**Curriculum evaluation focused on the experience of IMG trainees in Yorkshire and the Humber - March 2010**

**Introduction**

UK LETBs are responsible for the delivery and quality assurance of GP specialist training, based on the GP curriculum. In 2009, Yorkshire and the Humber conducted a service evaluation of delivery of the curriculum, looking specifically at the experience of International medical graduates (IMGs) and their educators. Yorkshire and the Humber is home to some of the largest Asian communities in the UK and has a significant number of IMG trainees, most of whom are Asian.

Although this focus was prompted by a wider national discussion on the disparity in performance in the MRCGP between UK and non-UK graduates, the evaluation was concerned with the educational rather than the assessment issues although each has implications for the other.

**Method**

A questionnaire was devised through an exercise with IMG trainees in Sheffield, further developed through a regional conference with training programme directors and senior educators. This generated a number of specific insights into engagement with the curriculum that could be used to introduce and prompt further thinking. The questionnaire was distributed electronically through the GP School to cascade to the training community in the region with a covering letter explaining the context and intended use of the material.

Although the GP School was the focus of this evaluation, the questionnaire was also shared with a number of other communities including educators from other parts of the UK, the UK GP trainees via the RCGP ‘Associates in Training’ group and with RCGP examiners.

The questionnaire gave headings from the GP curriculum with short explanations of the meaning of the curriculum context where this was needed. An additional section on ‘teaching methods’ was included as this was pertinent to the use of the curriculum. Recipients were prompted with the insights previously gained and were asked to:

* Provide insights of their own into how the curriculum was being used by IMG trainees and particularly any difficulties that were being experienced
* How these issues could be addressed by the training community
* Where possible, who respondents thought would be best placed to address the issue.

**Results**

42 educators and trainees responded to the full questionnaire although many other comments were received informally from around the UK. The questionnaire responses have been collated have not been edited so as to convey the authenticity of the views expressed. The material has then been:

* Themed
* Analysed at curriculum context level, resulting in a number of comments and observations shown in boxes.
* Used to produce guidance for educators, targeted to different audiences.

Looking at the experience of a particular community is as sensitive as it is challenging and we have tried not to extrapolate inappropriately beyond the material that we have gathered.

**Next steps**

This material will be disseminated through the GP School website so that it can be used as a resource, particularly for the training community. Further developments will follow and groups have been formed within Yorkshire and the Humber to look specifically at IMG issues and more widely at the delivery of the curriculum to all trainees, the one being a subset of the other.

**Educational possibilities arising from the evaluation**

This is presented in a separate document accompanying this analysis. We hope very much that both documents will contribute to a wider discussion that helps the professional community to understand the challenges but also the great opportunities that diversity brings.

**Collated responses and commentary**

**Communication**

|  |
| --- |
| **Communication**  **Observations and comments based on the survey**   * Communication is the single biggest issue and many of the other problem areas are compounded by this. * In addition, without the language, it is very hard to educate, improve understanding and thereby address other problems * Language problems include colloquialisms, which can be learned through familiarisation with local culture. * Pronunciation and accents can cause difficulty for both doctors and patients and need to be addressed in their own right. * Developing stock phrases to use in consultation is an understandable shortcut but is not advisable in the long term as a key feature of the consultation is the doctor’s ability to adapt language to the patient and the problem. * Acquiring the non-verbal communication skills is at least as important as addressing the language skills as people may react disproportionately e.g. if cues are missed or the doctor’s body language appears inappropriate or unhelpful. * Beyond the language barrier, some communication tasks may need particular attention, for example, if doctors are not used to having to explain thoughts and plans. This may be as much a ‘medical culture’ issue as an ethnic one. * Given that the UK is a multicultural country, many of the problems and ‘solutions’ identified could apply to all doctors when there are language and cultural differences between them and their patients |

**What do IMGs and others say?**

**Cues**

* British people often don't demonstrate much emotion, so the cues are subtle
* I sometimes get these wrong--- and sometimes I don't know that I am doing so

**Explaining the problem and confirming understanding using appropriate language**

* I'm not used to having to explain things. Back home, most patients would accept my ‘authority’ without question.
* Because I don't often have to explain, I’ve found my own way of doing it, but tend to do it in the same way every time. Therefore, I find it difficult to change the way I explain and modify it to what the patient might need.
* Patients use humour, which I don't always understand. It makes me nervous about using humour myself
* Accents are sometimes a problem-- for both me and the patient

