasons |
| 7 | 4 | Speaking | problems with a / an / the, problems with subordinate clauses e.g. using 'at', 'in' / 'on' to add information | Problems noticing the rules and patterns of English, Language classes, the people around me and/or my location |
| 7.5 | 10 | Reading | problems with superlative forms e.g. the better in the world / The more hottest , problems with subordinate clauses e.g. using 'at', 'in' / 'on' to add information , problems showing comparison and contrast e.g. compared with / in contrast to, problems with past and perfect verb tenses e.g. did/ have done, problems with modal verbs e.g. will do/ would do/ can do/ could do/ must do /should do, problems with subordinate clauses e.g. using 'who' or 'which' to add information , problems with conditional forms e.g. if I were rich, I would buy a Porsche, problems with using infinitives and gerunds e.g. I don't want to eating/ she is eat, problems with subject-verb-object e.g. I television watch / That car I would like to drive, problems with do, problems with it / they / them, problems with when / if / whether, problems using prepositions with nouns and verbs e.g. on the internet / provide with, problems with uncountable nouns e.g. some oil / two loaves of bread, problems with punctuation and spelling | Avoiding using English, worrying about making mistakes and / or feeling that there are other emotional reasons, Problems noticing the rules and patterns of English |

| | | | | |
|-----|----|--|--|---|
| 7 | 5 | Listening, Reading, Speaking, Writing | problems showing comparison and contrast e.g. compared with / in contrast to, problems with punctuation and spelling, problems with past and perfect verb tenses e.g. did/ have done, problems with subordinate clauses e.g. using 'who' or 'which' to add information | Failing to use English naturally or notice my mistakes / looking for a general meaning, Avoiding using English, worrying about making mistakes and / or feeling that there are other emotional reasons |
| 7 | 3 | Speaking | problems with superlative forms e.g. the better in the world / The more hottest , problems with using infinitives and gerunds e.g. I don't want to eating/ she is eat, problems with conditional forms e.g. if I were rich, I would buy a Porsche, problems with punctuation and spelling | Language classes, the people around me and/or my location |
| 7 | 3 | Reading, Listening | problems with have / be, problems with uncountable nouns e.g. some oil / two loaves of bread, problems with punctuation and spelling, problems with conditional forms e.g. if I were rich, I would buy a Porsche, problems with superlative forms e.g. the better in the world / The more hottest , problems with using infinitives and gerunds e.g. I don't want to eating/ she is eat, problems with modal verbs e.g. will do/ would do/ can do/ could do/ must do /should do, problems with past and perfect verb tenses e.g. did/ have done | Failing to use English naturally or notice my mistakes / looking for a general meaning |
| 7 | 5 | Reading, Writing, Listening, Speaking | problems with modal verbs e.g. will do/ would do/ can do/ could do/ must do /should do, problems with punctuation and spelling, problems with a / an / the | Avoiding using English, worrying about making mistakes and / or feeling that there are other emotional reasons, Language classes, the people around me and/or my location |
| 7 | 3 | Speaking, Listening | problems with punctuation and spelling | |
| 7 | 10 | Listening | problems with subordinate clauses e.g. using 'at', 'in' / on' to add information , problems using the passive voice e.g. the food was eaten / the computer has been broken, problems with punctuation and spelling, problems using prepositions with nouns and verbs e.g. on the internet / provide with, problems with a / an / the, problems with have / be | |
| 6.5 | 6 | Reading, Speaking, Listening | problems with punctuation and spelling | Language classes, the people around me and/or my location |

| | | | | |
|---|---|--|--|--|
| 8 | 2 | Reading, Writing, Listening, Speaking | problems with conditional forms e.g. if I were rich, I would buy a Porsche, problems with using infinitives and gerunds e.g. I don't want to eating/ she is eat, problems with subordinate clauses e.g. using 'who' or 'which' to add information | Failing to use English naturally or notice my mistakes / looking for a general meaning |
| 7 | 3 | Reading, Listening | problems with uncountable nouns e.g. some oil / two loaves of bread, problems with modal verbs e.g. will do/ would do/ can do/ could do/ must do /should do, problems with past and perfect verb tenses e.g. did/ have done, problems with using infinitives and gerunds e.g. I don't want to eating/ she is eat, problems with conditional forms e.g. if I were rich, I would buy a Porsche, problems with subordinate clauses e.g. using 'at', 'in' / 'on' to add information | Failing to use English naturally or notice my mistakes / looking for a general meaning, Problems noticing the rules and patterns of English |
| 7 | 3 | Reading, Speaking | problems with subordinate clauses e.g. using 'at', 'in' / 'on' to add information , problems with punctuation and spelling, problems using prepositions with nouns and verbs e.g. on the internet / provide with | Failing to use English naturally or notice my mistakes / looking for a general meaning, Problems noticing the rules and patterns of English |

| Language classes, the people around me and/or my location. | Problems noticing the rules and patterns of English | Failing to use English naturally, notice my mistakes / looking for a general meaning. | Avoiding using English, worrying about making mistakes and/or feeling that there are other emotional reasons. | Age, memory and/or any other cognitive changes. | Feelings towards English speaking cultures, my ability in English and/or losing my culture. | Please write about any methods or strategies that you used to overcome any language learning difficulties that you may have had. | Please write about your goals to get over your language learning problems and how you will improve your English. |
|--|---|---|---|---|---|--|--|
| | I am trying to learn too much and none of it seems to stay with me, I often try to follow the rules of my first language when using English | | | | | | Hoping one day I will be able to speak English as if my mother tongue (I don't mind my unique accent).By learning more and more , socialising with the native people of the UK, and reading English books. |
| | | | I am worried that I will make a mistake if I try to make new sentences | | | | I would like to speak without thinking about mistakes and pronunciation all the time. I want to be more confident in speaking. I can improve it by practising. |
| The English I encounter is too complicated | I often try to follow the rules of my first language when using English | | | | | | I am trying to learn on a daily basis but the most difficult part of the language is a wide range of words and making complex sentences. I also found it difficult to write academically in English language. |
| | I can't easily identify the patterns of English, I am trying to learn too much and none of it seems to stay with me, I have other problems, as well as following the rules of my first language, I often try to follow the rules of my first language when using English, I can't easily identify things like verbs, adverbs, and clauses | | I am worried that I will make a mistake if I try to make new sentences, I try to convey the general meaning rather than getting it right, I remember the way that I was taught my first language and use that way for learning English, I feel that I'm not learning in the right way | | | | I usually listen to the radio 4 and I try to read more non medical books in English in my spare time.In addition to the previous measure I have tried my best to avoid medical Jargon during my consultation with the patients and their family.finally I have put a great effort to think in English and avoid thinking in my first language. |

| | | | | | | | |
|--|--|--|---|--|--|--|--|
| | | I don't pay much attention to my errors, I don't notice my own mistakes, I use forms from my first language without thinking, I understand the general meaning rather than the details | I feel differently about things now and this has had a negative effect on my English, I feel that I'm not learning in the right way | | | | practice and learning from native speakers. self study and learning from native speaker teachers. |
| The English I encounter is poor, Nobody corrects me when I make mistakes | | | | | | | more reading, more communicating with english people will definitely improve my English |
| | | It takes me a long time to use new English forms without thinking, I don't get the chance to practise my English | | | | | Regarding my experience with english language, I feel that language barrier was the hardest one I faced in the UK. To start with, my English is not bad and I can interact with others without difficulty directly or over the phone. However, I feel the language is a barrier to feel completely engaged. As I mentioned, my previous study was in English and my standard in academic language is high and I got Distinction score in my MSc degree, but still I feel the street language is difficult. I think that more listening to radio and TV as well as talking with native English will be of great importance to improve the standard of language. |
| I am not taking enough English classes, The English I encounter is too complicated | | | I feel that I'm not learning in the right way, I use basic English too much | | | | practice everyday language with native speakers. |
| | | | | | | Working as a receptionist helped me in improving my speaking and listening skills. Listening to BBC. Also work gave me the confidence to speak in English. | |

| | | | | | | | |
|----------------------------------|---|---|--|--|--|--|---|
| | | | | | | Taking English class with an experienced teacher and working as a volunteer in charity shops to practice spoken English with native speakers can be extremely useful to improve speaking ,listening and writing , while reading newspapers such as the economist , the guardian and the independent has helped me a lot to improve my reading skills . | |
| My English lessons don't help me | | | | | | | I have problems in writing. I am trying to write more and ofen, using text from newspaper amd magazine. But this wasnot enough, becouse I need someone to guide me through my writing journey. |
| | | I use forms from my first language without thinking | | | | | |
| | I don't have a strategy to develop my English based on the patterns I have identified | It takes me a long time to use new English forms without thinking, I can't pick up the small details of English any more, I don't get the chance to practise my English, I understand the general meaning rather than the details | | | | | I am listen more for BBC4 programmes. Read as much as I can. However, most of the reading is academic one which helps little in general language. The difficult part is the layout language which is very difficult to improve. I believe that without interaction with native people, it is difficult to improve language. |
| | I often try to follow the rules of my first language when using English | I try to understand the general meaning rather than the details | | | | | Language problem can be a big barrier in our careers. For this, having a strategy to overcome language learning problems is very important for me and one of my plans is, " recognising my weak points and correcting them until my English as good as the native speakers". Keen to learn with open minded is a stepping stone for me to improve my English. |

Appendix 18: Response to Follow-up Email Questions

INTERVIEW QUESTIONS

Impact of life history

Communication experiences

1. Can you recall a memorable experience, good or bad, in your own language learning?

During the starting of language learning in The Parade, there was feeling of returning to school again. I have worked for many years before coming to the UK and part of my job was teaching students. Return to study as a student gave me the feeling of starting from the first step. However, meeting people from different backgrounds and cultures was a very positive issue as I was able to know more about other cultures as well as ease my feeling of a restart.

Cultural differences

2. Do you feel that there are more similarities or differences between your culture and UK culture? What impact might this have on your professional role as a doctor?

There are many cultural differences between my original culture and that of the UK. However, these don't affect the profession as the medical approach are almost the same.

Motivational aspects

3. What are your top three sources of motivation to improve your English language skills?

Medical text books, TV, BBC 4

Coming to the UK

4. Did your knowledge of English influence your decision to come to the UK at the time of your displacement?

Although it was an important part, however, it was not the main reason.

Impact of educational history

Second languages

5. How do you think your first language (or any additional languages you know) influences your English language skills?

I am efficient and interested in my first language. It doesn't influence my English skills.

Early English leaning

6. When did you begin learning English? What influence did this have on your English language skills?

In my country, we start study English in year 4, which means at the age of 10. However, the standard of speaking and listening were not high. The studying in University had very important influence on my English skills.

Reflections on teaching styles

7. What are your preferred methods of learning a language?

Reading books and searching the web.

Observations on language acquisition

8. Can you think of anything about your English lessons that may have held you back?

Dearth of speaking and listening.

Reflections on English learning experiences

9. Can you describe your most positive English language learning experiences?

Speaking sessions based on certain topics and every one can speak about similarities and differences in his original culture.

Impact of other experiences

Psychological factors

10. Do you think that a good learner needs to be unafraid of making mistakes? How do you overcome a fear of making mistakes?

Yes of course. However, it is not easy. I think that contacting native English speakers may help to overcome this fear.

Environmental factors

11. How do you make contact with native speakers?

By using clear and simple language.

Observations on IELTS

12. Are there any other things that you think might affect your IELTS scores?

I believe that IELTS is not ideal assessing system for English skills especially the reading part as it is filled with a lot of extra words to make confusion for the candidate. I personally believe that continuous reading articles in newspaper as well as listening to the radio are of great help.

Appendix 19: Constant Comparison of Interviews

Participant profile

Gender

similarities

None of the participants identified themselves as third gender or transgender.

differences

Dr. Ali, Dr. Bader, Dr. Cadi, Dr. Dafi, Dr. Farid and Dr. Ghanem are male. Dr. Hadeel, Dr. Irene and Dr. Jasmine are female. It is assumed that Dr. IE is male although this interview took place online and identification of gender was possible only through their name.

L1

similarities

None of the languages spoken as an L1 by the participants are agglutinative languages.

differences

Dr. Ali, Dr. Bader, Dr. Cadi, Dr. Dafi, Dr. IE, Dr. Farid, Dr. Ghanem and Dr. Hadeel have Arabic as their first languages, although Dr. Bader sees his first language as being equal status with Zaghawa. Dr. Irene is L1 Russian and Dr. Jasmine L1 Farsi.

L2

similarities

All participants spoke English as a second language.

differences

Dr. Ali, Dr. Bader, Dr. Cadi, Dr. Dafi, Dr. IE and Dr. Hadeel have only English as a second language. Dr. Farid and Dr. Ghanem have two second languages: English and French. Dr. Irene has two second languages: English and Azerbaijani as a second language. Dr. A has four second languages: English, Arabic, Turkish and Romanian.

Country

similarities

The UK has received refugees from all of the participants' countries since 1946.

differences

Dr. Ali and Dr. Bader are from Sudan. Dr. Cadi, Dr. Dafi and Dr. IE are from Iraq. Dr. Farid, Dr. Ghanem and Dr. Hadeel are from Syria although Dr. Hadeel holds a British passport. Dr. Irene is from Russia and Dr. Jasmine is from Iran.

Time learning English

similarities

All participants began learning English in formal lessons before they came to the UK.

differences

Dr. Ali, Dr. Bader, Dr. Cadi, Dr. Dafi, Dr. Ghanem, Dr. Hadeel, Dr. Irene and Dr. Jasmine all began learning English in School. Dr. Farid began learning English in a private school as an adult. Dr. Ali, Dr. Bader and Dr. Cadi state that they have studied intermittently. Dr. Dafi states that he has been learning English for fifteen years. Dr. IE alludes to rejoining study more intensively for the past year. Dr. Farid mentions a gap in English language study. Dr. Ghanem and Dr. Hadeel say that they have studied English intensively for six months, Dr. Jasmine said that she has studied more intensively for one year and Dr. Irene has studied intensively for two and a half years.

% of PMQ in English

similarities

All of the participants mentioned, either during their interviews or in field notes, that they relied on English textbooks to support their learning.

differences

Four of the ten participants: Dr. Farid, Dr. Ghanem, Dr. Hadeel and Dr. Irene, state that none of their PMQ was in English. Dr. Cadi, Dr. Dafi and JK stated that all of their PMQ was in English. Dr. Ali and Dr. Jasmine said that most of their PMQ was in English and Dr. Bader gave a rough approximation of 60% of his PMQ, as well as all final exams, being in English.

Significant problem areas and minor problem areas

similarities

All of the participants identified as having problems, minor problems or both in the grammatical areas that were explored in the interviews.

differences

| Linguistic area | Participant | Total |
|------------------------------|---|-------|
| at/in/on | Dr. Bader, Dr. Dafi, Dr. Farid, Dr. Hadeel and Dr. Irene | 5 |
| comparison & contrast | Dr. Ali, Dr. Bader, Dr. Dafi, Dr. Farid, Dr. Hadeel and Dr. Irene | 6 |
| conditionals | Dr. Dafi, Dr. IE and Dr. Irene | 3 |
| have / be | Dr. IE | 1 |
| infinitives & gerunds | Dr. Ali, Dr. Bader, Dr. Cadi and Dr. IE | 4 |
| it/they/them | Dr. Ali, Dr. Farid, Dr. Irene and Dr. Jasmine | 4 |
| modal verbs | Dr. Ali, Dr. Bader, Dr. Dafi, Dr. IE, Dr. Irene and Dr. Jasmine | 6 |
| passive voice | Dr. Ghanem and Dr. Hadeel | 2 |
| past and perfect verb tenses | Dr. Ali, Dr. Bader, Dr. IE, Dr. Ghanem and Dr. Jasmine | 5 |
| pronunciation | Dr. Ali, Dr. Bader, Dr. Cadi, Dr. Ghanem and Dr. Jasmine | 5 |
| punctuation | Dr. Bader, Dr. IE and Dr. Jasmine | 3 |
| spelling | Dr. IE and Dr. Jasmine | 2 |
| subject-verb-object | Dr. Ali | 1 |
| superlatives | Dr. IE and Dr. Ghanem | 2 |
| uncountable nouns | Dr. Ali, Dr. Bader, Dr. Dafi, Dr. IE and Dr. Ghanem | 5 |
| when/ if/ whether | Dr. Bader and Dr. Jasmine | 2 |
| who & which | Dr. Bader | 1 |

Perceptions of their own common SLEs

Assessment of SLEs identified in the study

similarities

All participants acknowledged that there were areas of their English language that were problematic.

differences

Uniquely, Dr. Ali felt that one of the areas strongly identified as a problem in the SLE quiz was negligible. Dr. IE identified his significant problem areas via an online interview rather than completing the quiz. Dr. Bader, Dr. Irene and Dr. Jasmine focussed on the more prevalent grammatical points that were identified in the quiz. Dr. Dafiq attributed his problems to backsliding and Dr. Cadi, Dr. Farid, Dr. Ghanem and Dr. Hadeel agreed that the significant problem areas (or minor problem areas) were accurately identified in the SLE quiz.

Factors for SLEs identified

similarities

None of the interviewees identified the Neuro-biological or Socio-affective domains as being causal factors for their SLEs

differences

Dr. Cadi, Dr. Dafiq, Dr. Hadeel and Dr. Irene felt that Environmental factors had held their English back. Dr. Ali, Dr. Bader, Dr. Dafiq, Dr. Farid, Dr. Ghanem, Dr. Irene and Dr. Jasmine identified the Knowledge Representation domain as interfering with their English language development. Knowledge Processing was identified as causing problems for Dr. Ali, Dr. Bader, Dr. IE, Dr. Farid, Dr. Ghanem, Dr. Hadeel and Dr. Jasmine. Dr. Bader, Dr. Cadi and Dr. Irene also identified the Psychological domain as being a factor that contributes their SLEs.