**General**

* This is the crux and input from linguistics and clinicians essential
* We should focus on both verbal non-verbal and written communication
* Preferably small group work with non-threatening role play and writing medical referrals or replying to letters
* This could be done by the GP School or Faculties who have a high IMG GP population

**Subtleties of language**

* The main issue here in my opinion and experience is understanding the subtleties of the English language in particular two aspects. Firstly, the double entendres and often the use of sarcasm. Colloquialisms can be difficult, for example, when asking patients about depression, one may tend to ask how is your “get up and go” to which most patients predictably will offer “doctor is got up and gone”.
* The use of understatement in English
* The role and the use of irony in the English culture
* Age – difference in attitude to illness and use of euphemisms to describe ailments
* Dialects – the local usage of words and phrases

**Formulaic language**

* Because IMG are often speaking in not their first language , explanations can sound stilted , or may ‘ learn ‘ one from a trainer etc., and not be able to adapt it to different situations , can sound formulaic and sometimes convey the wrong impression e.g. ‘ what do you think I can do for you ‘
* I have been told to phrase things in certain ways and I do always fine this successful

**Accents and pronunciation**

* I have sometimes had great difficulty in understanding senior colleagues with foreign accents. This can immediately affect rapport & medically, instructions/advice can be misinterpreted. It’s also difficult for patients to understand. When I have sat in clinics with foreign doctors, I sometimes haven’t understood what they said, so how can the patient (or examiner) understand? Generally I have found foreign trainee’s knowledge of the English language is excellent (far better than my knowledge of foreign languages) & I greatly admire that. The problem is pronunciation for some. I think patients can be prejudiced to foreign accents and I think it’s mainly because they can’t understand the doctor, especially if elderly & deaf. If they don’t understand the doctor, it can create mistrust.
* Accents are important and recording and playing back may be a useful tool.

**Ideas on how to address this**

**General**

* Perhaps this is an area we as educators need to be smarter about – we do devise educational sessions around a UK model and don’t often appreciate how different this must be for others. With any educational exercise the beginning / start is crucial and if this isolates some people we will struggle to engage them thereafter is there a role for new modules for all trainees, designed to raise awareness of cross-cultural communication issues?
* Not sure if said already – but patients should be surveyed about this topic – what are the issues they identify?

**Cultural familiarisation**

* Trips out – Theatre, National Trust etc., and discussion
* The doctor needs to immerse them self in British culture-they can get involved with local groups serving their community-meeting people in the non-medical setting would help.
* Encourage trainees to attend residential meetings and social events.
* TV or Press study groups e.g. could be cross cultural so that white British trainees watch and comment on Al Jazeera and IMGs on UK media. What about the US, China or Russia?
* Films, Books, Television extracts.

**Communication skills**

* Trainer to introduce these ideas in tutorials or debriefs. I do following an early in house MSF to introduce comments and observations on how the team communicate with each other.
* Simply keep practicing the way that is currently being taught. Say what you think your data gathering and clinical examination are pointing at i.e. a likely diagnosis, what the different available options are, gently nudge your patient into making a choice from what is on offer. Just practice it. Forget about what you did at home.
* Observe trainer consultations – evaluate the feelings you observed as shown by the patient, compare this with your trainer, i.e. to show accurate picking up on cues and understanding of the conversational tone.
* Use of video and role playing different ways to say things . Sit in with a variety of different GPs to observe their style.
* Watch videos of consultations with sound off Look at what is happening rather than listening. Could be done by VTS or GP School suggest this is highly skilled perhaps a GP School member with special interests in IMG should be responsible. Needs expert facilitation by linguists or ESOL teachers.
* Balint Groups.
* Language trees can be given by GP School but trainees can add to them themselves.
* DVDs of examples of good clinical care and management, use of simulators with their feedback as a patient as a goldfish bowl .
* Developing Rapport and Problem Framing Modules.
* Using acting lessons to improve communication skills.

**Cues**

* Understand cues: Use games , role-play social scenarios than just patients( Sales person, bank transaction).
* Learning about cues: Madads, skits, comparing cartoons from different countries, Pictionary, language games.