Other observations

similarities

All interviewees recognise that they still have work to do in order to improve their English to the desired level.

differences

Sentence formulation presents a problem for Dr. Ali and Dr. Irene. Gerundial forms cause problems for Dr. Ali and Dr. Cadi. Dr. Ali and Dr. Dafiq also mention problems with uncountable nouns but Dr. Ali believes that this is due to confusion with articles when contrasted against his L1; a problem area shared by Dr. Bader. Dr. Ali also feels that this L1 interference contributes to problems with determiners. Dr. Bader also struggles with stylistic uses of past and perfect tenses as well as prepositions and comparatives. Dr. Cadi, Dr. Hadeel and Dr. Irene all discussed problems with pronunciation. Dr. Cadi, Dr. Ghanem, Dr. Irene and Dr. Jasmine mentioned that a lack of fluency has led to hesitation in constructing new utterances. Dr. Dafiq and Dr. IE felt that time spent with other speakers of Arabic has narrowed opportunities to practise. Dr. Dafiq says that this has led to SLEs and stated that he has difficulty noticing his own errors. He also said that his top-down strategy is inhibiting learning and that he relies on translation. Dr. IE, Dr. Ghanem and Dr. Irene have all struggled with automatization to some degree but all acknowledge that this takes time. Dr. Farid finds it difficult to translate idioms and metaphors but attempts to do so without much trepidation. Dr. Dafiq, Dr. Farid and Dr. Irene all identified other factors for their SLEs in the mapping exercise but then changed them to the factors that were recorded when further explanation of the factors was provided. Dr. Ali, Dr. Farid and Dr. Ghanem all mentioned that interlanguage with their L1 caused them problems. Dr. Dafiq, Dr. Hadeel and Dr. Irene all referred to a need to depart from their L1 in order to improve their English. Dr. Hadeel felt that writing was her problem area. Dr. Irene felt that her L1 grammar was strong and felt that her receptive skills were stronger than her productive skills. Dr. Ghanem and Dr. Irene felt that more study of general grammar would be necessary. Dr. Cadi and Dr. Jasmine attribute poor

learning and teaching strategies to slow progress. Dr. Jasmine also felt that having to travel a long distance to classes can be a demotivating factor. Dr. Jasmine also admitted to not noticing the rules and patterns of English grammar and punctuation but felt that she is able to get by without an explicit knowledge of all of the grammatical rules.

Impact of life history

Communication problems

similarities

There are no common similarities between the participants in this area.

differences

Dr. Ali, Dr. Bader, Dr. Dafi, Dr. Irene and Dr. Jasmine all mentioned communication problems; Dr. Ali discussed them in a professional context, Dr. Bader in conducting daily tasks, Dr. Dafi recounted a humorous misunderstanding, Dr. Irene was not able to communicate in English in a healthcare situation and Dr. Jasmine mentioned instances of miscommunication but was not perturbed by them. Dr. Cadi, Dr. IE, Dr. Farid, Dr. Ghanem and Dr. Hadeel did not explicitly mention any instances of communication problems but Dr. Cadi suggested trepidation in communicating with native English speakers, Dr. IE felt that the language barrier is the biggest one that he has faced in the UK. Dr. Farid felt frustrated that he has lost his eloquence compared to using his L1. Dr. Ghanem said that he had not experienced any major communication problems and Dr. Hadeel had not experienced any as she was born in the UK and grew up using English as a second language.

Cultural differences

similarities

All of the participants identified a change in moving from one culture to another.

differences

Dr. Ali felt that there were more differences than similarities between his culture and that of the UK and felt that lifestyle in the UK is totally different. Dr. Cadi also suffered culture shock upon arrival to the UK, as did Dr. Dafi. Dr. Farid says that he has suffered a loss of status due to the language barrier. Dr. IE felt that while there are cultural differences, they do not intrude in to professional practices. Dr. Bader, Dr. Ghanem, Dr. Hadeel, Dr. Irene and Dr. Jasmine all felt that there were no difficulties caused by cultural differences and all felt positive towards their host country.

Motivational aspects and learning strategies

similarities

All of the participants have a desire to use English professionally, although this is most apparent from field observations rather than the interview summary.

differences

Dr. Ali says that he was motivated by peer competition when he was younger. Dr. IE is motivated to use English to improve interactions. Dr. Farid is self-motivated but enjoys group study. Dr. Jasmine is motivated by the benefits of learning and international language. Dr. Irene is motivated to learn so that she could look after her family and Dr. Ghanem also uses interactions as a parent to improve his English. Dr. Hadeel implies integrative motivation, as she has always loved English as a language. Dr. Bader recognises that other commitments can reduce opportunities to study. Dr. Dafi suffered from demotivation after receiving poor test results but was overcoming this at the time of the interview. Dr. Cadi learnt an interlanguage of Arabic and English from a friend when he arrived in the UK and felt that this left a legacy of errors.

Coming to the UK

similarities

All of the participants remain in the UK.

differences

Dr. Ali, Dr. Bader, Dr. Cadi Dr. Dafi, Dr. IE, Dr. Farid and Dr. Hadeel all stated that they felt that their prior knowledge of English influenced their decision to come to the UK at the time of their displacement. Dr. Dafi also considered living in the US for the same reason. Dr. Ali expressed disappointment that he has been trying to pass the IELTS exam for years. Dr. IE said that his knowledge of English was not the sole reason for choosing to come to the UK. Dr. Farid felt that integration would take time and support, in spite of his knowledge of English. Dr. Hadeel made her decision based on English language skills as well as holding a British passport. Dr. Ghanem made his decision to come to the UK due to his partner and sons having British passports. Dr. Irene had a very low level of English when she arrived and her decision to come to the UK was not based on language aptitude. Dr. Jasmine did not wish to discuss her reasons for coming to the UK.

Impact of educational history

Second languages

similarities

All participants had English as a second language.

differences

Dr. Cadi, Dr. Dafi and Dr. Hadeel speak only their L1 (Arabic) and English. English was the first language that Dr. Hadeel spoke but considers Arabic to be her L1. Similarly, Dr. IE does not mention any other languages apart from Arabic and English. Dr. Farid and Dr. Ghanem both have French as their strongest second language. Dr. Bader ranks Zaghawa as equal status with Arabic as his L1 and Dr. Ali mentions a dialect but said he did not know it well. Dr. Irene said that Russian and Azerbaijani were of equal status as her L1. Dr. Jasmine said that she spoke Farsi as her L1 and English her strongest second language, as well as Arabic, Turkish and Romanian.

Early English learning

similarities

Everyone interviewed in the project had some prior experience of using English before they came to settle in the UK.

differences

Dr. Cadi, Dr. Dafi, Dr. IE, Dr. Ghanem and Dr. Hadeel had been taught English in primary school or prior to the age of eleven. Dr. Ali, Dr. Bader, Dr. Irene and Dr. Jasmine all began learning English at high school. Dr. Farid began learning English in local private institutes in his adulthood.

PMQ delivery

similarities

There are no common similarities between the participants in this area.

differences

Dr. Cadi, Dr. Dafi, and Dr. IE studied all of the PMQ in English. Dr. Ali, Dr. Bader and Dr. Jasmine said that most of their PMQ was in English. Dr. Farid, Dr. Ghanem, Dr. Hadeel and Dr. Irene said that none of their PMQs were in English but in the case of Dr. Irene, this was by election. Many of the participants supplemented their learning by reading English textbooks.

Reflections on learning and teaching styles

similarities

There seems to be a vein of emotional learning in all of the interviewees' responses.

differences

Dr. Ali, Dr. Irene and Dr. Jasmine describe relationships with their teachers being important. Dr. Bader and Dr. Cadi mention their preferences for the methods that were used when they were taught. Dr. Dafi, Dr. IE and Dr. Ghanem relate to learning

experiences in their early lives: Dr. Dafiq describing backsliding, Dr. IE the feeling of first entering a learning environment and Dr. Ghanem that he began to learn English too young. Dr. Bader describes a preference for studying with native speaking teachers. Dr. Farid and Dr. Hadeel speak of their classroom peers with Dr. Farid saying he prefers group study and Dr. Hadeel saying that her classmates are of lower level and that this holds her learning back.

Observations on language acquisition

similarities

Everyone commented on their approaches learning English.

differences

Dr. Ali, Dr. IE and Dr. Irene all discuss aspects of the content that they learnt in their English classes. Dr. Bader and Dr. Cadi refer to the teaching methods that they have experienced. Dr. Dafiq, Dr. Farid, Dr. Ghanem, Dr. Hadeel and Dr. Jasmine focussed on learner strategies inside and outside the classroom.

Reflections on English learning experiences

similarities

There were few similarities apart from to note that all participants had an opinion to give about their English learning experiences

differences

Dr. Ali, Dr. Bader and Dr. Cadi all commented negatively on the methods that were used to teach them in their countries of origin. Dr. Dafiq and Dr. Jasmine both mentioned their previous teachers but Dr. Dafiq felt that their teachers level of English was sufficient whereas Dr. Jasmine felt that her teachers did not teacher her adequately. Dr. IE mentioned the positive experience of studying with language learning peers in the UK. Dr. Irene said that her current classes are good but that IELTS learning was beginning to eclipse her medical knowledge. Dr. Farid and Dr. Ghanem both felt that a hiatus in their English language studies has caused them to backslide. Dr. Farid and Dr. Hadeel both mentioned that they would have preferred to study for their PMQ in English and that the decision by their government to teach it in Arabic was a mistake.

Independent learning strategies

similarities

All students mention using the media as a way of studying independently.

differences

Eight of the participants, Dr. Ali, Dr. Cadi, Dr. Dafiq, Dr. IE, Dr. Farid, Dr. Ghanem, Dr. Irene and Dr. Jasmine said that they listen to the radio with Dr. Cadi, Dr. Dafiq, Dr. IE and Dr. Farid specifically mentioning Radio 4 and Dr. Ghanem mentioning the BBC World Service. Dr. Ali, Dr. Bader, Dr. Cadi, Dr. Hadeel, and Dr. Jasmine also said that they read newspaper. The third most popular methods of independent study were watching TV, which was mentioned by Dr. Ali, Dr. Dafiq, Dr. IE, Dr. Farid and Dr. Irene, as well as seeking contact with native speakers; mentioned by Dr. Dafiq, Dr. Farid, Dr. Ghanem, Dr. Hadeel and Dr. Irene. Dr. Ali also mentioned that he studies grammar books and Dr. Dafiq mentions looking at additional IELTS materials as well as reading journals. Dr. Bader and Dr. Farid said that they read their class notes after classes. Dr. Cadi writes independently each day and Dr. Jasmine reads novels and translates new vocabulary.

Impact of other experiences

Emotional learning

similarities

Emotional responses to trial and error language learning were mentioned by all participants.

differences

Dr. Ali and Dr. Bader both expressed shyness about making mistakes. Notwithstanding, Dr. Bader and Dr. Hadeel felt that it would be beneficial if native speakers pointed out his errors. Dr. Ghanem felt that it was embarrassing when he made mistakes but remained unafraid of making further mistakes. Dr. IE suggested that learners might overcome their shyness about making mistakes through prolonged contact with L1 English speakers. Dr. Dafi, Dr. Farid, Dr. Hadeel, Dr. Irene and Dr. Jasmine all agreed that they are unafraid of making mistakes. Dr. Dafi has been demotivated by poor test results. Dr. Farid said that he preferred practical study to theoretical study and Dr. Jasmine believes that learning encourages further learning. Dr. Cadi reflected on physical health affecting linguistic performance and also mentioned that daily life can impinge on study opportunities.

Contact with native speakers

similarities

There were no similarities between the interview responses in this area.

differences

Dr. Ali, Dr. Bader and Dr. Cadi find it difficult to make contact with native speakers. Dr. Ali said that he has little opportunity to build relationships beyond the L1 community. Dr. Bader said that he worked in a charity outlet to increase contact with native English speakers. Dr. Cadi said that he initially suffered from culture shock. Dr. Dafi, Dr. Ghanem, Dr. Hadeel and Dr. Irene said that speakers of their L1 surrounded them but that they sought contact with native speakers either through their children or friends and neighbours. Dr. IE used the media to increase fluency and Dr. Jasmine did not mention contact with native speakers.

Observations on IELTS

similarities

There were no similarities between the interview responses in this area.

differences

Dr. Ali feels that IELTS assessment is difficult, mostly due to time constraints in Reading. Dr. Bader feels that IELTS assessment is inconsistent without being given feedback on the exam and that it is subjective he also mentions that prior knowledge of exam topics is an advantage. Dr. Cadi finds IELTS assessment difficult due to productive skills being affected by time constraints; he also mentioned conflation between slang and academic language in the exam. Dr. Dafi feels that learning IELTS strategies is distinctly different to learning English language but that he finds IELTS classes a good way to prepare in the productive skills. Dr. IE feels that IELTS is inappropriate, in particular the breadth of vocabulary in the reading section. Dr. Farid finds IELTS a major barrier to returning to work and states that he has problems with idioms and metaphor. Dr. Ghanem and Dr. Irene find IELTS assessment difficult due to time constraints and anxiety. Dr. Ghanem struggles with homophones in particular. Dr. Hadeel agrees that IELTS assessment is difficult due to time constraints and she feels that the required band score for writing is a little excessive. Dr. Jasmine did not comment on this aspect of the interview.

Appendix 20: Transcription Summary of Semi-Structured Interview

| | | | | | |
|--|--|--|--|---|---|
| <p>Participant profile</p> <p>Gender</p> <p>L1</p> <p>L2</p> <p>Country</p> <p>Time learning English</p> | <p>Dr. Ali</p> <p>Male</p> <p>Arabic</p> <p>English</p> <p>Sudan</p> <p>Began learning English in intermediate school, studied intermittently for fifteen years</p> | <p>Dr. Bader</p> <p>Male</p> <p>Arabic and Zaghawa</p> <p>English</p> <p>Sudan</p> <p>Began learning English in high school, studied intermittently since then</p> | <p>Dr. Cadi</p> <p>Male</p> <p>Arabic</p> <p>English</p> <p>Iraq</p> <p>Began learning English in primary school, studied intermittently for twelve years</p> | <p>Dr. Dafi</p> <p>Male</p> <p>Arabic</p> <p>English</p> <p>Iraq</p> <p>Began learning English in primary school, studied English for fifteen years</p> | <p>Dr. QIE</p> <p>N/A</p> <p>Arabic</p> <p>English</p> <p>Iraq</p> <p>Began learning English in school at the age of 10 but states 1 year (with 6 years in an English speaking country)</p> <p>100%</p> |
| % of PMQ in English | Most subjects | Roughly sixty per cent with final exams in English | All (six years) | 100% in English but focussed on scientific English | 100% |
| Problem areas | it/they/them, past & perfect tenses | uncountable nouns, comparison & contrast, past & perfect, at/in/on | infinitives & gerunds, pronunciation | uncountable nouns, at/in/on | have / be, punctuation, spelling, uncountable nouns, past and perfect verb tenses, modal verbs, conditionals, infinitives & gerunds, superlatives |
| Possible problem areas | uncountable nouns, comparison & contrast, subject-verb-object, modals, infinitives & gerunds, pronunciation | when/ if/ whether, punctuation, modals, infinitives & gerunds, pronunciation, who & which | No obvious areas. | comparison & contrast, modals | N/A - did not take the quiz as they responded to follow up email to complete the interview |
| Perceptions of their own common SLEs | Dr. Ali | Dr. Bader | Dr. Cadi | Dr. Dafi | Dr. QIE |
| Assessment of SLEs identified in the study | Felt that the following factors were not major problems: it/they/them, comparison & contrast, subject-verb-object, modals and pronunciation | The participant acknowledged their possible problems but the focus was on the four problem areas identified in the quiz | Acknowledged both problem areas as identified in the quiz | Acknowledged problem areas as identified in the quiz but attributes these problems to backsliding | N/A - Self identified problem areas in survey |
| Factors for SLEs identified | Knowledge Representation: past & perfect tenses Knowledge Processing: uncountable nouns, infinitives & gerunds | Knowledge Representation: past & perfect tenses, uncountable nouns Knowledge Processing: at/in/on Psychological: comparison & contrast | Environmental: pronunciation Psychological: infinitives & gerunds | Environmental: conditionals, uncountable nouns, at/in/on Knowledge Representation: conditionals, uncountable nouns, at/in/on | Knowledge Processing: have / be, punctuation & spelling, uncountable nouns, past and perfect verb tenses, modal verbs, conditionals, infinitives & gerunds, superlatives |
| Other observations | Has had problems with sentence structure since school; cannot differentiate infinitive and gerunds due to L1; problems with uncountable nouns comes from difficulty using articles or the correct determiners, again, L1 causes problems; sentence structure still presents problems | Is overcoming problems with articles; still struggles with past & perfect tenses due to their various stylistic uses in English e.g. newspapers; struggles with general use of countable nouns as in 'systems' or 'the system'; expressed general confusion with prepositional use; finds comparison difficult due to irregular adjectival forms | Expressed confusion with gerundial forms vs. continuous verb forms; feels that learning experiences are responsible for confusion with pronunciation and that this has led to errors and hesitation to use new words in spoken English | Feels that being in homogenous L1 Arabic groups does not afford sufficient opportunities to practice and improve; has difficulty noticing mistakes; has a top down strategy and relies on translation; has problems with using prepositions and uncountable nouns | States that they get little opportunity to practise English and that automatization takes a long time. |