**Humour**

* Discuss arts and British humour which is widely used by patients and useful to understand.
* Popular press / TV might be helpful to see what makes British laugh ( e.g. mock the week, any questions?).
* Some British GPs don’t find all their patients’ humour that acceptable either, don’t be afraid to say when it isn’t.
* Don’t go there. Jokes are intensely regional and class/education dependent. Better just to stay cheerful.

**Accents and pronunciation**

* Would foreign trainees benefit from formal help with pronunciation of the English language? Trainers can help by reminding trainees to speak slowly and clearly – there can be the tendency for all trainees to speak fast.

**Working with colleagues**

**Working with colleagues**

**Observations and comments based on the survey**

* Finding out about the culture, which is important for communication with patients, is equally important for communicating with colleagues. With colleagues, doctors need to find out about the social culture but they also need to understand the professional culture so that they know what colleagues expect from each other in the UK.
* These expectations are often related to the context in which doctors work, such as the values, nature of hierarchy, leadership, accountability and formality in the team.
* These features may be different to the trainees’ previous experience.
* Learning is two-way! Colleagues need to learn from the new member of the team; what are the doctor’s background, beliefs and expectations? If the motives are made clear, sharing such things is potentially enriching for all those involved in the discussion.
* Culture should be a source of pride and it is important to integrate with the team but to maintain one’s identity whilst doing so. Seeing and learning from these differences rather than hiding or denying them is the key to using the power of diversity.
* We are all ambassadors for our cultures. Lessons learned from colleagues can have a great influence on how we perceive and interact with others from the cultures they represent.

**What do IMGs and others say?**

**Working with colleagues**

* The work culture in the UK is likely to be very different -- I'm not really sure
* For example, back home, doctors have the main responsibility and are expected to take the lead. I would treat other members of the team with respect, but they are not meant to be ‘equal’ I also don't know the work culture, what employers and employees expect from each other and what the implications might therefore be for my work as a GP. How do I get to find all this out?
* The way that doctors and staff talk to each other in this country is different. I'm not sure what is ‘the right way’. For example, what are acceptable topics of conversation? I always seem to be meeting new people but how should I break the ice?
* How and when do I move from being formal to being informal?
* Once I know people, I find that I can relate to team members even better than some of the UK graduates!

**Induction periods**

* We get told a lot of stuff, but I'm not just learning about the training process. I also need to know about the new country and the new culture.
* Socialising can be a great help in meeting future colleagues and finding out how to fit in.
* It's great when the scheme organises this, but it's also an issue for trainers.
* I'm not always sure that people are interested to find out about ***my*** background and why I think and believe in the ways that I do.

**General**

* What are the primary health care team members’ jobs are and what they can do would be a start.
* I don’t always ask trainees about their background as I don’t want to appear rude or prejudiced. I suppose I am in fear of unintentionally highlighting differences and making them feel different. I suppose I need to realise that by asking people about their background actually makes them feel included and helps me understand their culture and them as an individual. My own ignorance about other people’s cultures also prevents me from initiating discussion about it.

**Ideas on how to address this**

**General**

* Just be yourself, be open and honest about your lack of knowledge, and demonstrate your desire to know how things work and what makes people tick, don’t be shy to ask questions, be nosey, go out with colleagues, sit in the tea room and keep listening/talking.
* A warm, friendly and intelligent person cannot be put down. Don’t feel shy to keep your own name, people generally like to hear your name, the meaning of your name. Westernising your name is not a necessity.
* Be aware that illness does not exist in isolation from the rest of the social environment
* Facilitate understanding the accepted norms of behaviour and how there are changes in greetings, topics of conversation, situations when they can be misunderstood etc., discussing ice breakers.
* I think that doctors from a different country can sometimes end up filling gaps (extra shifts )as they are generally hard working and sometimes more flexible – doctors working with them are likely to be relieved they are not having to fill that shift themselves and perhaps keep a distance because they feel guilty about it.
* Having worked with a lot of Asian doctors I have observed the differences discussed here and I am fascinated to hear about things from their perspective. I have never had a problem with peers but in several cases I have worked with a registrar who has trained abroad (in an Asian country) and have occasionally felt that when I have said something they do not listen to my opinion. I would be interested if this was explored further, i.e. the diff. in seniority, is it viewed differently?
* UK is multicultural and multi-social –each has its own set of accepted behaviours and customs