| | Dr. Ali | Dr. Bader | Dr. Cadi | Dr. Dafiq | Dr. QIE |
|---|--|--|--|--|---|
| <i>Impact of life history</i> | Has experienced problems with miscommunication in a professional context | Has experienced problems with miscommunication when buying goods | Suggested trepidation in communicating with local native English speakers | Has experienced communication problems but recounted a humorous instance of misunderstanding syntax | Felt that the language barrier is one of the biggest they have faced in the UK |
| <i>Cultural differences</i> | Has experienced more cultural differences than similarities; feels that UK lifestyle is totally different | Feels that studying English in an English speaking country is better | Suffered culture shock upon arrival; feels afraid of different habits and mind-sets | Experienced some culture shock in the first six months | Mentions many cultural differences between original culture and that of the UK. However, these don't affect the profession as the medical approach are almost the same. |
| <i>Motivational aspects and learning strategies</i> | Was motivated to learn English through competition with peers | Recognises that having other responsibilities detract from the language learning process | Learnt broken/informal English from a peer upon arrival to the UK, this left a legacy of language errors | Suffered demotivation after unsatisfactory test results but has overcome this and is attending classes once more | Is motivated to read medical books, watch television and uses BBC radio four to improve English interactions |
| <i>Coming to the UK</i> | Felt that prior knowledge of English would ease integration when displaced to the UK; spent years trying to pass IELTS | Felt that prior knowledge of English would ease integration when displaced to the UK | Felt that prior knowledge of English would ease integration when displaced to the UK | Chose the UK above other European countries due to a prior knowledge of English; had considered the US for the same reason | Felt that a prior knowledge of English was important but not the main reason for choosing the UK upon displacement |
| | Dr. Ali | Dr. Bader | Dr. Cadi | Dr. Dafiq | Dr. QIE |
| <i>Impact of educational history</i> | Understands another local dialect but does not speak it | Arabic and Zaghawa are equal status (Arabic main language for education) | Does not speak any other languages apart from L1 and TL | Does not speak any other languages apart from L1 and TL | Does not mention another L2 |
| <i>Second languages</i> | | | | | |
| <i>Early English leaning</i> | English taught in school curriculum from 12 years old | Basic English taught in school for 1 or 2 hours per week | Started learning English in Primary school | Started learning English in Primary school | Started learning basic English at the age of 10 and PMQ in English had a very positive impact |
| <i>PMQ delivery</i> | PMQ mostly in English apart from religious subjects | PMQ mostly in English, particularly textbooks and exams | PMQ all in English; translated into Arabic when dealing with patients and students | PMQ all in English; focussed on scientific function over form | PMQ all in English and feels that academic English is of a good standard |
| <i>Reflections on learning and teaching styles</i> | Had a good rapport with a native English speaking teacher in secondary school | Prefers native English speaking teachers; most teachers used their L1 rather than the TL | Feels that teachers taught him in the wrong way using different grammar and pronunciation rules | Felt that he has experienced some backsliding since study English grammar in school | Felt that returning to English classes in Cardiff was a return to the first steps in school |
| <i>Observations on language acquisition</i> | Learnt English literature as well as language | English learning mostly grammar translation; did not have writing corrected | Learnt inadequate approaches to the four skills; has problems with register | Feels that opportunities to practise and improve are limited within the community in which they live | Feels that L1 is proficient and does not interfere with English skills, laments a dearth of listening and speaking classes |
| <i>Reflections on English learning experiences</i> | Feels that the English curriculum was flawed | Feels that grammar translation is insufficient | Feels that students were confused by teaching methods | Was not able to judge their teachers and lecturers' English ability but felt that their level was sufficiently fluent | Feels that meeting other learners of English in the UK was a positive experience |
| <i>Independent learning strategies</i> | Studies independently with grammar books; reading newspapers, listening to the radio and watching television | Studies independently reading magazines and newspapers and revising class notes | Studies independently by listening to BBC4, reading newspapers and writing 600 words per day | Studies independently by reading additional IELTS materials and journals, watching television, listening to Radio 4 and seeking contact with native speakers | Reads medical books, watches television and uses BBC radio four |

| | Dr. Ali | Dr. Bader | Dr. Cadi | Dr. Dafi | Dr. QIE |
|--|--|--|---|---|---|
| <i>Impact of other experiences</i> <i>Psychological factors</i> | Expresses shyness about making mistakes | Expresses shyness about making mistakes; would prefer that native speakers point out mistakes | Feels that physical health affects performance; feels that daily life can restrict study opportunities | Is unafraid of making mistakes; has been demotivated by unsatisfactory test results | Believes that learners should be unafraid of making mistakes but that it is not easy and may improve through further contact with L1 English speakers |
| <i>Contact with native speakers</i> | Finds it difficult to make contact with native speakers; does not get opportunities to build relationships beyond the L1 community | Finds it difficult to make contact with native speakers; works in a charity outlet to increase contact | Finds it difficult to make contact with native speakers; suffers from culture shock | Is surrounded by L1 speakers but tries to make contact with local native English speakers through a friend | Uses to media in the UK to improve English fluency |
| <i>Observations on IELTS</i> | Feels that IELTS assessment is difficult, mostly due to time constraints in Reading | Feels that IELTS assessment is inconsistent without being given feedback on the exam; feels that it is subjective; feels that prior knowledge of exam topics is an advantage | Finds IELTS assessment difficult due to productive skills being affected by time constraints; conflates slang and academic language in the exam | Feels that learning IELTS strategies is distinctly different to learning English language; finds IELTS classes a good way to prepare in the productive skills | Feels that IELTS is inappropriate, in particular the breadth of vocabulary in the Reading section |

| <i>Participant profile</i> | Dr. Farid | Dr. Ghanem | Dr. Hadeel | Dr. Irene | Dr. Jasmine |
|-------------------------------|---|--|--|--|--|
| <i>Gender</i> | Male | Male | Female | Female | Female |
| <i>L1</i> | Arabic | Arabic | Arabic | Russian | Farsi |
| <i>L2</i> | English and French | English and French | English | English and Azerbaijani | English, Arabic, Turkish and Romanian |
| <i>Country</i> | Syria | Syria | Syria | Russia | Iran |
| <i>Time learning English</i> | Began learning English as an adult in a private school for two years and, after a gap in learning, has recently restarted | Began learning English in primary school, studied intensively over the last six months | Began learning English before primary school, studied intermittently since and more intensively for six months | Began learning English in school, studied intensively for two and a half years | Began learning English in primary school, studied intensively for one year |
| <i>% of PMQ in English</i> | None | None | None | None, by election | Most of it, apart from hospital placements |
| <i>Problem areas</i> | at/in/on | past & perfect, pronunciation | No obvious areas | comparison & contrast | it/they/them, past & perfect |
| <i>Possible problem areas</i> | comparison & contrast, infinitives and gerunds | uncountable nouns, superlatives, passive voice | comparison & contrast, at/in/on, passive voice | it/they/them, modals, at/in/on, conditionals | when/ if/ whether, punctuation, spelling, modals, pronunciation |

| | Dr. Farid | Dr. Ghanem | Dr. Hadeel | Dr. Irene | Dr. Jasmine |
|--|--|--|--|---|--|
| <i>Perceptions of their own common SLEs Assessment of SLEs identified in the study</i> | Acknowledged problem areas and possible problem areas as identified in the quiz | Acknowledged problem areas and possible problem areas as identified in the quiz | Acknowledged possible problem areas as identified in the quiz | Acknowledged problem area and selected two of the more prevalent possible problems for discussion | Acknowledged problem areas and selected the most prevalent possible problems for discussion |
| <i>Factors for SLEs identified</i> | Knowledge Representation: at/in/on, comparison & contrast, infinitives and gerunds Knowledge Processing: at/in/on, comparison & contrast, infinitives and gerunds | Knowledge Representation: past & perfect, pronunciation, uncountable nouns, superlatives, passive voice Knowledge Processing past & perfect, pronunciation, uncountable nouns, superlatives, passive voice | Environmental: passive voice, comparison & contrast Knowledge Processing: at/in/on | Environmental: comparison & contrast Knowledge Representation: comparison & contrast, at/in/on Psychological: modal verbs | Knowledge Representation: past and perfect, punctuation, it/they/them Knowledge Processing: past and perfect, punctuation, it/they/them |
| <i>Other observations</i> | Transformation of idioms and metaphors from L1 to TL causes confusion but is willing to risk restructuring; Initially identified the Neuro-biological domain as being the principal cause of SLEs but required the researcher to explain the domains thoroughly and changed his mind to identify the Environmental factor briefly before settling on Knowledge Representation and Knowledge Processing as the main factors for their SLEs; | Participant identified both of their chosen domains early on in the interview; feels that L1 interference is a big problem; they acknowledged emotional reasons as another barrier to fluency but stated that it is led by a lack of automatization more than a fear of failure; firmly disagreed with any socio-affective barriers; showed an awareness of his weaknesses | Stated early in the interview that their classmates were of a lower level and that this held them back; rejected Neuro-biological and Socio-affective domains; feels that a general lack of L1 English speaker input in error correction is a problem; acknowledges additional problems with pronunciation and writing | Feels that all factors contribute to SLEs in some way; home environment is L1 Russian; struggles with pronunciation in spite of good orthographic skills, needs pronunciation to be modelled by an L1 speaker; English language skills not yet automatized; feels that knowledge of L1 grammar is strong; receptive skills stronger than productive especially spoken English; hesitates when formulating new sentences; feels that age is not an issue as long as the mind is exercised; lacks some confidence but feels more study of grammar is needed and that L1 interference is a problem | Feels that a poor teacher can demotivate learners; also acknowledges a lack of motivation may be tied into location e.g. distance from the school; does not notice patterns and rules of English due to its breadth; feels that shyness slows production but does not inhibit learning, will remain silent until confidence is high; admits weak knowledge of punctuation which is improving in current classes; is able to use verb tenses but does not know explicit rules |

| | Dr. Farid | Dr. Ghanem | Dr. Hadeel | Dr. Irene | Dr. Jasmine |
|---|---|--|---|--|---|
| <i>Impact of life history Communication problems</i> | Finds the task of self-expression frustrating compared to operating in L1 | Has been in the UK for six months; no major communication problems | Has not experienced communication problems; has been using English since birth | Needed a translator to speak to midwife when pregnant; felt like a burden upon English speaking friends at that time | Has experienced miscommunication but is unperturbed by any embarrassment that it may cause |
| <i>Cultural differences</i> | Suffers a loss of status due to the language barrier | Came to the UK because their partner has a British passport; feels that there is no clash between English culture and Syrian culture | Was born in the UK and has made frequent visits to the UK ever since; was persuaded by their father to use English as much as possible in Syria | Finds the UK a much more accepting host country for their family than Russia had been | Describes the effects of the rigour of a peripatetic lifestyle; finds the UK liberal; appreciates the UK government |
| <i>Motivational aspects and learning strategies</i> | Self-motivated to learn English independently; enjoyed studying their subject with high-level medical students | Works on learning English and integration into UK life through children's school | Suggests integrative motivation to use English, although this was not stated explicitly | Was motivated by having a family and wanting to operate in the UK without the need for translators | Was motivated to learn English, among other languages, for communication; regards English as a useful tool for international communication; has brothers who are polyglots; left Iran due to study in Romania due to limited opportunities and finances |
| <i>Coming to the UK</i> | Felt that prior knowledge of English would ease integration when displaced to the UK; recognises that time and support are needed with this | Cited partner's passport as the driving reason for choosing the UK after displacement | Felt that prior knowledge of English as well as holding a British passport would ease integration when displaced to the UK | Participant had very low level English language skills at the time of arrival in the UK | Participant did not wish to discuss reasons for arrival in the UK; has overcome emotional problems through determination to succeed |
| <i>Impact of educational history Second languages</i> | Learnt French in primary and secondary school | Speaks French as strongest L2 | English was the first language that this participant spoke but L1 is Arabic | Russian and Azerbaijani are equal status (Russian main language for education) | Speaks a number of languages; L1 is Farsi and English is the strongest L2 |
| <i>Early English leaning</i> | Learnt English for 2 years in local institutes after leaving school | Learnt English from the age of 6 or 7 and had 3 or 4 lessons per week for 6 or 7 years | Has spoken English since birth; returned to Syria at the age of 5 and had English classes for 1 hour per day | Learnt English for 1 hour per week in school | Basic English taught since high school once a week |

| | | | | | |
|--|---|--|--|---|---|
| <i>PMQ delivery</i> | None of the PMQ in English; supplemented learning by reading English textbooks | None of PMQ in English; Postgraduate study in Orthodontics in French | None of PMQ in English; supplemented learning by reading English textbooks | None of PMQ in English through choice | PMQ mostly in English as a Lingua Franca in Romania; contact with patients in Romanian |
| <i>Reflections on learning and teaching styles</i> | Prefers to study with native speakers but finds all group study beneficial | Feels that their English learning started when he was too young | Feels that studying with lower level students is stalling progress | Feels that her English school teacher was terrible; has come to love English over the last 2.5 years | Feels that English language classes in school were superficial; holds current teacher in high regard |
| <i>Observations on language acquisition</i> | Finds that English grammar is easier than French or Arabic; is learning metalinguistic terms in current classes | Suffers from L1 interference | A lack of formal training in English has had a negative impact; current classes are helping this | Difficulties with English pronunciation and grammar dissuaded learning; has problems with register | A lack of formal training in English has had a negative impact; struggles with vocabulary and register |
| <i>Reflections on English learning experiences</i> | Feels that a hiatus in learning English has affected him negatively; feels that the Syrian policy of delivering PMQs in Arabic is a mistake | Feels that a hiatus in using English has affected him negatively | Feels that the Syrian policy of delivering PMQs in Arabic is a mistake and inhibits communications | Feels that current classes are good but that IELTS learning is eclipsing medical knowledge | Feels that non-native English speaking teachers did not teach adequately |
| <i>Independent learning strategies</i> | Studies independently by reviewing class notes, watching the BBC channels, listening to Radio 4 and seeking contact with native speakers | Studies independently by listening to the BBC World Service and seeking contact with native speakers | Studies independently by reading newspapers and seeking contact with native speakers | Studies independently by seeking contact with native speakers, listening to the radio and watching television | Studies independently by listening to the BBC, reading newspapers and novels and translating new vocabulary |
| | Dr. Farid | Dr. Ghanem | Dr. Hadeel | Dr. Irene | Dr. Jasmine |
| <i>Impact of other experiences</i> <i>Psychological factors</i> | Is unafraid of making mistakes; does not enjoy theoretical study, prefers practical learning in groups | Is unafraid of making mistakes but finds it embarrassing when they do | Is unafraid of making mistakes; would prefer that native speakers point out mistakes | Is reasonably unafraid of making mistakes because they see it as an opportunity to build confidence | Is unafraid of making mistakes; believes learning encourages further learning |
| <i>Contact with native speakers</i> | Is unafraid to make contact with local native English speakers | Is surrounded by L1 speakers but makes contact with local native English speakers through their children | Is surrounded by L1 speakers but makes contact with local native English speakers via an elderly neighbour | Is surrounded by L1 speakers but makes contact with local native English speakers through their children | N/A |

| | | | | | |
|-----------------------|--|---|--|--|-----|
| Observations on IELTS | Finds IELTS a major barrier to returning to work; has problems with idioms and metaphors | Finds IELTS assessment difficult due to time constraints and anxiety; struggles with homophones | Finds IELTS assessment difficult due to time constraints; feels that the required band score for writing is a little excessive | Finds IELTS assessment difficult due to time constraints and anxiety | N/A |
|-----------------------|--|---|--|--|-----|

Appendix 21: Full Thematic Analysis According to Putative Causal Factors

Environmental

Lack of input

- I think I have to::: to uh r- read more about it and I would remember (Dr. Ghanem)

Reinforcement from linguistic environment

- we stay in the same community, we speak all the, our (0.5) own language (Dr. Ali)
- I'm surrounded by people who are uh Arabic speaking uh my wife my friends my colleagues here everyone speaking uh English uh in Arabic (Dr. Dafiq)
- the class group are uh they talk uh they speak Arabic but we try to speak to each other between us in English (Dr. Farid)
- I think for me uh everybody around me speaks Arabic (Dr. Ghanem)
- I am studying uh a business course in the Parade college (.hh) but the students all of them are uh are not uh English native speakers (Dr. Hadeel)
- in my family everybody speaks Russian (0.4) and (.hh) why it's difficult and even if I know that we need to speak (0.6) maybe in English, but, um, sometimes maybe it's not a good idea because we don't have a perfect English (Dr. Irene)

Lack of instruction

- I live in Swansea uh to attend the class I need to travel from Swansea to Cardiff and this need more effort and time you know uh attending class need orientation and uh to think about everything right your brain need high blood sugar (Dr. Cadi)
- in the other Arabic country uh countries uh uh all the uh universities study in English specially or spe- uh specially for uh medical or dentistry uh but in Syria only Arabic for reason politics something like that. (Dr. Ghanem)
- The other countries around uh study medicine (.hh) or teachi- teach medicine in English but uh Syria is the only country in the Middle East who teach uh medicine in Arabic. (Dr. Hadeel)
- I am not taking enough English classes, no, it's not right, I try to take, um, as much as I can, with two children (Dr. Irene)

Language complexity

- I face difficulty in that (.hh) why because there are certain things you use it like how I'm speaking or in general form like how I am speaking with you the way you write it down let's say but academic you can't put those words down let's say in writing and there are s- let's say there is a sentence, you can change that word let's say uh, I don't know there is many um (1.2) words which are similar to each other (Dr. Jasmine)