**Social activities/ group working**

* An IMG would need to spend longer with primary healthcare team members, perhaps even up to a week so that they learn the role. Given the GP training is extended, I do not think that this should be a problem. Furthermore, the induction periods are often extremely compact and condensed often seeing two members of the primary healthcare team on the same day without much time for reflection. Equally often during the induction period, the time with the other members of the primary healthcare team is missed due to illness, sickness, and other work commitments.
* The medicine and literature day at Yorkshire Sculpture Park was a useful opportunity for me to discuss with a IMG some of the differences / difficulties he and his wife found in NHS medicine. Difficult to force anyone to learn about cultural issues when they perceive ‘book learning’ as higher priority.
* ‘Getting to know you’ exercises, life maps, magic questions, Kiddy ring,
* Stay with a UK family for a day!
* This really should come from simply observing how other colleagues interact, and copying that.
* More integration and socialising can address many of the above issues – twice term social night out, away days and active encouragement of IMGs to attend
* At work, mentors maybe social mentors or a buddy scheme may help integration relationships with colleagues.
* Smaller groups help trainees get to know each other
* Actively encourage participation in group discussion
* Trainees could facilitate sessions about their own cultures – this gives colleagues the opportunity to get to know them & understand them but also it helps us understand our patients who may have the same culture
* Take a curry to work! Be prepared to talk about it. Amazing how much this is appreciated.
* Participate in Multidisciplinary Team meetings whenever possible
* Attend Case Conferences
* Attend management meetings in Hospital and in GP
* Concept that every Firm or GP Practice has its own history of how to communicate and how to deliver quality service The variation of hierarchy The learning workplace and the openness to learn from patients down to staff needs to be stressed
* Observation of Practice Meetings of every sort would be helpful especially time to reflect on what was going on with the Chair of the meeting afterwards
* Joint surgeries – observing how it’s done in practice
* Family and discussing what their aspirations are when they attend a doctor as well as spending time with other primary healthcare team members both in hours and out of hours would also be beneficial.

**Holism**

**Holism**

**Observations and comments based on the survey**

* Understanding holism is part of understanding the culture. IMG and UK doctors will have different experiences of the way in which holism is practised in healthcare and society generally, and this is an important area of joint learning that will be as helpful for UK doctors treating patients from other cultures as for IMG doctors themselves.
* IMG doctors understand holism and experience it especially through the extended family system. This may lead to assumptions about the degree to which holism is part of British culture and reduce spontaneous enquiry.
* Psychological illness is taboo in some cultures and this may affect doctors’ attitudes, willingness and skills to explore this dimension.
* Doctors from fee-paying health services may be more conscious of the cost to the ‘consumer’ of their time and may limit psychosocial enquiry as this may be seen as time-consuming and irrelevant by the patient.

**What do IMGs and others say?**

**Holism: understanding problems in a psychological, social & cultural context**

* Because the expectations of doctors are different, my focus back home was more medical. I'm not used to thinking in terms of a multi-layered problem with a mix of psychological, social, and cultural factors.
* Back home, I know the social structure very well, particularly what is expected from the various members of an extended family.
* For example, the elderly often have a significant say in what goes on, the younger members less so.
* Therefore, I'm not used to thinking about or checking out how patients are supported by their families. Perhaps I just assume that families offer support?
* If I did ask about psychosocial factors or family support back home, patients would be perplexed or even insulted that I assumed the possible lack of support.
* I don't know how people interact with each other over here. What are their expectations of each other? What is it permissible to talk about? What are the taboos? What are the different social classes and what practical difference does this make for my work as a doctor?
* Most Asian cultures maintain a respect for the elderly not seen in the usual British community. This might lead to erroneous assumptions. This might also lead to inappropriate veneration of trainers and reduce critical faculties.
* I have different values with respect to relationships, socialising, food and alcohol. I find it difficult to understand the values of people here and that my culture may be strict.
* How do I empathise effectively?
* Within the Asian subcontinent, healthcare is not a free service. It is paid for by the individual at the point of contact and need. Treatment, I believe, will not occur if there are no funds to pay for it. Harsh and alien though this may seem to those working in the NHS, but it is a very cruel and literal “fact of life” in the Asian continent. Therein, doctors with a training in IMG countries will be expected to treat the here and now quickly and efficiently. There is a trend to explore social and cultural impacts of a disease or a chronic illness, but even within the higher classes that IMGs may treat, a good doctor is seen to be regarded as one who can quickly diagnose and treat the presenting patient’s complaint without recourse for further treatments, assessments, and follow-ups. Such markers of higher patient centred and deliberated healthcare delivery in the United Kingdom would be perceived in Asian continent as “overegging the pudding or indeed lining one’s own nest financially”.
* Delivery of healthcare in Asian countries is very specialist centred where patients would choose to go and see a specialist whom they perceive can deal or is most appropriately qualified to treat their symptoms. Psychological problems are often swept under the carpet or not addressed for fear of the stigma that it attaches not only to the person, but to the person’s family and if there are children of marriageable age, then this would be treated even more covertly often being hid within the family itself.
* By dealing with the patient over a long period of time, the holistic issues of the psychological implications, the sociological implications, and the socioeconomic implications for the patient and his family are encountered by the doctor and dealt with. This is not a typical feature of IMG training.