Quality of input

- you know in slang language uh there are many (1.2) uh letters (hh) disappear ((laughs)) and this make me uh this makes me uh not just confused but unable to understand what people said exactly. (Dr. Cadi)
- firstly when I arrived in UK you know I need some one who know the area and who can speak my Eng- uh my language I start contact with them and I uh start listening to them (0.4) uh:: firstly I uh a- ad- adopt the idea of them I uh started to follow their uh (0.3) way in speaking but when I uh compare the way of the speaking with the Eng- uh rule of grammar specially when I attended the class they were wrong (Dr. Cadi)
- Uh e- environment in term not just in uh in terms of language but in general any sounds and knowledge you need to acquire if you- if you were between- if you are between the experts in this knowledge you can acquire uh much easier and uh and a lot from them much more than if you are alone or by your personal efforts. (Dr. Farid)
- maybe this classes, they don't help me with speaking, yeah, it can be because they can help me with grammar, with writing, reading, but not with speaking (Dr. Irene)
- we learn this formal English because, uh, we need to do it and we need to know (.hhh) and yeah, it, um (0.5) like, it's our future and in medicine (.hhh) but it doesn't help me with people with their slang (Dr. Irene)
- you don't go in very deep into the book, or, into grammar, you just- it's second language (Dr. Jasmine)

- surrounding me was not like England I ca- I believe it's like most of us were foreigners some were Greek, some were Arabs, Israeli different nations and the first language of them were also though the students were not English so (0.6) like, in England no, wherever you go (1.0) they talk in English, you will learn a small word, also the accent is different, you will come to know the correct ans- accent (Dr. Jasmine)

Instruction

- studying at uh uh high school they introduce it but- uh but it is uh::: it was uh (1.2) basic language like uh you that's uh name of things by language um by English and also uh we studied uh (0.8) some grammar tenses (Dr. Bader)
- for us to uh i- it w- wasn't h- uh helpful for- helpful for us uh also um because (0.8) even uh was teachi- uh our teacher was uh (0.5) teaching us uh uh:: in the English lesson (1.1) uh seventy five percent uh he was speaking in Arabic (Dr. Ali)
- the English teacher in our coun- in my country uh (1.1) uh taught us in a wrong way. (Dr. Cadi)
- I uh become lecturer in medical uh school uh our student need to explain everything uh in Arabic in addition to English (Dr. Cadi)

Knowledge Representation

L1 influence conspiring with other factors

- I open the class here for using of the present perfect and sometimes when I read newspaper it uh they use it in a different way (Dr. Bader)

L1 influence

- Yes it is (0.6) really hard (0.8) uh because sometimes when- when you know something uh by uh in Arabic and when we about trans- uh trans- uh translate it in English it uh sometimes the meaning doesn't match. (Dr. Bader)
- the way that uh we use the grammars this uh completely different from the way English people speak [in some ways] (Dr. Bader)
- when I need to say it in English I d- directly I- I go to the expression in my own language and I try to (1.1) to translate it (Dr. Farid)
- depends uh also the- the difference between the Arabic language and English language for that I choo- I choose uh these uh two reason. (Dr. Ghanem)

Failure of parameter resetting

- I suffer from this point because I'm- I try to transform my expression as in Arabic to in English and this is the problem and uh in most cases if you know the English exp- and y- I know it uh already (1.0) but uh it's not easy to recall it. (Dr. Farid)
- I did not know and I was like writing and my teacher he corrected me and he is like everything starts with capital name this, this, oh okay (.) at the time yes I came to know yes this is my (.) problem and I started correcting it slowly (1.5) past and perfect verb tenses... (Dr. Jasmine)

Learning inhibiting learning

- Different, yeah, definitely they are tenses there (0.9) (quietly) from learning. (Dr. Ali)
- when I was uh studying in Sudan we used to translate every (0.5) words uh by uh in Arabic which I think uh it uh it is uh hardest way for us (Dr. Bader)
- when I read the newspapers or or the the books sometimes they don't uh put uh by or before they just uh use uh pa- uh past perfect and here when we use it it's wrong uh u- u- until now I am confused (Dr. Bader)
- Not exactly what (0.9) I have learnt here in the UK and this is uh this makes me confused in some points. (Dr. Cadi)
- they didn't focus on the uh grammar or something it is only scientific English or scientific language yeah. (Dr. Dafi)
- English was uh the first language I have ever spoken (1.0) but uh I went back (0.5) to Syria when I was at age of five and I forgot the spoken English (Dr. Hadeel)

Representational deficits in the language faculty

- English writes left to the right (.hh) uh in Arabic every letter uh has pronou- uh or has uh it's own pronunciation but in- in English you mix two letters uh to- to get th- third pronunciation (Dr. Ghanem)
- My opinion pronunciation in general I think good but uh uh some letters it's very difficult for- for me especially uh B- and P- (hh) it's catastrophe for me in Arabic uh I- I know always I do mistake (Dr. Ghanem)
- the way you have to deal with it, how- from where the grammars it comes (0.5) this is very big thing I (0.5) in my point of view yeah (0.6) I am one of them (Dr. Jasmine)
- before coming to IELTS class I did not know that for example for a::: city or a name you have to use capital letter of course it won't rely on the punctuation but it matters in English. (Dr. Jasmine)

Knowledge Processing

Inability to notice input-output discrepancies

- when I started to study uh I- I noticed that I have to use uh for in the end uh endings ((coughs)) uh singular noun I have to use uh:: articles (0.6) a::nd also u- using other (0.8) still now uh sometimes I am confused between using the (0.4) the present perfect and uh and the past perfect. (Dr. Bader)
- British people use a lot the perfect tenses but people who are learning English they don't they try to be strict with the present uh past and the present simple (Dr. Hadeel)
- I can't pronounce it, so I need to hear this word from other people and just after I can repeat it, again, maybe not for a first time I can say it right (Dr. Irene)
- when you read it you know it's right and y- I know this is, all this is, all this words but I can't use them easily when I speak with someone (Dr. Irene)

Automatization of the first language system

- I s- try to translate it from Arabic to English so I think second c- cause for my um m::y weak point (Dr. Dafiq)

The speed and extent to which automatization has taken place

- the idea or the speaking is clogged yeah that the problem. (Dr. Dafiq)
- for example now before I speak to you I have to organise all of the statement in my mind and that take my uh take time and make me uh do a lot of mistakes (Dr. Ghanem)
- it takes me a long time to use new English form (0.6) I'm used to certain things I cannot leave it these two are very close to each other. (Dr. Jasmine)

Processing constraints

- I forget uh uh some rules but uh I c- when I uh read about the rules of grammar I remember everything but uh you know everything uh have (0.7) take uh have to take time (Dr. Ghanem)

Failure to detect errors

- sometimes uh::: some people te- tell you that you- you do a mistake here and then it would be a beneficial for us to (0.5) to try to over pass it next time (Dr. Bader)
- yes in general I don't notice- I- I don't used to notice my mistakes in the prepositions before (Dr. Hadeel)

Failure to resolve the inherent variation in interlanguage

- I think in my language it is, uh, for, uh, it is, uh, a bit easier, maybe you can just add, uh suffixes or, or, uh, prefixes (Dr. Ali)
- the rules are easier I think regarding uncountable nouns (Dr. Ali)
- if I am inside the bus station why you don't say inside the bus station in the bus station you just say at the bus station or inside the bus station (Dr. Bader)

Lack of verbal analytical skills

- I know how to use uh, past and present or future but I don't know from where it rises, uh rise up like from where it comes, and so maybe I am in this pattern of past and perfect verb tense, tenses are my problem (Dr. Jasmine)

Lack of sensitivity to input

- some the- uh these problems uh depends uh:: on uh on my knowledge uh of language and especially in grammar or rules of the language (Dr. Ghanem)

Psychological

Inappropriate learning strategy

- I think uh sometimes uh I lack uh uh I have- I have a lack in motivation but uh (4.2) in my natural uh le- uh the process of uh (2.2) st- uh d- dry studying if I can say dry studying or the theory. (Dr. Fadi)

Change in the emotional state

- when you uh (0.9) you reach uh a level of age (1.9) because of that uh learning for the children much easier because they don't consider this uh (0.7) embarrassing (0.8) thing. (Dr. Farid)

Reluctance to take the risk of restructuring

- someone afraid to communicate because he think that he speak uh, wrong word (Dr. Ali)
- I feels from uh embar- uh I feel embarrassed when uh when I want to try to speak about something an:::d and uh I try to s- say for example the words uh to pronounce it uh correctly and again the people ask me what, what did you say (Dr. Bader)
- I don't know what's good sometimes I just say there is no rules uh i- it depend uh on the way of the sen- s-s sentence. (Dr. Bader)
- when I started uh start uh speaking or writing as especially in spe- uh speaking uh uh I- I uh start over thinking i- is tha- is that way or that way uh is this way or that way it uh and after that at the end of day I (1.2) put the sentences maybe in wrong way (Dr. Cadi)
- or you take an exam uh speaking exam uh you will be uh in stress uh situation, uh maybe that affect you- your- your fluenc- fluently or uh fluency of- of language (Dr. Ghanem)
- I always try to think before and think about grammar and um, it (0.6) tuh, prevents me as well from speaking and because I- I think too much stick ((laughs)) in my head and (.hhh) I try to avoid some mistakes (Dr. Irene)
- for me I am worried that I will make a mistake if I try to make new sentences. (Dr. Irene)
- I did not speak Romanian, unless I was fluent in it once I became fluent in it I start (Dr. Jasmine)

Natural tendency to focus on content, not on form

- I notice my mistakes but uh (1.9) uh (2.4) not easy to::: and sometimes I correct myself but uh many times as ((laughs)) as you have noticed now uh I did uh I don't (2.1) I worry about making mistakes (Dr. Farid)

Neuro-biological

Changes in the neural structure of the brain

- I did not study since long long time it's like two thousand three I graduated (.hh) I'm very new to this country another problem of me sometimes I'm really emotional (1.0) sometimes I canno- uh like I can't concentrate on (1.2) studying (0.9) uhh it's not my mistake because life is not always good. (Dr. Jasmine)

Age

- I'm now thirty six and especially after you are you ha- you had a break from (0.3) a long period off long period from studying and learning (1.7) this is uh become a big problem. (Dr. Farid)

Socio-affective

Satisfaction of communicative needs

- after I left school I uh I started uh to learn English in uh English courses (0.8) in the local institutes in Damascus (0.9) and uh for uh two years, then uh I stopped learning English and uh it was a sufficient level for me to uh manage my needs in this language. (Dr. Farid)

Lack of acculturation

- people not, uh, abl-, uh, communicate effectively with other, uh, or, uh native speakers because there's cultural differences definitely (Dr. Ali)

- I think I- I can identify with the English speakers also but in the first uh let's say uh six months I found it difficult and even you know um us we are refugee us we are refugees (.hh) when we arrive we are uh busy about our uh cases in the Home Office and our uh uh grant leave to remain diff- difficult situation so you can't adapt with the whole situation around you not only for the language here (Dr. Dafiq)
- I never studied English and even at school, um, we had English classes maybe one hour per week and it was terrible teacher and I'm just hated English (Dr. Irene)

Socio-psychological barriers

- the uh way of learning or also antisocial behaviour of the people here I always try to contact with people to improve my speaking but th- the people um uh nowadays prefer to stay indoors rather than go outdoors and contact people (Dr. Cadi)
- when I first arrive in the UK uh I had cultural shock. (Dr. Cadi)
- a person who suffer from uh cultural shock uh uh become afraid of the people uh uh around them and uh if he or she afraid uh is afraid from the people how can contact people how can improve his or her speaking uh and this has a I told you (Dr. Cadi)
- I was uh a little bit uh stress- in stress uh I uh realised uh in that exam I uh I didn't uh uh do well exam I did a lot of mistakes (Dr. Ghanem)
- I don't know but I feel refugees are like that (2.1) because many problems are how they left, what they did (1.0) I feel that away from family everything changed suddenly (1.7) maybe um (0.9) I lose nothing if I want to take my IELTS (1.0) I want to finish it (1.0) I want to make at least my teacher and myself happy (Dr. Jasmine)

Appendix 22: The Interview Schedules for the Expert Witness Interviews

Specific questions for expert witnesses

Teachers

Expert T1 *Author of IELTS practise materials and teacher of refugee doctors*

1. What inspires you to work with asylum seeking/refugee doctors?
2. What are the specific challenges that asylum seeking/refugee doctors face in trying to pass the IELTS test?
3. How do these challenges differ from other IELTS test takers?
4. How long, on average, does it take for an asylum seeking/refugee doctor to pass the IELTS test? Why do you think this is?

Expert T2 *IELTS teacher working with refugee doctors*

1. What inspires you to work with asylum seeking/refugee doctors?
2. What are the specific challenges that asylum seeking/refugee doctors face in trying to pass the IELTS test?
3. How do these challenges differ from other IELTS test takers?
4. How long, on average, does it take for an asylum seeking/refugee doctor to pass the IELTS test? Why do you think this is?

Policy Makers

Expert PM1 *Author and advisor*

1. How does the IELTS test prepare doctors for joining the GMC?
2. In your opinion, what other English language tests might prepare doctors for joining the GMC?
3. Is it possible that the GMC would consider a bespoke English language test for doctors who wish to join the GMC?
4. What considerations (ethical, accessibility, transferability etc.) were made in the assessment of the suitability of IELTS as a test for GMC entry?

Expert PM2 *Policy maker in GMC*

1. In your opinion, how successfully does the PLAB test work in conjunction with the IELTS test?
2. According to statistics, many asylum seeking/refugee doctors struggle more with the IELTS test than they do with the PLAB test or any other further qualifications, why do you think that might be?
3. Do you feel that IELTS is the most appropriate test for progression to PLAB tests? Why? Why not?
4. In your opinion, is there scope for the PLAB test to address English language levels of overseas doctors without a second test?

Experts working with refugee doctors post IELTS

Expert P1 *Researcher into the trajectories of refugee doctors*

1. What is the success rate in your organisation for refugee doctors attempting to pass the IELTS examination? Why do you think this is?
2. What are the specific challenges that asylum seeking/refugee doctors face after passing the IELTS test?
3. How long, on average, does it take for an asylum seeking/refugee doctor to join the GMC after passing the IELTS test?
4. Do you feel that IELTS is the most appropriate test for progression to PLAB tests?

Expert P2 *Work placement officer for refugee doctors*

1. What is the success rate in your organisation for refugee doctors attempting to pass the IELTS examination? Why do you think this is?
2. On average, how long does it take for an asylum seeking/refugee doctor to join the GMC?
3. What is the success rate for asylum seeking/refugee doctors who wish to join the GMC?
4. What trajectories do doctors who are not able to join the GMC have?

General questions for all expert witnesses

5. In your opinion, what are the main obstacles to English language learning as experienced by doctors trying to pass the IELTS test?
6. What other challenges do you think refugee doctors face in the UK?
7. Are there any specific characteristics of refugee doctors that you have observed that may differ from other English language learners or doctors?

Appendix 23: Thematically Analysed Transcript of Focus Group

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| 5 10 | <p>GR: Okay good afternoon everyone thank you very much for joining in the group discussion interview today. I really appreciate you sharing your views in this interview for this project. On initial analysis, the most striking observation that's come out of the interviews is that none of the participants chose the neuro- biological domain, which is age memory or other mental changes, or the socio-affective domain, which is feelings towards English speaking cultures, feelings about your ability in English or losing your culture. So, what I wanted to do is just to talk through any aspects of that, which you might wish to discuss. So the first thing that I'd like to talk about is life history, so I'll make a statement and then, if you could all tell me whether you agree with the statement or disagree with it and then give your reasons why. The first statement is 'I enjoyed learning English as a child'.</p> | |
| 15 | <p>Dr. Ghanem: I agree.</p> | |
| | <p>GR: You agree?</p> | |
| 20 | <p>Dr. Karimah: Not as a child I started learning English in secondary school since about twelve years old, not a child.</p> | |
| | <p>GR: Okay, and what did you enjoy about it?</p> | |
| 25 | <p>Dr. Karimah: It's a different language and my score was high in secondary school so that made me interested to progress and to achieve a high score all through secondary school.</p> | <p>Comment [GR 1]: Extraneous motivation</p> |
| 30 | <p>Dr. Farid: I think what makes learning English in childhood enjoyable, the atmosphere of learning for children the main thing is repetition and a teacher in a children's classroom always repeats the information and the other thing is that children find it easier to learn English, to acquire this foreign language. As you said earlier one of the main factors is psychological and that one is the least. The child may not feel shy if he makes a mistake or something like that. I think these two factors: the atmosphere of the classroom of the children and the bravery of children to acquire a language and not to worry about making mistakes.</p> | <p>Comment [GR 2]: Environmental</p> <p>Comment [GR 3]: UG</p> <p>Comment [GR 4]: Psychological</p> |
| 35 | <p>GR: What about your personal experience?</p> | |
| 40 | <p>Dr. Farid: Honestly, in my primary school the second language was French and I wasn't happy about that because the main reason was that the teacher wasn't that successful.</p> | <p>Comment [GR 5]: Environmental - Instruction</p> |
| | <p>GR: Okay.</p> | |
| 45 | <p>Dr. Ghanem: For me, I agree also and I was really lucky because when I was young in primary school, I was in a private school which the second language was English and I think that the most important factor is the encouragement from parents at that age and as my parents encouraged me a lot, especially because my father is a teacher in university, he understood the importance of a second language, especially for the future, for studying or for my future career.</p> | <p>Comment [GR 6]: Extrinsic motivation</p> |

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| 50 | And I was really happy to learn a new language. And I think it helped me when I did my postgraduate study, I learnt a third language, which was the French language, and on one hand it helped but on the other hand, sometimes it became a disadvantage because you mix between the two languages. | Comment [GR 7]: L2 interference |
| 55 | Dr. Jasmine: For me, I, personally speaking, I started being very good in English in university because most of my subjects were in English the environment around me, people who were talking beside me were talking in English, it was the main language, like an international one. Personally speaking I never liked the grammar part of English, it's very difficult even until now. Yes, I'm very fluent | Comment [GR 8]: English as a Lingua Franca |
| 60 | in speaking, maybe I make a few mistakes but what I learnt was not from the textbooks. I learnt it more from people, like how to use the past tense, present, future, this is my own experience regarding English language and the problem with English is the mixture between, like when I want to translate a topic or subject, first I refer to my mother tongue and there are some differences | Comment [GR 9]: Learning styles |
| 65 | between the mother language and the English language. This is the only thing with English. | Comment [GR 10]: L1 interference |
| 70 | Dr. Farid: Just one comment about what Dr. Ghanem just said earlier. I have many friends who are really fluent in English and they were before they came here and the common thing between them is the positive parental influence. Especially the father role. All of their fathers encouraged them to learn and motivated them especially for English and personally that's maybe what made my experience bad because the second language was French in my primary school and my parents speak English as a second language so they didn't care about | Comment [GR 11]: Extrinsic motivation |
| 75 | French they chose this school for me simply because it is a well-known school, it is L'Alouette, which is one of the most famous schools and another positive factor which affects the process of learning languages is movies. The common thing between those friends is that they were interested in English movies and English songs. | Comment [GR 12]: Input |
| 80 | GR: I think we've already started to identify... I mean, you've talked about being successful in school but I think you mentioned as well about how we learn and the way we do it, you know, not sitting with grammar books in front of you but experiencing real interactions. | |
| 85 | Dr. Jasmine: Personally, I am a person who doesn't like to be forced to do something because until now with IELTS, as a doctor, or a dentist, or a nurse you have to be very good in English but we don't have to go backwards. It's like going to the basics of English. I can tell you what I mean with certain things but in IELTS, let's say the writing part, it's not going to come up in our future career if they want to concentrate on certain things like grammar. Now everything is computerised especially when doctors are sitting in front of their computers they will record or a secretary will write for them. The main thing is to let the patient know what he has, this is the thing. Pushing me to get 7 in IELTS will make me go | Comment [GR 13]: Cross refer to Duncan Cross 'why should we?' |
| 90 | backwards. This is personal experience. | Comment [GR 14]: Spiral |
| 95 | Dr. Karimah: I'm not sure that I will use writing in the future as I have to use it now in the IELTS. Apart from research, writing is just copying and pasting. I will | Comment [GR 15]: Suitability of IELTS |
| | | Comment [GR 16]: Status and the role of technology - Socio-psychological? |
| | | Comment [GR 17]: Suitability of IELTS |

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| 100 | take the sentence that I like and it will be organised or corrected by my computer) so I don't know why it must be 7, especially in writing because I think everyone in this class is good in speaking, listening and even reading but because writing is all expressions and the different subjects that come in the IELTS test are not interesting for me to express myself in writing. Even if it was in Arabic I would never write a 250 word essay because I'm more likely to express myself in a short sentence, not in the detail that we learn here in the class.) | Comment [GR 18]: Status and the role of technology |
| 105 | GR: Has anyone got any thoughts over here? (interviewer gestures to the other side of the table) | Comment [GR 19]: Challenges in improving written skills in L1 - Lack of communicative relevance? Satisfaction of communicative needs? |
| 110 | Dr. Farid: I agree with the view that forcing learners to learn has a negative effect on the educational process, however I'm afraid I don't agree with the point that writing is not important because for professional people like doctors, pharmacists and dentists it's normal to be able to write an essay of 250 words and if we haven't got this ability now, we have to do that. | Comment [GR 20]: 'Why should |
| 115 | Dr. Jasmine: No I disagree with you because as a doctor or dentist, I have been to a doctor and asked her for a letter I needed for something else and the secretary was doing it, anywhere in the world the secretary does it, or the computer does the job for us. We can refer to the secretary for what we want for the patient, it's a report or if we go to a conference we are not sitting in the conference writing and writing. | Comment [GR 21]: Suitability of IELTS - supporting standards |
| 120 | Dr. Farid: This is a general responsibility and I agree with you but I'm talking about the ability of a doctor or dentist or pharmacist to write an essay of 250 words about a general thing. | Comment [A22]: Status and the role of technology |
| 125 | Dr. Jasmine: About what? About education? About health? We all know what the benefits are, the advantages and disadvantages of. | Comment [A23]: Disagreement with the above topic |
| 130 | Dr. Farid: And you have to know. | |
| 135 | Dr. Jasmine: ... media, what is media going to do for example for a dentist or a doctor? Yes, we will learn English if it's based on our careers, let's say if they talk about, write an essay, for example, I don't know, about general health things, not about media, crime police. | Comment [A24]: Suitability of |
| 140 | Dr. Farid: I think this is related to culture, our culture in the middle East in general doesn't care about the ability of a professor or a doctor to talk about something in general. Why do they give such importance to these topics here? Because they consider that those people who are professionals should be able to give a presentation, for example. | Comment [GR 25]: Lack of acculturation |
| 145 | Dr. Jasmine: What is a presentation? It's a report coming out of a computer, yeah? If a report is saved and we give it in front of everyone and we are reading from it, yes. | Comment [GR 26]: The role of technology |

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| 150 | <p>Dr. Farid: Yeah, you may be right in terms of some spelling mistakes or some mistakes in typing because a word processor will correct them but I'm talking in general, the ability to write, the ability to express your ideas by writing. And you are right, there should be some facilitation for waiving students for spelling mistakes or something like that.</p> | <p>Comment [GR27]: Ability to write</p> <p>Comment [GR28]: Usage versus</p> |
| 155 | <p>GR: Some interesting views there, I think it kind of comes into the next statement (participants laugh) which is (participants laugh again) 'I enjoy using English as an adult', so that very good discussion came about from learning English as a child and as you say, being forced to do these things, so 'I enjoy using English as an adult', and I think there might be some quite differing views here so, does anybody want to agree or disagree with that statement?</p> | |
| 160 | <p>Dr. Ghanem: I agree.</p> <p>Dr. Jasmine: I agree.</p> | |
| 165 | <p>Dr. Ghanem: Because the English language is a scientific language and also a trade language and also when you travel everywhere, in general, you have to speak English. For that reason I really enjoy learning English and to be able to speak fluently but to return to the subject of IELTS, or the issue for us, I have a balanced position because as professionals we have to write, for example, 250 words but what I feel is unfair is the time limit of one hour or forty minutes to write that in forty minutes because even in university or for you (the interviewer) for a PhD, you have to prepare a presentation, there is not a fixed time of forty minutes to prepare it. It is unfair and it is illogical to me, but of course they have their own conditions or...</p> | <p>Comment [GR29]: Benefits of using English</p> <p>Comment [GR30]: Unrealistic time constraints of IELTS writing</p> |
| 175 | <p>Dr. Farid: Rules.</p> <p>Dr. Ghanem: Rules for fixing this time but I think it is really unfair.</p> | |
| 180 | <p>Dr. Farid: I enjoy using English as an adult, yes usually (participants laugh) yeah I enjoy it and I want it because, in terms of communication skills, the language is one of the main areas for us to become integrated with others and sometimes I feel a little bit depressed when I compare the my previous stage in my life, when I was in my community and my native language and how I was able to interact with others and convince others because I am a pharmacist and I used to work in my own pharmacy so I used to negotiate with the suppliers, convince customers to buy the goods. So, what I found necessary and essential in learning English in this community and as I said earlier, in general in the international community was to have good English. Strong English is crucial to improve yourself and gain more relationships and communicate with others positively.</p> | <p>Comment [A31]: Benefits of using English</p> <p>Comment [GR32]: self-expression and a return to status - integration</p> |
| 190 | <p>GR: When do you enjoy using English most?</p> <p>Dr. Jasmine: I enjoy it when I speak, I love speaking, I enjoy English when I'm speaking but the writing part of English, there are two differences between</p> | |

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| 200 | writing and speaking English. Speaking, now I'm talking with you, you can see my expression, you can know what I mean by talking to you and listening but in writing, it's different, even if I might want to want to explain certain things, you are not there to see what it is. It depends on the knowledge, maybe I am very good in expressing my knowledge to you by speaking. These are the two things but English is a dominant language, I believe that, at the moment in the world and everyone likes to speak, the way of communicating. | Comment [GR33]: Paralinguistic gesture aiding spoken communication - skills transfer |
| 205 | Dr. Karimah: So, I enjoy English generally when I watch movies, when I go to the cinema, when I use it in a general situation not specifically in classes. So when I speak English and others understand me I feel happy about using English and even when I watch TV I understand the full movie without reading the translation, that makes me happy and it's a waste of time when I read the translation, not hearing it, when I hear it, it's better than the translation but in the class I think it is better when I was young because the lessons were regular in the past but I didn't use English since I entered university because it was an Arabic university, not English, apart from scientific English but we don't use English for conversation or speaking, we didn't listen to native English speakers so that made me upset when I came here that I didn't continue learning English because by this time I have to be experienced in English if I continued reading English from an early stage). | Comment [GR34]: This reflects Krashen's ideas on input |
| 210 | | Comment [GR35]: Successful communication - Input |
| 215 | | |
| 220 | GR: Okay I think I've got to move the questions around because something that you touched on Dr. Farid is very much a question that I wanted to ask, I will say, it's probably the most sensitive question I'm going to ask you today so you do not have to answer this if you don't want to but it relate to what you were saying about the change in status that you have experienced from your life before and your life now and so I guess the statements could be in two parts but I'll make the statement and we'll see where we go. "The language barrier and/or displacement has affected my sense of status" | Comment [GR36]: frequency and quality of input |
| 225 | Dr. Farid: Affected my st- | |
| 230 | Dr. Ghanem: Can you explain all? | |
| 235 | Dr. Jasmine: Can you repea- | |
| 240 | GR: Yeah so your status, obviously, back home your status I imagine would have been quite high in your communities and then coming to Cardiff and struggling with IELTS, you don't have that position at the moment, so has the language barrier affected that at all or do you disagree with that statement? | |
| 245 | Dr. Farid: Actually it could be a negative, it could have a negative effect. When I said earlier that it could be depressing for us but on the other hand it could be motivation because I still have the will to improve myself here and to make progress in my career so in this way it is motivating me to acquire this language). | Comment [GR37]: intrinsic motivation |
| 250 | Dr. Jasmine: It's a barrier for me, between my dentistry in which I wish to work and be a successful dentist and at the moment I feel that if English is necessary | |

245 for overseas students, then even the ones who are coming from most of the
European countries have to do English. They don't have to separate between
Asia or Europe. A Spanish person can not speak [English] a Spanish doctor can
register very easily here, or a Polish [doctor]. It's not their mother tongue so if
it's a rule, it's a rule for everyone and I think this language barrier, yes, there is a
250 difference between my carrier. At the moment it's like putting, it's like a stone in
front of me which I have to break. When it will be broken, I don't know. So it
requires lots of hard work. I worked many years, I have dental experience, I have
a lot of experience but I find it, sorry to tell you, I find it very silly. At the end of
the day coming and starting to learn grammar, why do I need it?

Comment [GR38]: inequality
within EEU - why should we?

255 GR: I think what you are talking about is a political barrier.

Dr. Jasmine: It's not political, no, no, no, I'm talking now about the language
barrier because most of us can speak English, most of us.

260 Dr. Karimah: Understand...

Dr. Jasmine: Understand, reply back but...

265 Dr. Farid: Yeah but...

Dr. Jasmine: It's a barrier, it's like...

270 Dr. Farid: Yeah but what Gabriel means, I think, it's political that, as you said...

Dr. Ghanem: By people...

275 Dr. Farid: For the different countries, maybe the Spanish doctor is qualified than
you and, as you said earlier, they can work without the requirements that you
have, that's the point.

Dr. Jasmine: Oh, okay.

280 Dr. Farid: (And I think I agree with it)

Comment [A40]: Why should we?

Dr. Jasmine: (Yeah)

Comment [A41]: Why should we?

GR: Well, I don't want to put words in your mouth, I'm here to...

285 Dr. Jasmine: (laughs) Yeah.

290 GR: I'm going to follow that up a little bit, we'll come back... (at this point
someone enters the room to collect some papers and leaves the room) we'll
come back to that point so that everyone can give their feelings on it but I just to
follow that up, I think... in the future, when you are qualified and working
alongside an EU doctor who cannot speak very good English, what effect do you
think that will have on you? Do you think you will be proud?

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| 295 | Dr. Jasmine: No. | |
| | GR: <i>Will you be annoyed?</i> | |
| 300 | Dr. Jasmine: It's not that, even if a person doesn't know how to speak English, we can still communicate somehow, we are all human beings, we can know, I will explain to the person in a simpler way so I don't think it has something to do with the personal feeling, like you have to be proud or to let the other person feel less, like the way you have to pitch, but it's, I don't know... | Comment [GR42]: Communicative strategies |
| 305 | Dr. Farid: I think it will be a mixed feeling because I will be happy that I am better than him in the English language but as well, I will feel annoyed because he was working and earning money while I was studying and coming from Swansea to Cardiff for IELTS lessons (participants laugh) four times a week. | Comment [GR43]: Eagerness to rejoin career - Integration |
| 310 | GR: What are your thoughts about that Dr. Ghanem? | |
| 315 | Dr. Ghanem: I think for me, if I have really mastered the English language, I will be proud of myself and it is a game for myself to master it and I have the same feeling as Dr. Farid and Dr. Jasmine, it is unfair to spend all this time on language, for example it would be a fair solution to be registered on the condition that maybe after a year or two that you have to pass IELTS but you are involved in your career and your speciality but to put this barrier, this stone like Dr. Jasmine said, it's really a stone and not a stone in front of you but in front of your family because all of accept our age and we have wives and children and you were really well qualified in the past and now you have a feeling of losing this qualification because you don't practise what you have usually practiced in the past and in our careers, such as dentistry, you have to practise to maintain this performance and I think it's a really negative policy. | Comment [GR44]: Instrumental motivation Comment [GR45]: Acknowledgement of standards - suitability of Comment [GR46]: Support for 'stone' analogy |
| 325 | Dr. Jasmine: (Yes) | Comment [A48]: Deprofessionalisation |
| | Dr. Ghanem: They have to arrange things between the requirement of English and our careers. | |
| 330 | Dr. Jasmine: Yes. | |
| | Dr. Ghanem: It's important. | |
| | GR: What do you think Dr. Karimah? | |
| 335 | Dr. Karimah: I will tell you an example, two of my senior friends were Sudanese, one was born here in the UK and has a British passport and the other was born in Ireland and has an Irish Passport, graduating in the same year and they came here in the same year to apply for their medical careers. The one who was born here in the UK and has a British passport had to pass the IELTS test and then had to apply. The other with the Irish passport applied immediately and enrolled in their career immediately. The difference between them became two years. When they applied to become surgeons registering in the same Deanery, they accepted | |
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| 345 | the one with the Irish passport because she was younger because she was working and had experience here while the other was working to get IELTS and PLAB all this stuff before. She was two years after the other and when she applied to surgery, they accepted the one who had an Irish passport and had practiced medicine earlier than the one that was wasting their time in IELTS and doing the PLAB and everything because they wanted experience here in the UK and they want people of a certain age to be enrolled in the registrar's job rather than the other...) | Comment [GR49]: Example of deprofessionalisation and further loss of opportunities due to inequality |
| | GR: Was it the surgeon's job? | |
| 355 | Dr. Karimah: Yeah, because when you get old, you can't apply as a surgeon. You can apply as any speciality but especially surgeon because they want a young surgeon and the competition is less when you are young. | |
| 360 | Dr. Farid: Well, I think professional careers should be reconsidered, the policy of dealing with professional refugees should be reconsidered.) | Comment [A50]: Policy |
| | Dr. Jasmine: Yes, I agree with this.) | Comment [A51]: Policy |
| 365 | Dr. Farid: Because even, for example, I am a pharmacist and I contacted the General Pharmaceutical Council here and I asked them if I have the right to work as a technician, a pharmacy technician. They said no, you have to follow two years training and get this qualification. I said to them that I had been working for more than twelve years in my own pharmacy. I think this should be reconsidered.) | Comment [GR52]: Excessive standards? Expectations on retraining. Policy. |
| 370 | Dr. Jasmine: I agree with him. They have to consider, they have to recognise a difference between professional and others because we are all, we have to practise our skills. We need practice, all of us but...) | Comment [A53]: deprofessionalisation |
| 375 | Dr. Farid: Yeah.) | Comment [A54]: Deprofessionalisation |
| | Dr. Jasmine: And we don't, we spend our time in English, learning English might be useful, the writing part of it might be, it's not 100%, it's really stopping us from moving forwards and I think it's unfair.) | Comment [A55]: Why should we? |
| 380 | Dr. Karimah: I think practising in a hospital will make everyone more experienced in English, more than studying at home.) | Comment [GR56]: Suggestions on retraining and integration - policy |
| | Dr. Farid: Mmm.) | Comment [A57]: Policy |
| 385 | Dr. Jasmine: Yes, you are right.) | Comment [A58]: Policy |
| 390 | Dr. Karimah: Because when you are communicating with patients and you concentrate on the specific words that are needed in a hospital you are in your career, rather than general topics that lose the interest of most of us.) | Comment [A59]: Deprofessionalisation |

GR: Mmm. Thank you. The last two points on life history. One of them is 'There was a positive view of English speaking cultures in my country.' Do you agree or disagree with that...