**Ideas on how to address this**

**Awareness-raising experiences**

* Be aware that illness does not exist in isolation from the rest of the social environment
* Buddy up with someone from similar culture locally Discuss in half day release groups about family dynamics, work ethic etc. in each, GPs culture in HDR group
* Have a friend or “buddy” which you meet with on a regular basis to discuss British culture and social norms in the UK over a drink or a meal in an informal environment
* Spend time working as para-medicals i.e. in nursing homes or on wards getting to chat to families and patients.
* Homework for trainer/trainee tutorial – watching a TV programme together
* Same culture peer group via VTS
* Read national newspapers, join local activities, join a local club, mix with others and talk about yourself and your own background and experiences openly
* Literature – a reading list of relevant novels preferably not overtly medical in content.
* Not easy – living in the UK after growing up abroad, not necessarily that everything ‘we’ do is right… but if you want to work/live here need to be aware of such cultural issues.

**Teaching**

* Perhaps we need to be much more overt about what we are training people for – i.e. to be a GP in the UK – and as a result understanding the culture and context is really important – not just for IMGs – but there are huge differences between different parts of the country – my region (North of Scotland) covers large urban areas to remote rural communities but trainees should complete training confident they can cope anywhere in UK.
* Session on support networks, normal household structure, using case scenarios – same clinical scenario but placed in different social and cultural settings and discussion on how these differences have an impact on clinical management decisions
* ‘Something I learned about the culture this week’
* Sessions on 'being unfamiliar with the local culture/being the stranger in this land' then extrapolate to colleagues & patients
* As a white doctor from the UK I feel these exact sentiments about people from different backgrounds living over here. I sometimes feel I apply my rules and don’t quite develop the Dr-patient relationship that I am aiming for. I feel I could learn a lot from Asian doctors coming from those backgrounds (I live in an area with a large longstanding Asian community) about their health beliefs and usual way of working. Perhaps GP teaching could include sessions on such topics and we can learn from each other about the more subtle differences in culture that are difficult and require honesty and reflection to explain.
* Sessions on 'being unfamiliar with the local culture/being the stranger in this land' then extrapolate to colleagues & patients
* Exploring with trainee colleagues more generally on differences in specialty training schemes about how families work, how generations interact, ideas and customs around family planning, spirituality, death,.etc. in a supportive environment would allow learning both ways and consideration of similarities and differences.
* Don’t think there’s an easy short cut – most knowledge of this comes from exposure over a lengthy period of time & this is the problem. However, an introduction to local culture/history might help at the beginning of ST3 we need assimilation, not immersion(i.e. dipping in and out)
* Construct and discuss family histories in GP
* Discuss any cultural sticking points with peer group at VTS. Needs to be an open and understanding forum where trainees are not embarrassed to speak up
* Trainer to have tutorial regarding cultural issues, discussion about trainee culture to understand trainee needs and understanding of cultural issues.
* Watch Coronation Street or EastEnders. Discuss the social aspects; are they representative of British Culture?