395 Dr. Farid: A positive view?

GR: Of English speaking cultures in your country when you were there.

Dr. Jasmine: Which way do you mean?

400

Dr. Farid: Do you mean how we look in our countries to the English speaking cultures?

GR: Yeah.

405

Dr. Jasmine: General, or?

GR: Well, to take China for example. Let's say twenty years ago, in China, you wouldn't see the western products, western styles as much as you do these days, so there's been a change there and, very obliquely, there's a more positive view of English speaking cultures in China at the moment, than there was twenty years ago.

410

Dr. Ghanem: Personally, as I come from the middle East area, Syria, I think that although the government and the regime is closed, the Syrian people are still open minded and due to our location, we had to communicate with other civilisations and cultures and I think in Syrian community we have a positive view towards English speaking cultures and the English language imposed its necessity upon others, it is an international language and a language of business.

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420

GR: Any other thoughts?

Dr. Karimah: In my country, because it was occupied by the English government for a long time in history it is a positive thing to hear of people of an early age that have English language and it is not a different or rare that...

425

Dr. Farid: People speak English?

Dr. Karimah: People speak English because in the fifties every school taught English from primary school and there is a recent change for English language because the new government have Arabic as the first language in primary school and as you get older, you have to select which language you wish to progress in, it's not the choice of the government.

430

435

Dr. Jasmine: For me, I come from Iran. Iran, as you know is supposedly an Islamic country and they had a long term sanction with Europe and we get products that are made in Iran because Iran itself is a rich country except the government part and we usually, as Dr. Farid, we are all open minded, we are all educated, you find less people educated to a professional level in Iran, we usually

Comment [GR 60]: A positive view but the participant says that the language imposed necessity upon others

Comment [GR 61]: Similarly, the language is taken positively but the historical occupation may not be seen so positively

Comment [GR 62]: Political policy to emphasise Arabic

Comment [GR 63]: Political

440 go for Higher Education but we never practise English but we do not see English
in a bad way because most of us had satellite, although the government does not
allow this, we have satellite indoors in order to see Europe and America and we
have a kind of mental connection with Europeans but due to certain details
between Europe and Iran, we cannot travel, we cannot go to lots of [places] for
445 example, I'm a dentist, I used to go mostly to conferences to Dubai, I cannot go to
Europe, if I wanted to go to Europe I had to go through certain long procedures
or go to another country to the embassy to apply for the visa so the application
process was difficult but we all loved to learn different languages for example,
one of my friends learnt Italian and now she's working as an interpreter in Italy.
450 Yes usually the people's view is different from the government's; there are two
different points here. English is nice overall but...

Dr. Farid: You're right.

455 **Dr. Jasmine:** Not the IELTS part, yeah.

GR: Anything to add?

Dr. Ghanem: I agree with my colleagues but especially in Syria people are very
460 welcoming to any other cultures and languages for that I think it crucially
depends on the atmosphere, for example, in my hometown Aleppo, it is well
known for trade and industry and I know that many of my friends have to learn
English and they have a very positive image of the English language because
learning this language opens doors for their trade or industry for that it depends
465 on the community and in general in the middle east and Iran in the same region
the best thing is to learn a foreign language especially English but also French,
Italian and Spanish. Many people I know learn Russian and Turkish because of
the trade relations between these countries are important also.

470 **GR:** Of course. Okay so the last part for life history 'I have changed my views
about English speaking cultures since being in the UK'

Dr. Jasmine: It's not true, I disagree. I totally disagree. (a long pause)

475 **GR:** Any other thoughts?

Dr. Karimah: It didn't change because we hear about English culture from our
early years so that way we didn't find anything that different from what we
thought English [culture] was.

480 **Dr. Farid:** Honestly I was surprised by some aspect that I hadn't expected for
example, some thing happened yesterday. I applied for a DNA paternity test to
prove my relationship with my sons, in order to bring them here. The worldwide
DNA company that specialise in that area sent the forms and the samples in
485 order to be taken to the surgery where I used to go. Although the nurse had the
forms three days before the appointment, I got into trouble with her because she
hadn't read anything about the steps that needed to be taken in order for the test
to work. She started the test but when I was reading the form, I noticed that what

Comment [GR64]: Technology
allowing cross cultural
communication

Comment [GR65]: This led to an
affinity with countries where
embargoes are in place

Comment [GR66]: Benefits of
learning an L2

Comment [GR67]: Benefits of
learning English

Comment [A68]: Benefits of L2

Comment [GR69]: No change

| | | |
|-----|--|---|
| 490 | was written totally contradicted the way that she was doing it. I told her that she ought to read the steps. Fortunately, she was cooperative and we read them together but this is one example of many. I thought people were more educated. | Comment [GR 70]: Surprised by lower professional standards in medical practice |
| | Dr. Jasmine: and more responsible | Comment [GR 71]: Misperception of educational standards |
| 495 | Dr. Farid: More responsible, than they are. | Comment [GR 72]: Misperception of professional responsibilities |
| | GR: Mmm. | |
| 500 | Dr. Ghanem: The only example for me, which surprised me, is when people speak slang and there are a lot of insults in their speaking. I didn't imagine that because what I had thought was very positive and that English speakers have a high level of education but, for example, in the city centre or busses they speak in a very negative way, which I really hadn't expected. | Comment [GR 73]: Surprised at conduct and related to educational levels |
| 505 | GR: Mmm, okay, thanks for that. What I think I'm going to do, because I'm aware that I'm imposing on your time, is, now that the life history is covered, and that's brilliant, thank you very much for your views on that. I think I might summarise the other two points because a lot of it has come up in the interviews before. I'm going to summarise the point on age memory and other mental changes. <i>I don't have the mental capacity to learn any more, I don't have space in my mind, I'm too old to learn and more language, I can't remember thing in the way I could before, my mind is completely set with my first language or I'm not good at learning languages.</i> Do you have any strong feelings about any of those points? | |
| 510 | | |
| 515 | Dr. Jasmine: Age might affect learning but, as we know, as much as we use our brain, the brain gets more space and take more information. To go back to learning, to be forced at a certain age, I am now thirty plus but I won't mention what, but it's not necessary to cover basic English or take the pressure. I am not interested in going back to the basics of my Iranian language that I learnt in primary school. So what I say is that it depends on what I have learnt so I think age can be a problem but I love using my brain but not being forced to use it. (participants laugh) That, I don't like. | Comment [GR 74]: Feels that age does not affect mental capacity but later statements indicate that returning to learning at a basic level difficult |
| 520 | | |
| | GR: Okay, thanks, any other thoughts? | |
| 525 | Dr. Ghanem: I agree with Dr. Jasmine but for me, it's not age because it's the capacity to learn. Age is important because the older you become, the more complicated responsibilities you have. This is the problem. For me to study IELTS now, I have take care of my children and my wife, to think about my family in Syria, which is a very dangerous situation and I don't work here so I have to think about earning money. After that, I have learn English. It's not a very positive position, for example, if I didn't worry about my family in my hometown, Aleppo, that they are living very well, if I didn't care about them and my children and work, I think my level of English would improve at least ten times faster. | Comment [GR 75]: The responsibilities that come with age rather than age itself |
| 530 | | |
| 535 | GR: That is important, isn't it, the situation. | |

| | | |
|-----|--|---|
| 540 | Dr. Ghanem: The situation is very important, not age but the responsibilities and the problems that you have while you learn English. | Comment [A76]: Responsibilities |
| | Dr. Jasmine: Yes, I agree with you, it's the main point. | Comment [A77]: Responsibilities |
| 545 | Dr. Farid: Yeah, I think the age factor contributes mainly to the language acquisition process because as you get older, your flexibility in your brain reduces; however, the responsibilities you have at this age, the concerns we are experiencing about our futures, about our families about our situations in general, these will affect us more directly. | Comment [GR78]: Acknowledgement of the effects of ageing but concession to the other socio-affective problems being greater |
| 550 | GR: What about depression? | |
| | Dr. Jasmine: Oh yes. | |
| 555 | Dr. Ghanem: I have one thing to add. I think age is a very marginal factor, especially for people in our situation because we used to learn a lot. All of us have a high level of education, we are professionals, dentists, doctors, pharmacists we are used to learning and not stopping at a particular age because, you know, science develops and for that reason, I don't think it is a problem to learn new things but like I said, the situation in general, depression, emotional and psychological situations are very important. | Comment [GR79]: Status and prior learning supporting the participants' attitudes to learning. |
| 560 | Dr. Karimah: Depression is mainly about my career because when I applied [for work] they always choose the one who has experience and is younger in age. This time, while I spent two years preparing for IELTS, another person is working and getting experience and when we apply for work they will definitely | Comment [GR80]: The current situation being the cause of depression rather than the symptom - deprofessionalisation |
| 565 | choose the one who has experience and shown progression over me because I spent two years out of a job and I have a career gap and they will question what I did in this two years. | |
| 570 | GR: So you're saying that the depression is actually caused by not practicing. | |
| | Dr. Karimah: Yeah. | |
| | GR: More than... | |
| 575 | Dr. Jasmine: Depression can count many things, Gabriel, it's a personal experience, it's related to myself, I faced a huge depression, I was really depressed and seeing a consultant every week and I was on medication. Why this depression comes is the time when you might change due to something like my colleague Dr. Ghanem said, you have certain things and your life totally changes | |
| 580 | in a way which you cannot expect. Many of these things can happen in a foreign country for example now, in the UK, many things happen to a person at once. It leads the person to drop automatically. So yes, depression is a problem. Depression has certain stages, when it's crazy and when it's normal but depressed and this will affect learning. It will never let you concentrate because | Comment [A81]: Depression |
| 585 | while you are reading, you are thinking what you had passed yesterday or earlier in the same day. So, yes, especially as most of the professionals come from a | Comment [GR82]: The impact of depression on ability to learn |

higher status of income, family, they used to work and now everything has reduced to zero, so this I think causes a huge strain. Not only in learning English, but in other things as well.

590

Dr. Farid: I believe that every one of us struggled between two ideas. The one is totally negative, as I said earlier about depression, for example I remember one situation that happened to me. It was last winter and I had booked a bus ticket and when the session finished, I ran to the bus station and I waited for the bus but the bus didn't come. When the next bus came, the bus driver came down and spoke. What he said, I don't know, you know, bus drivers speak quickly and use slang. I felt extremely depressed in that situation because I was really cold, I was a little bit ill, I had the flu and ultimately I didn't understand what the bus driver had said. I asked nearby man what this driver said, he told me that there was a mistake made by the previous driver which caused this inconvenience for the schedule, so I had to go to the train station and I bought a train ticket and I remember that I spent all the trip crying, really, because, as I told you, I was cold, ill.

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Dr. Ghanem: Pressure.

Dr. Farid: Yeah I faced it, very much pressure. But when I arrived at my house I paid attention to myself, I said 'no', I had to stop these negative feelings, if I was haunted by them I would be in serious trouble, so I had a shower and prayed and I promised myself to eliminate this feeling since my experience.

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GR: I think as you said earlier, it's not always possible but if you can turn it into a motivating factor, this is the key. Okay, thank you for sharing your thoughts with me. I think we've probably covered the majority of this quite adequately but I'd like to discuss the socio-affective domain, I mentioned before we started recording, feelings towards English speaking cultures, ability in English, being afraid to lose your culture, not being able to identify with English speaking cultures. I think we have talked about it in depth already but are there any other thoughts that any of you would like to add?

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Dr. Farid: For me, when you mentioned it earlier, I asked myself if that is a factor in my English learning process. I don't believe that it is, I'm not afraid of losing my culture, I love my culture, I have my beliefs and I am holding them strictly and this will not affect my learning.

625

Dr. Ghanem: I agree with Dr. Farid for myself but I am really anxious for my children. (the group all agree) It's very important for me and I think of my children every day, every hour, every minute because I think at a certain age, which are at, it is very important to learn English and it is an enrichment for our culture but because we had our own culture previously we can choose what is important and beneficial for us or not but for my children, I have two sons, seven and five years old, I think all the time, if we are still living in this country for five or six years more, when they will be teenagers, it will be very difficult for them and they will not be as strong as I am in regard of our culture. It's very important.

635

Comment [GR 83]: Motivation through fighting depression

Comment [GR 84]: Unafraid of losing culture and no effect on learning

Comment [GR 85]: Fear of a generational loss of culture

Dr. Farid: It's really concerning and because of that Dr. Ghanem has sent his children to an Arabic school even though he hasn't here for a long time and that's what I'm planning to do with my sons when they arrive)

Comment [GR86]: Attempts to retain culture within the host culture

640 **Dr. Karimah:** I agree with Dr. Ghanem and Dr. Farid but I'm not worried about my culture and beliefs because it has affected me for a long time but in the future I have the same worries about our children and whether they will be affected by different cultures which they find in school and find at home so that their beliefs will be mixed and there are different habits that they have to practice at home

Comment [GR87]: Reinforcement of the same point

645 and they have to practice them in school.

Dr. Jasmine: For me I don't have any comment because I don't have a family but I think I have always loved European culture but it depends on the family and the way that they bring up their kids, that's what I believe. Like me, I am a single girl living in the UK with a very broad culture that's totally different but it depends on how my family brought me up, so I might disagree with my colleagues, it all depends. Yeah, outside influence plays a huge role when the kids are teenagers they might not have control of their teenage kids but I told you, I cannot give a comment about English culture and those things.

Comment [GR88]: Disagreement based on not having a young family

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GR: What about English or Welsh friends?

Dr. Jasmine: I like to have them but I think every human is different they are positive and negative but I like to have English friends. Until now, the British nationals that I have met were good to me. Maybe it depends on the person, we are looking at the person, maybe we don't know where each other are from but we can communicate well, it's a matter of communication and understanding. If you don't insult my culture and my language, I won't insult yours, it depends on the personal experience, the ways of a family. Yeah, I cannot stand some British nationals, I find that some of them are really disrespectful but on the opposite side, it's different. Even in Iran, I have the same. (participants agree) There are some very respectful people there are others who you'd better not talk to because you can't understand each other, so it's a huge thing culture. (laughs)

Comment [GR89]: Acknowledgement of good and bad behaviour in all cultures

670 **GR:** Okay, well thank you very much.

Dr. Farid: Thank you.

Dr. Karimah: Thank you.

675

Dr. Ghanem: Thank you.

Dr. Jasmine: Thank you Gabriel.

680 **GR:** I really appreciate it.
(END OF RECORDING)

Appendix 24: Constructionist Analysis of the Focus Group

The focus group started with a greeting and an explanation of its purpose. My request (as moderator) (lines 9-11) was for the participants to agree or disagree with a set of statements and to provide reasons why. The first statement (lines 11-12) was made openly to the whole group. After a pause, the first person to answer was Dr. Ghanem. Immediately after the moderator sought confirmation from Dr. Ghanem, Dr. Karimah interjected with her view. Dr. Karimah was the only participant who had not met the moderator on at least one occasion before the focus group, and may have had more to say than the others who had all been interviewed previously, but was not willing to be the first to take the turn in responding to the moderator's statement. As such the moderator (GR) encouraged her to expand upon her response.

Subsequently this allowed Dr. Farid, one of the more vocal participants, to offer his thoughts on why children may enjoy language learning more. However, when prompted for his personal experiences, he mentioned that his first L2 was French and that his own experiences were poor. After Dr. Farid had made his point, Dr. Ghanem made a further contribution, which supported Dr. Farid's statement. This was the first instance of an apparent dynamic between these two doctors and countrymen where they would support each other's statements throughout the interview (e.g. the statements beginning in lines 38 and 44, lines 164, 175, 177 and 179, lines 591, 605 and 607 and in lines 621, 626 and 636). Dr. Farid, who seemed to be one of the most confident members of the group, mostly led this dynamic during the focus group.

After Dr. Ghanem had taken his turn, Dr. Jasmine's response (lines 55-66) represented a shift in the topic, to focus on her preference for communicative learning over more form-focussed learning. This was a theme that Dr. Jasmine would return to throughout the interview (lines 86-95, 116-121, 143-145, 252-254, 376-378, 516-518) but was not picked up by the rest of the group at this stage. Instead, Dr. Farid returned to the earlier discussion on the early learning environment, in particular following up from Dr. Ghanem's statement.

The moderator (GR) pursued Dr. Jasmine's statement (lines 81-84) about communicative learning and opened the discussion up to the group to respond. As mentioned above, Dr. Jasmine returned to this point and expanded it to the suitability of IELTS and, in particular, the nature of IELTS training representing the idea of having 'to go backwards... to the basics of English...'. With the exception of Dr. Ghanem, most of the participants gave their views on this; Dr. Karimah supported Dr. Jasmine's view that in the practical situation of being a doctor, there is support in the form of electronic spell-checking software. This was another dynamic within the group, particularly during the first half of the session, where Dr. Karimah would take her cues from the other female member of the group, Dr. Jasmine (lines 86 and 97, lines 194 and 204 and lines 376 and 380). Dr. Karimah also stated that it was unlikely that she would need to write 250 words to express her views on the variety of topics that feature in IELTS writing, either in English or in Arabic. When the moderator (GR) urged the other participants to give their views, Dr. Farid challenged the implication that the expectations were too high, stating that 'for professional people... it's normal to be able to write an essay of 250 words' (lines 112-114). This became the most contentious part of the focus group session, mostly focussing the variety of themes that IELTS writing covers and their relevance to medical practice. The main disagreement (lines 110-151) was between Dr. Jasmine and Dr. Farid, the former showing signs of frustration with the standards that are in

place and the latter supporting a more practical point of view on the expectations of healthcare professionals in the UK. Each side seemed unwilling to concede and after some time (exactly three minutes and twenty-two seconds) the moderator (GR) moved on to put forward the next statement on using English as an adult. The participants recognised this as an attempt to defuse the tension and laughed while the segue was made.

Dr. Ghanem was the first to respond to this statement, possibly as he had not responded to the last. Before he had begun providing his view, Dr. Jasmine also agreed with the statement, possibly to counter her somewhat negative response to the last discussion. Dr. Ghanem then supported his agreement with the statement on using English as an adult but also provided his view on the length of time candidates are expected to produce 250 words in the writing exam. Dr. Farid then provided his view, stressing that he usually enjoyed using English (line 179), which seemed to be another attempt to diffuse the tension and was received by the participants with a laugh. He then discussed a loss of status in the community, which was brought about both by his change in professional circumstances and also through his comparative lack of eloquence in English.

The moderator (GR) pursued this point by asking the group when they enjoyed using English, to which Dr. Jasmine provided the first answer and related it to spoken English skills. As mentioned above, Dr. Karimah followed this statement and expanded on it, mentioning how she enjoyed her successes in using English.

At this stage in the interview, the moderator (GR) rearranged the questions as they were laid out in the schedule because Dr. Farid had mentioned a change in status and this was something that GR had wanted to introduce sensitively. After reassuring the participants that they were under no obligation to respond to the statement, he asked about loss of status. It is quite possible that the point was obfuscated by the moderator's framing of the statement on displacement 'The language barrier and/or displacement has affected my sense of status' (lines 224-225). After further explanation, Dr. Farid understood the point that was being suggested and talked about using negative experiences to motivate them positively in terms of rebuilding their lives. Dr. Jasmine's response was more focussed on the political situation where EEU doctors did not have to pass the IELTS test and she perceived this to be what was meant by 'the language barrier'. She also made an analogy to training for the IELTS being like hard labour: 'At the moment it's like putting, it's like a stone in front of me which I have to break. When it will be broken, I don't know. So it requires lots of hard work.' (lines 250-252). This analogy was picked up later (line 316) by Dr. Ghanem, who expanded it to be a barrier to his family as well. The moderator (GR) did not make an attempt to reframe the question at that time but brought up the matter of depression later in the focus group (line 544).

Instead, he asked about the hypothetical future situation of the participants working alongside doctors from the EEU who had not passed the IELTS test and how it might make them feel (lines 290-292, Line 296). Dr. Jasmine said that it would not make her feel any pride that she had gained the additional IELTS qualification, nor would it annoy her. She took the statement to mean that she might have to simplify her English when dealing with EEU doctors and said that it was a matter of necessity. Dr. Farid said that he would have a sense of pride in his English but that it would be at the cost of lost earning while he was training for the test. Dr. Ghanem echoed the thoughts of Dr. Jasmine and Dr. Farid and stated that he was worried about losing his professional knowledge while he was in training

for the IELTS test. When prompted by GR, Dr. Karimah provided a powerful example of two friends of hers from Sudan; one who held a British Passport and the other who held an EEU passport from Ireland. The former had to train for the IELTS test for two years while the latter was able to begin medical training immediately. This hiatus of two years meant that the person who needed the IELTS qualification was too old to apply to be a surgeon by the time she had gained the qualification. Dr. Farid and Dr. Jasmine both agreed that it would be beneficial if the policy for refugee doctors were more supportive in recognising their professional experience and the need to maintain it (lines 358-378). Dr. Karimah also agreed with this.

The moderator (GR) then moved to the next statement which sought to drill down into any socio-affective factors, as described by Han (2004), which the participants had not acknowledged during the interviews. While all of the participants agreed that there had been a positive view of English speaking cultures in their countries, there were some interesting phrases that came up in the participants' responses. Dr. Ghanem said that 'the English language imposed its necessity upon others' lines (418-419) and this was echoed by Dr. Karimah's statement that her country had been 'occupied by the English government for a long time...' (lines 423-424). In both cases, the participants had said that they were pleased to have a working knowledge during the interview and were positive in their responses to this statement, however, imposition and occupation are words that carry a negative connotation. Crystal (1997, p301) defines pragmatics as being, among other things, the choices that language users make. In this sense, these perceivably negative terms may have been an erroneous pragmatic decision or a sign that, although English is generally well respected in some countries, its hegemony is sometimes resented in some populations. Dr. Jasmine's response (lines 435-451) was quite different, indicating that there was an aspect of rebellion in using English in an area where the government had sanctioned against European nations. Dr. Ghanem concluded this part of the focus group by reinforcing his earlier statement that, similar to Russian and Turkish, English was a useful language for commerce and industry.

The moderator then asked the participants to comment on whether their views of English speaking cultures had changed since they had arrived in the UK. Dr. Jasmine strongly disagreed with this question and Dr. Karimah supported her point of view by explaining that extended exposure to English culture back home had meant that there were no surprises for her upon arrival. Dr. Farid related a recent story of how he had been surprised at a lack of professionalism that he had encountered. Dr. Ghanem expanded on this to say that he was surprised at a lack of etiquette that he had encountered in his daily life.

After allowing a space for further responses to the statement, the moderator apologised for taking a lot of their time and moved on to make a summarised statement about Han's (2004) 'psychological' domain. The summary covered mental capacity, age and its effects, neural entrenchment and poor language skills. With such a broad range of concepts being dealt with in one statement the moderator felt that some detail would be lost, however Dr. Jasmine's response covered most of the points that fall under the domain. Dr. Ghanem supported Dr. Jasmine again and added that he perceived the main problem to be the responsibilities that come with age, as well as concerns about family who remain in a conflict zone. Both Dr. Jasmine and Dr. Farid agreed with this point as being the most relevant.

At this point, the moderator (GR) felt that it was appropriate to return to the point about depression, made by Dr. Farid in line 182. As the topic had previously been introduced in the context of a loss of status, GR was able to ask the question more directly (line 549). Dr. Jasmine agreed immediately that depression had a part to play in hindering their progress. Dr. Ghanem returned to his earlier point about responsibilities being a major barrier, and attempted to dispel the idea that doctors would be negatively affected by age, stating that they are in a profession where continuous learning is the norm. He also linked the impact of responsibilities to the situation in general, depression, emotional and psychological situations. Dr. Karimah supported this (lines 561-567) and clarified that her depression stemmed from her inability to work in the role for which she was trained. Dr. Jasmine introduced the aspects of medication, counselling, the volatility of depression and a loss of status, saying that they can impinge on opportunities to study a language, as well as in other areas of life. Dr. Farid concluded the discussion on depression with a personal account of a time when he was at his lowest point but was able to use it as motivation (lines 591-610).

In order to move away from a sensitive topic at a positive point, the moderator (GR) revisited the factors that are under the 'socio-affective' domain in Han's (2004) taxonomy, asking if the participants had anything to add that had not been covered. Dr. Farid, Dr. Ghanem and Dr. Karimah agreed that, while they felt that their cultural orientation was robust, they had concerns for their children losing their culture as they grew up in the UK. Dr. Jasmine was not a parent and was not able to comment on this aspect of a loss of culture. In an attempt to include her views, GR asked her about the influence of local friends and she responded by mentioning that there are some agreeable people and some who are more disrespectful in all cultures. This concluded the interview.

Appendix 25: Notes on Interviews with Expert Witnesses

Notes on interview with the teacher

1. How long, on average, does it take for an asylum seeking/refugee doctor to pass the IELTS test? Why do you think this is?
 - 1.1. It depends on the initial level but on average a year to eighteen months
 - 1.2. Around six months to increase by 0.5
 - 1.3. Going from 6.0 to 6.5 may be quicker than going from 6.5 to 7.0
 - 1.4. Going from 6.5 to 7.0 in writing is hard for some students
 - 1.5. The requirement of 7.0 in each skill was difficult
 - 1.6. Transfer of skills can be a problem between spoken English and the written word
2. How appropriate do you believe the IELTS is for refugee doctors? Why?
 - 2.1. It's not particularly appropriate that they have to write two essays in one hour to prove their worth as a doctor
 - 2.2. 7.0 in speaking, listening and even reading is definitely appropriate a minimum 6.5 in writing would be fair: it's a time test looking at the ability to write 400 words in an hour
3. What are the specific challenges that refugee doctors face in trying to pass the test?
 - 3.1. Many come with their families and are trying to sort out integration for their families as well as passing IELTS
 - 3.2. Signing on is unfamiliar to professional people
 - 3.3. Some people are good at writing: in writing you have a blank canvas and this might be enjoyable, for example doctors who have studied humanities, others are scientific people who are not so flexible in their writing
 - 3.4. It's easier to teach aspects of the speaking test by using various techniques
 - 3.5. The nature of refugees is different but in some aspects, this can help their speaking because they have to use survival English on a daily basis
4. In what ways do you think these challenges impact on them and their potential for success in joining the GMC?
 - 4.1. All these challenges come together, something that can occur is that after two years, they have forgotten aspects of their medical knowledge
 - 4.2. Many specialists need to start over in their specialities to have an established career: this has led to a couple of people going back, even though it is to a potentially dangerous situation because they can't bear to start all over again
 - 4.3. Medical training is possibly more general overseas and seems to be more practical at the start
 - 4.4. Although students would have learnt English from textbooks, it is very specialised and many students from certain areas will have a poor command of general English but be good at specific medical English
5. How do you think these barriers can be overcome?
 - 5.1. Refugees are being thrown into UK life but running parallel it would be helpful if they could do some voluntary work in a medical setting, taking blood pressure to show the expectations of a British medical centre
 - 5.2. This would necessarily need strict procedures to set up including ethics, clearance and other training
6. In your opinion, what are the main obstacles to English language learning that are experienced by overseas doctors trying to pass the IELTS test?
 - 6.1. Writing but more generally, people staying within their ethnic groups: having the opportunity to speak English outside the classroom beyond basic transactions
 - 6.2. The different uses of the present perfect, the article, pronunciation
 - 6.3. Transferring good performance in grammar tests to the skill in IELTS context under time constraints
 - 6.4. Older students are more receptive to the repetition elements in learning English than younger students
7. What other challenges do you think refugee doctors face in the UK?

- 7.1. Upon passing the IELTS, getting registration forms from their country of origin
- 7.2. Being able to work in a British environment: the PLAB 2 test highlights the differences in medical practice overseas as opposed to in the UK, adapting to the doctor/student relationship as it is in the UK
8. Are there any specific characteristics of refugee doctors that you have observed that may differ from other English language learners or doctors?
 - 8.1. They are far more motivated, it's a pleasure teaching them but the challenge is to reassure them that you are doing enough for them
 - 8.2. That they have so many problems with their adjustment to their situation and the toll that it has taken on them emotionally

Notes on interview with the author

1. How long, on average, does it take for an asylum seeking/refugee doctor to incrementally improve by 0.5 the IELTS test? Why do you think this is?
 - 1.1. How long is a piece of string; some students have gone from 5.5 to 8.0 in a week, whereas it has taken others a year
 - 1.2. All students are capable and all students hit plateaux
 - 1.3. Doctors do not know the system of language related to the way in which they are taught medicine
 - 1.4. What prevents the students from performing well is not knowing what is expected of them linguistically and in PLAB, IELTS loosens them up a bit
 - 1.5. Declarative knowledge of language is a problem
 - 1.6. Medical students have to memorise everything, the transfer to a more inquisitive style is difficult
 - 1.7. An inquisitive style is important for taking medical histories
 - 1.8. May not necessarily understand what it is that they are declaring
 - 1.9. "Students pack suitcases but don't open them"
 - 1.10. A rare example of a student binding their own vocabulary dictionary was provided
 - 1.11. Students don't do transfer of skills
 - 1.12. "IELTS is anatomical"
 - 1.13. When students cotton onto structures for use they go fast: the younger they are, the better they are
 - 1.14. Students are unwilling to risk restructure: the ego is a problem due to powerful personalities
 - 1.15. Students want everything to suit them
 - 1.16. Fossilization is in the emotional and intellectual development, which imposes upon linguistic structures
 - 1.17. Refugee doctors who could memorise were fine when IELTS was straightforward but it has become more flexible
 - 1.18. Students do well in certain areas but don't complete the task: this is a major problem
 - 1.19. Students like this do well in reading but get lower scores in writing
 - 1.20. Issues with flexibility re: statement on fossilization
 - 1.21. Status change is frustrating
 - 1.22. Example given of a polyglot with a lot of social problems with various groups: would switch to different languages depending on his emotional responses
 - 1.23. Jagged profiles with interchangeable successes in skills could be attributed to a lack of ability in transfer
 - 1.24. Classic EAP 'noticing' techniques are useful
 - 1.25. IELTS is to do with competence not to do with knowledge
 - 1.26. Students used to spend 20 minutes of every hours complaining about IELTS at the start
2. How appropriate do you believe the IELTS is for refugee doctors? Why?
 - 2.1. It's the best of the bunch: UCLES is too knowledge based

- 2.2. 1,000 students interviewed and tested by interviewee in London in the past: only assessed two wrongly but it was to do with a lack of knowledge of function
- 2.3. Sometimes the medical language is fossilized, not the general language
- 2.4. The functional vocabulary may be too set due to protocols in medicine: it is not encouraged to think outside the box in treatment
- 2.5. The declarative side of their knowledge makes doctors wonder why they have to learn things again
- 2.6. Resistance to IELTS is caused by seeing it as a barrier rather than a pathway to PLAB: perhaps IELTS is a fast track compared to what student doctors face in universities
- 2.7. The part of the exam that people (stakeholders) don't like is the fact that scores might need to be lowered to get people through even though they would prefer students of a higher proficiency
- 2.8. Doesn't follow standard procedures to teach, focussing on flexibility and competence
- 2.9. The old PLAB was difficult and prior to using IELTS, more people were failing
- 2.10. Prior to 1995 GMC had a set list of universities which would be accepted: then the WHO list was used but was too broad
- 2.11. IELTS was forced up by nurses and dentists having to achieve higher scores in IELTS than doctors
- 2.12. OSCE based exam for EEU doctors was due to come in (this has since been eclipsed by the latest IELTS announcement that EEU doctors need to take IELTS)
- 2.13. Anger in refugee doctors that EEU doctors did not need to take IELTS
- 2.14. EEU law meant that they were exempt
- 2.15. Having a medical exam for doctors might be problematic for doctors who needed general English for dealing with patients this is a problem with OSCEs
- 2.16. Learning chunks is not flexible enough
- 2.17. Students who are lost in high level classes are too shy or bullish to go back to basics
- 2.18. Could see a difference in how doctors performed (behaved) in general English tests than they did in medical tests
- 2.19. Teaching grammar can sometimes be seen as 'unteaching' medicine
- 2.20. Teaching doctors to be creative can be dangerous and doctors using grammatically accurate sentences in surgery may be equally dangerous
- 2.21. Surgeons have needed to study general medicine in order to do the PLAB
- 2.22. IELTS is a minor step in the long continuum: it can take seven years to get started e.g. documents getting verified in war torn countries
- 2.23. Younger students have marched through it
- 2.24. Women are no better than men
- 2.25. Flexibility is key: "students who move seats pass exams quicker"
- 2.26. If there were a choice of exams, it would be a disaster
- 2.27. IELTS has higher stakes for doctors and this pushes students down
- 2.28. Doctors who do not acknowledge Neuro-biological may well be in denial, this may not be the same for socio-affective matters
- 2.29. 'Why should we?' is probably the biggest barrier for more mature doctors.
- 2.30. Recognition of barriers is itself a barrier: how can students know what they need to do to overcome them?
- 2.31. Some students have had family problems which has affected them enormously
3. What are the specific challenges that refugee doctors face in trying to pass the test?
 - 3.1. ANSWERED ABOVE
4. In what ways do you think these challenges impact on them and their potential for success in joining the GMC?
 - 4.1. ANSWERED ABOVE
5. How do you think these barriers can be overcome?