Discuss:

* Role of the Doctor and the status
* Society’s expectation of a doctor
* Multi-cultural society
* Wide social differences
* Look at videos and concentrate on holism for say one whole surgery and then build it into routine. Show videos to your trainer and get feedback on how u could have approached this issue.
* Methodology – exposure to GP / practice swaps / group-work / sessions on local history, culture
* Emphasise the importance of Social and Psychological issues. Medical Complexity is trans cultural but is clearly framed differently in different cultures.
* Dissect Descartes

**Questioning**

* This I think can be done by a more confrontational approach by the trainer. I think this paradigm or essential competency is best tested by questioning the candidate to see to what depth the doctor can manage the patient, for example, consider a teenage diabetic and once the medical issues have been discussed then psychological issues, social implications for the girl, cosmetic implications as perceived by the girl, reproductive conceptions, family implications, meal times, holidays….. Essentially the idea for the trainer to keep going and pulling out scenarios and questions as though it is a rabbit out of a hat, for example, a good candidate may be able to address that in reproductive issues whether or not how the girl might fear the diabetes affects her pregnancy equally the good candidate may go on to suggest that they are worried that it may be “passed on to their children”
* How do I react to new situations?
* What questions can I ask of a patient given their social and cultural background?
* How to ask these questions?
* We run an induction course for IMGs/refugee Drs/EU Drs.
* We run a course for those who have failed the CSA and concentrate on culture/ language therefore offering something different from the other faculty led CSA courses
* Quiz with statements about British Culture – true/false, what is and is not acceptable to discuss with people you do not know well.

**Clinical management**

**Clinical management**

**Observations and comments based on the survey**

* What patients expect from the consultation will differ in different cultures. This may affect the way doctors consult and influence who the patient chooses to see.
* The UK consulting model encourages GPs to ‘wait and see’, to educate and involve patients and use other options than just issuing a prescription. Doctors and patients from other cultures where the emphasis is on making a definitive and speedy diagnosis/ prescribing a ‘cure’ may find this problematic.
* Additionally, doctors may not be used to the range of management options available in the NHS and this may limit the choices that are offered to the patient.
* Doctors from countries where medico-legal challenges are rare, do not have the extra spur to practising careful medicine that UK graduates grow up with.
* ‘Common conditions in primary care’ means very different things in different countries. In addition, the implications of symptoms and signs vary widely, e.g. fever may mean a life-threatening disease in the tropics whereas it may be badged as a ‘minor illness’ in the UK.
* Cultural factors may create additional difficulties for consultation between men and women particularly when sexual issues need to be discussed.

**What do IMGs and others say?**

**Clinical management**

* In other cultures, patients may expect a concrete solution. e.g.: problem identified, prescription /treatment given, but not advice/education/wait and see--- which to them would seem negligent on my part.

**Patient expectation**

* Some patients **choose** to see me (a non-UK trainee) because they think I can give them what they can't get from the British doctors. Sharing the same language is an obvious reason, but also doing tests/giving prescriptions/referring quickly to a specialist. Maybe also they don't want to be involved in making the decisions?

**Safety netting**

* I'm comfortable with the idea of reducing patient risk. However, I don't have the additional driver of reducing risk to myself caused by patient complaints or medico-legal problems. Therefore my ability to reduce risk overall, e.g. through the safety net, is less developed than it needs to be.
* IMGs are used to “hard definitive symptoms and hard diagnosis”. Where the symptoms are vague a rather fixed, rigid symptom selection process is performed
* The watchful waiting philosophy and temporization that is often the hallmark of general practice could again be perceived by the patient as lining one’s own nest and so IMG doctors would not follow this pattern or be familiar in following this pattern. IMGs should be encouraged to recruit the history and as much information as they can from patients of different speaking languages, but their treatment should clearly be consistent with British standards. Often in Asian countries, patients will seek a magical one tablet that would cure their diabetes, asthma
* The medical strategies I use have often been more limited by resources. Medical care is sparse and has to be reserved for the most important cases or patients who can pay for it. I’m therefore not used to the idea of patient choice or to the range of the choices that are available in the UK.
* I'm therefore also not used to the idea of changing the system to improve resources and choices locally.

**Ideas on how to address this**

* Nothing can replace getting more experience under the belt, seeing more patients in general practice, watching how your trainer does it, practice, practice, practice. It’s not rocket science, it will come to you if you have the knowledge and can think logically.
* Create aware of Medico legal cases which illustrate what ‘risk’ means in the UK : use MDU/MPS cases
* Explore with trainees why they don’t have this additional consideration of personal risk?
* Discuss the concept of GP as gatekeeper
* Be aware of illnesses more common here than in other countries
* Difficulty for male GPs discussing sexual and emotional problems with female patients, which might be considered inappropriate in other cultures
* Attachments to sexual health clinics / FPC
* CbD and COT
* Discuss role of non- doctors clinical staff

**Managing medical complexity**

This competency is about aspects of care beyond managing straightforward problems, including the management of co-morbidity, uncertainty and risk, and the approach to health rather than just illness.