- 5.1. Teacher training: short courses are good but professional training is needed at all levels. This is lost with the disappearance of PGCE TEFL
- 5.2. Funding is maybe not important but more research is needed on the applied research side of linguistics
- 5.3. More dedicated centres such as the REACHE centre, which is located within a hospital and take students from low level to IELTS preparation
- 5.4. Perhaps more money for such centres
- 5.5. Students who study medicine at the same time as IELTS increase the declarative aspect which holds them back
- 5.6. Students can't transfer from medicine e.g illness, diagnosis and medication equals past, present and future
- 5.7. Language, emotional, situational and competence transfer are problematic
- 5.8. Students can memorise huge chunks
- 5.9. High level of intelligence with low levels of competence in transfer is a problem
- 5.10. Students whose knowledge of language is lower than their skills do well but for doctors this is the opposite "this deficit has fossilized"
6. In your opinion, what are the main obstacles to English language learning that are experienced by overseas doctors trying to pass the IELTS test?
 - 6.1. ANSWERED ABOVE
7. What other challenges do you think refugee doctors face in the UK?
 - 7.1. The system e.g. benefits system and obligation to take up work offered by the employment agencies, families and the stress of daily life reducing the opportunities to study. Some refugees are put in very difficult situations and their situations can become extremely complicated
8. Are there any specific characteristics of refugee doctors that you have observed that may differ from other English language learners or doctors?
 - 8.1. ANSWERED ABOVE

Notes on interview with the advisor

1. In what ways does the IELTS test prepare doctors for joining the GMC?
 - 1.1. Not sure that IELTS prepares doctors as much as acting as a screening mechanism for the PLAB test
 - 1.2. English is tested in IELTS and PLAB for medical training
 - 1.3. Band 7 in IELTS indicates that they have acquired a certain level of language proficiency but it is not sufficient without PLAB
2. What considerations (ethical, accessibility, transferability etc.) were made in the assessment of the suitability of IELTS as a test for GMC entry?
 - 2.1. A lot of dissatisfaction with overseas doctors taking PLAB and failing
 - 2.2. IELTS is available in many centres worldwide: this was one of the reasons that it was selected as the sole test as it prevented doctors going to great expense to arrive in the UK only to fail the PLAB test
 - 2.3. This doesn't relate to refugees who do not have the opportunity to prepare for arrival in the UK
3. Do you feel that IELTS is the most appropriate test for progression to PLAB tests? Why?
 - 3.1. The consensus was that IELTS was a good screening test, although there were some aspects that were not adequate; the biggest problem was listening but the rest was good as a screening test for PLAB in terms of language proficiency and communication skills
 - 3.2. It seemed that the OSCE would be difficult to employ with graduates from within the EEA as it tests medical knowledge
4. In your opinion, what other English language tests might prepare doctors for joining the GMC?
 - 4.1. Occupational English Test that Cambridge bought from the Australian government but work needs to be done to bring it in line with other Cambridge tests but it could one day become a contender

5. What are your views on the US Medical Licensing model of a test of professional competence with an integrated language assessment for all medical practitioners?
 - 5.1. The model is that everyone has to do an internship which is an excellent model but may not be financially viable: senior doctors on panel felt that everyone should have exactly the same training – what is a native speaker nowadays?
 - 5.2. Of the British doctors on the panel, 11% did not speak English as an L1: the concept of a native speaker is outdated
 - 5.3. Any homogenisation is likely to be just as difficult: unhappiness about the disparity between overseas and EEA doctors is certain to be addressed
 - 5.4. There is a historical element to this: there wasn't a concern when the EU was very small: Obani came to the UK as a German and this was the catalyst for the concerns
 - 5.5. Language would have been a part of the Obani case but there were other contributing factors such as tiredness and greed
6. In your opinion, what are the main obstacles to English language learning that are experienced by overseas doctors trying to pass the IELTS test?
 - 6.1. There are several problems with IELTS but the main one is that it was developed to be a university entrance exam which was culturally adapted to life in Britain
 - 6.2. It assessed whether people would be able to benefit from UG study in Britain
 - 6.3. There is a gesture to Australia via the accents used in the listening tests
 - 6.4. People who are not enveloped in UK culture might be disadvantaged by the cultural bias
 - 6.5. The environmental aspect is less relevant to refugee doctors who live in the UK, depending on how and where they live: this is possibly easier than for overseas doctors preparing to come to the UK
 - 6.6. The interviewees may not have understood terms like Socio-affective and Neuro-biological but interviewee accepted that it was simplified for the refugee doctors
7. What other challenges do you think refugee doctors face in the UK?
 - 7.1. There are so many challenges that everybody faces in living in the UK: no comment, has not met any refugee doctors
8. Are there any specific characteristics of refugee doctors that you have observed that may differ from other English language learners or doctors?
 - 8.1. The problem is that their background is not known: apart from the research project, how would a person know if someone is a refugee doctor if they have integrated successfully?
 - 8.2. The traumas of being a refugee and leaving family behind as well as other experiences don't apply to most people may give some insights but may also be left behind
 - 8.3. Inappropriate questions in IELTS speaking interviews may be problematic
 - 8.4. It all boils down to using IELTS for the purpose for which it wasn't originally designed
 - 8.5. Initial medical pathway in IELTS was problematic due to is being quite general and easily outdated
 - 8.6. The research that goes into IELTS development is very well done, a general academic genre should suffice for everyone
 - 8.7. Many economics students think that IELTS is too scientifically oriented but learners should be able to cope
 - 8.8. Teaching students to make answers up is easier said than done for the students: the test is high stakes and an honest answer is a lot easier and less stressful to provide
 - 8.9. It's a matter of training and the degree of training that a student has received

Notes on open answer questionnaire with the researcher

1. What is the success rate in your organisation for refugee doctors attempting to pass the IELTS examination? Why do you think this is?
 - 1.1. The success rate really depends on the level of the refugee doctors.
 - 1.2. Over the last 10 years we have had approximately 205 students pass the IELTS.
 - 1.3. 193 of those are now in employment in their original roles.

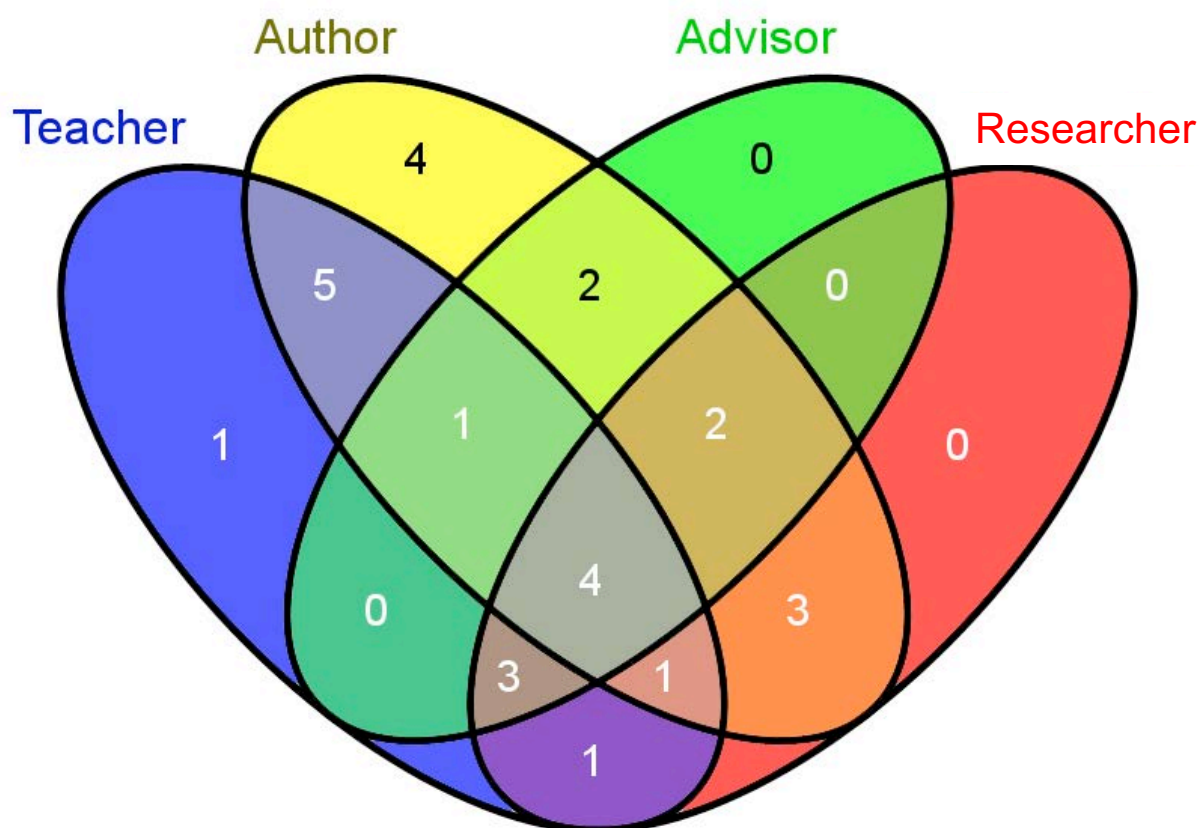
- 1.4. We have found that they overestimate their own ability and will take the examination before they are ready, solely relying on examination technique to get them through.
- 1.5. Many don't seem to realise that the level of their General English needs to be quite high and that they need a certain flexibility and resilience to be able to answer the questions.
- 1.6. Very often they have spiky profiles (low in some modules and high in others) and there is often some indignation that we can't accept their high levels and ignore the areas that they are weaker in.
- 1.7. We spend a great deal of time increasing their vocabulary and broadening their general knowledge in English ensuring that they have thought about a wide variety of topics in English.
- 1.8. Scaffolding around the Arts and then take them to concerts, exhibitions etc, then follow up to ensure that they can communicate effectively around these areas.
2. How long, on average, does it take for an asylum seeking/refugee doctor to join the GMC after passing the IELTS test?
 - 2.1. It usually takes between 12 to 24 months,
 - 2.2. depends on the length of time out of clinical practice
 - 2.3. also how long it takes them to obtain all the relevant documents for the GMC.
3. Do you feel that IELTS is the most appropriate test for progression to PLAB tests?
 - 3.1. The IELTS exam (academic path) is appropriate for the PLAB1 test as it is testing their ability to cope with academic rigour
 - 3.2. PLAB in its entirety is supposed to be equivalent to a UK medical qualification.
 - 3.3. However, IELTS does not prepare the overseas/refugee doctors for the nuances of idiomatic patient and colleague communication.
 - 3.4. Colloquial language and dialect are a huge part of communication and this is missed in the IELTS.
4. What are the specific challenges that asylum seeking/refugee doctors face after passing the IELTS test?
 - 4.1. Firstly there is often a gap in the understanding of medicine in a UK context.
 - 4.2. For overseas doctors this is different as they are coming to the UK willingly, for refugees this is often not the case and there is some reluctance to adapt to UK practice.
 - 4.3. There are cultural issues which also need to be addressed for example in some cultures domestic abuse is seen as a private matter, which is resolved in the home. However, in the UK there are legal frameworks to safeguard children and adults which the Refugee Doctors are very often unaware.
 - 4.4. Doctors who come from cultures where alcohol is prohibited also have difficulty understanding the difference between an alcoholic and a drunk.
 - 4.5. Some of these issues can also be seen in overseas doctors who are not prepared for UK life.
 - 4.6. Clinical reasoning, ethics, clinical governance, PDP, study skills, reflective writing, capacity, mental health, drugs are all areas which they often struggle with.
 - 4.7. For some of the doctors who have been quite senior in their own countries, there is often a period of adjustment needed.
 - 4.8. Their specialities are often very different in the UK and that they may have to start working in a junior role.
 - 4.9. Most of the doctors want to take a more senior job, but they often forget that they have no UK experience and have no experience of the UK training system.
 - 4.10. The responsibilities can become overwhelming if they don't give themselves a reasonable adjustment period.
5. What is the impact of the length of time dedicated to IELTS study on refugee doctors' professional knowledge?
 - 5.1. This is difficult to quantify as for some this will have no impact for others it can be detrimental.
 - 5.2. It's important to note that they must meet the minimum requirements for the GMC.

- 5.3. What we have observed as detrimental is 'IELTS as a barrier', a mindset then occurs around the exam and the focus of getting back to work.
- 5.4. If IELTS is seen as a requirement there is less negativity around the exam and the process as they understand that 'patient safety' is the focus in the NHS.
6. In your opinion, what are the main obstacles to English language learning that are experienced by overseas doctors trying to pass the IELTS test?
 - 6.1. Over-focusing on IELTS techniques rather than learning English thoroughly and comprehensively.
 - 6.2. They also get stuck in the trap of 'in book x it said I must use...' when they have missed the contextual use.
 - 6.3. The doctors also forget that the patients will not speak in an academic manner and they need to understand more colloquial and idiomatic language than the academic word lists.
 - 6.4. Very often they dismiss language learning around general topics as unnecessary (e.g. environment, education) because they know about it in their own language but the vast majority do not have the English language skills to be able to effectively communicate their thoughts without the practice in English.
7. What other challenges do you think refugee doctors face in the UK?
 - 7.1. Beyond language learning there are cultural and social issues which they are often unaware. They may offend an interview panel by refusing to shake someone's hand.
 - 7.2. Or feel isolated when they don't participate in team outings to the pub, not realising that you do not have to drink alcohol and it's often better to explain why you don't want to go, rather than rebuff every attempt of engagement by colleagues.
 - 7.3. Many of the doctors don't understand UK working practice around probationary periods e.g. being monitored and feel that they are being discriminated against.
 - 7.4. There are so many issues it's very difficult to pinpoint exact issues. For example, the language that we use in the workplace, suggesting rather than commanding/telling can often be confused by overseas doctors as it's not clear to them what was said.
 - 7.5. Other issues include being able to ask patients for clarification as in their own culture admitting not understanding or knowing would be professional suicide
8. Are there any specific characteristics of refugee doctors that you have observed that may differ from other English language learners or doctors?
 - 8.1. Refugee doctors are very often resistant to the process for re-qualifying as they don't generally want to be in the UK, they want to be in their own countries.
 - 8.2. Many of them just want to be working to gain some semblance of normality and see the process as a hindrance/barrier rather than as a requirement.
 - 8.3. Many are in a cycle of being a victim, especially for those who have been in the asylum process for a long time.
 - 8.4. They are very often strong willed and we see cultural differences being imposed on their peers from other countries but also on the teachers.
 - 8.5. They generally all want to be seen as normal overseas doctors, not refugee doctors.

Appendix 26: Coding of the Notes from the Expert Witness Interviews

| Codes | Teacher | Author | Advisor | Researcher |
|---|--------------------|---|--|--|
| Age related performance | 6.4 | 1.13, 2.23, 2.28 | | |
| Alternatives to IELTS | | 2.12, 2.15, 2.26 | 3.2, 4.1 | |
| Capability | 6.2 | 1.2 | | |
| Cultural aspects | 8.2 | | 6.4, 6.5 | 4.4, 4.5, 4.6, 7.1, 7.2, 7.4, 7.5, 8.4 |
| Declarative knowledge vs competence | | 1.5, 1.6, 1.7, 1.8, 1.9, 1.25, 2.5, 5.7, 5.9, 5.10 | | 6.2 |
| Deprofessionalisation | 4.1, 4.2 | | | 2.2, 5.1, 5.2 |
| Differences in medical cultures | 4.2, 4.3, 7.2 | | 5.5 | 4.2, 4.3, 4.7, 4.9, 4.10, 4.11, 7.3, 7.4 |
| Disparity in policies for EEU doctors | | 2.13, 2.14 | 5.3, 5.4, 5.5 | |
| Emotional learning | | 1.22, 2.17, 5.7 | | |
| Flexibility in learning style | 3.3 | 1.15, 1.16, 1.17, 1.20, 2.8, 2.16, 2.25, 5.8 | 8.8 | 1.7, 1.8, 6.4 |
| Gender related performance | | 2.24 | | |
| IELTS teacher training | | 5.1 | | |
| Impact of displacement | 3.5, 7.1, 8.2 | | 2.3, 7.1, 8.1, 8.2 | 2.3 |
| Impact of social responsibilities | 3.1, 3.2 | 2.31, 7.1 | | |
| Learner strategies | 3.4 | 1.10, 1.18, 1.19, 1.24 | | |
| Length of training for success | 1.1, 1.2, 1.3, 1.4 | 1.1 | 8.9 | 1.1, 1.2, 1.3, 2.1 |
| Link between IELTS and PLAB | | 1.4, 2.9, 2.22 | 1.1, 1.2, 1.3, 2.2 | 3.1, 3.2, 6.3 |
| Medical to language skills transfer | 4.4 | 1.3, 1.12, 2.3, 2.4, 2.18, 2.19, 2.20, 2.21, 5.5, 5.6 | | |
| Motivation | 8.1 | | | |
| Negative attitude towards requirements ('Why should we?') | | 2.29 | | 8.1, 8.2, 8.3 |
| Negative learner attitude to IELTS | | 1.26, 2.6, 2.27 | | 5.3, 5.4 |
| Recognition of barriers | 1.5 | 2.30 | 6.6 | 1.4, 1.5 |
| Research, funding and support | 5.1, 5.2 | 5.2, 5.3, 5.4 | 5.1, 5.2, 8.6 | |
| Risk taking | | 1.14 | | |
| Status | | 1.14, 1.21 | 5.2 | 4.8, 4.9, 4.10, 4.11, 8.5 |
| Suitability of IELTS | 2.1, 2.2 | 2.1, 2.2, 2.7, 2.10, 2.11 | 1.3, 2.1, 3.1, 6.1, 6.2, 6.3, 6.4, 6.5, 8.3, 8.4, 8.5, 8.7 | 3.3, 3.4 |
| Transfer between language skills | 1.6, 6.1, 6.3 | 1.11, 1.23, 5.7 | | 1.6, 6.1 |

Appendix 27: Details of the Intersecting Elements Discussed by the Expert Witnesses in the Venn Diagram



The teacher discussed 16 elements in total, the author discussed 22 elements in total, the advisor discussed 12 elements in total and the researcher discussed 14 elements in total

Elements only in "Teacher":

Motivation

Elements only in "Author":

Emotional learning

Gender related performance

IELTS teacher training

Risk taking

Common elements in "Teacher" and "Author":

Age related performance

Capability

Impact of social responsibilities

Learner strategies

Medical to language skills transfer

Common elements in "Teacher" and "Researcher":

Deprofessionalisation

Common elements in "Author" and "Advisor":

Alternatives to IELTS

Disparity in policies for EEU doctors

Common elements in "Author" and "Researcher":

Declarative knowledge vs competence

Negative attitude towards requirements ('Why should we?')

Negative learner attitude to IELTS

Common elements in "Teacher", "Author" and "Advisor":

Research, funding and support

Common elements in "Teacher", "Advisor" and "Researcher":

Cultural aspects

Differences in medical cultures

Impact of displacement

Common elements in "Teacher", "Author" and "Researcher":

Transfer between language skills

Common elements in "Author", "Advisor" and "Researcher":

Link between IELTS and PLAB

Status

Common elements in all expert witness statements:

Flexibility in learning style

Length of training for success

Recognition of barriers

Suitability of IELTS