**Managing medical complexity**

**Observations and comments based on the survey**

* Because of differences in GP role and patient expectation, trainees from other cultures may not be used to dealing simultaneously with multiple problems, to spending time on preventative activities or to the emphasis on continuity of care.
* The demographics may also mean that there are fewer older patients and therefore fewer opportunities for using the skills of medical complexity. However, the need to practice ‘complexity’ remains as the skills are relevant to all age groups.
* Health promotion can’t be seen in isolation but requires doctors to understand it in the wider context of the values, aims and processes of the NHS in which it is set.

**What do IMGs and others say?**

**Medical complexity**

* Abroad, patients are usually younger, cases more acute and very much less protocolised.
* I can't assume that my patients will return to me, so ‘continuity of care’ doesn't attract the same emphasis back home.
* Because I'm much more used to dealing with medical disease back home, there is the emphasis (or luxury?) of focusing on health promotion and preventative measures.

**Ideas on how to address this**

**Multiple problems**

* Case sharing Videoing own consultations One to One feedback
* Discuss non-clinical patient problems as these can be new and unexpected to trainees
* Mentoring from more experienced doctors when new doctors qualify-discussion groups looking at management of patients with complex problems to make sure all aspects of care have been addressed.
* Sit in with your trainer - see how they do it
* The patient as a jigsaw – pieces all need to fit together and need to have complete jigsaw as can miss the whole picture if one piece missing. Make up jigsaw of patient with several chronic problems, acute problem, several social aspects – carer, mother, wife, occupation, overweight, smoker, etc.
* I would expect this to be best tackled in groups / day release sessions and to a greater or lesser extent applies to all trainees – but because of the particular issues in transferring into a different culture we again need to be more overt and open about what we’re hoping trainees will learn – in the past there’s often been an expectation that exposure and experience will naturally broaden trainees’ approaches but with the curriculum, WPBA etc we have the opportunity to be more explicit
* Every HDR should have a good chunk of time set aside for role play in the context of the subject for the session. Trainers and trainees need to get into the chair and demonstrate how a consultation is best handled in both straightforward cases as well as medically/socially complex cases.

**Health promotion**

* Address the change in view of health care from treatment of disease to treatment of an individual
* Fairly early on my first GPR post I was asking / making appointments for patients (e.g. with mental health problems) to come back and see me.
* Perhaps feel more confident to do this even with more minor stuff – will help with safety net aspect as well.

**Understanding the approach to ‘health’ in the NHS**

* Consider system failure & system re-design within the NHS. May utilise audit or significant event monitoring or quality improvement projects.
* Formalise PCT exposure for IMGs so may spend some time working with / in the PCT
* The role of education of the patient and preventive measures
* The changing nature and processes of NHS
* Adaptability of the doctor so as to recognise the similarities/differences between wards and hospitals, GP practices
* The recognition that the NHS is a ‘political issue’ so will always be the subject of change because it is in the political spotlight
* The role of funding in the NHS
* NHS – ‘cradle to the grave’ – healthcare is a life-long issue. How does the doctor interact with this issue?
* Each area has its own particular management patterns GPs/ PBC etc.
* Could written information about these issues and about how UK medicine works and is focussed be given out just to raise awareness when starting work?

**Professionalism**

**Professionalism**

**Observations and comments based on the survey**

* Professionalismrequiresdoctors to follow certain codes of practice.Codes of practice reflect many problem areas, such as how to manage patients in the grey areas of the law. Many of these problem areas are highlighted through the GMC ‘Duties of a doctor’, which is a vital resource for all doctors to debate what medical professionalism means in the UK and to benchmark their own standards.
* Ethics, like all values, vary between cultures and the same action may be seen as good professional practice in one culture and unethical in another. It is therefore possible that a doctor might be thought to be unethical when they might have acted out of ignorance and from highly principled motives.
* Doctors’ views and actions have to be understood in this light and it is important to routinely explore ethical issues so that attitudes and behaviour can be discussed and shaped in line with the expectations of British society.
* Autonomy is an ethical principal that causes difficulty for those trained in a doctor-centred approach, where the notion of helping patients to make decisions about their care may be seen as inappropriate or unkind. When these doctors consult in the UK, the clinical aspects of management may be sound but encouraging autonomy by discussing management options, explaining risks and sharing decisions can be difficult and can feel ‘wrong’.
* If the background is not understood, such doctors can be thought to be unprofessional in their behaviour.
* The patient-centred may be unfamiliar or unnatural to some, but can be taught through discussion of attitudes and the development of communication skills.

**What do IMGs and others say?**

**Ethical approach**

* Some ethical approaches don't translate. For example, end of life care is different and back home it would not be acceptable to stop active intervention in terminal care. I therefore wouldn't discuss it because if I did it would be unethical. However over here, I might be thought unethical if I didn't discuss it!
* Therefore, I might be interpreted as being unethical in a new culture when in fact; I have ethical reasons for my behaviour according to my own culture and reasoning.
* Confidentiality is an issue I am not used to dealing with in the same way at home and the UK. Involving patients and varied relatives/carers does not come naturally
* Problems reconciling the law with patient care. For example, under age sex is against the law, but when a 15 year old comes requesting contraception I’m not expected to call the police or social services even though I know she’s engaged in illegal activity. The first time I encountered this my lack of knowledge meant the patient didn’t get the care she should have if I’d been more aware of these issues.

**Patients in the UK are given opportunity to be involved**

* UK GPs respect and encourage autonomy, but in many other cultures being paternalistic is thought of as being kind. “I will take care of your medical problems”.
* There is a major cultural barrier here. Back home, I am expected to take responsibility and dictate the plan.
* I don't appreciate what it feels like to patient to be told rather than involved
* A patient-centred approach sometimes feels to me like a doctor-absent approach. I ask myself ‘Why am I here in this consulting room ---- I don't feel like I'm doing my job’
* I am not used to dealing with conflict i.e. patients not agreeing to my management plan. It makes me feel threatened. Not sure how to manage this or who to ask for help at the time
* Back home, patients may seek alternative help because there is no NHS and occasionally because they believe in other types of healer (examples – shamen, witchcraft, quacks, abortionists).This makes me as a doctor feel that I have to protect my patients. When I 'instruct' patients, it is partly driven wanting to keep them out of harm's way.
* Patient complaints in other cultures may not be the norm and suing the doctor may not be a genuine risk. Therefore the importance of safety netting to avoid medico-legal risks is not appreciated.

**Appropriate management plan**

* My clinical management from the textbooks is generally okay. However, because of the lack of emphasis back home on choice and autonomy I'm not used to seeking patients’ needs and preferences. This means that even though my clinical reasoning is good, I don't develop what is regarded as an appropriate management plan and I am heavily penalised for it in the exam

**Ideas on how to address this**

**Attitudes**

* Whilst there are numerous different pillars that make up the concept of professionalism, essentially at the end of the day, reading other people’s mistakes would, in my opinion, be startlingly and shockingly exemplary. Examples of what level of behaviour and professionalism is expected. Reading other people’s mistakes will allow them to test their own moral virtues and moral constitution and therein from others mistakes learn and adapt to how one needs to behave “when practicing in the United Kingdom as a doctor with registered medical council

**Discussion of:**

* The demise of the ‘infallibility’ and reverence of the doctor
* Rise of the ‘blame culture’
* The role of CPD
* Knowing that as a doctor that I need to follow systems and processes
* Patient’s rights and expectations
* Plenty of UK patients see their own range of complementary practitioners…thee may be more similarities than initially apparent. (Suggest trainee led session, use a forum or debate to discuss why this is important)
* To make mistakes is not always a disaster
* Need to learn from my mistakes and the mistakes of others
* Doctors are not perfect- mistakes will happen. The skill is what I do about them
* Actions are rarely black and white
* Need to develop a strategy on what I tell colleagues about my background. Otherwise how will colleagues know about my background unless I tell them? What do they need to know?
* How do I dress for work?
* How do I address my colleagues and deal with ‘informality’ at work

**Ethical approach**

* I think the best way to start addressing this is to look at the GMC website to look at the cases that are being held. Looking at this will show that there are doctors who are being subject to the fitness to practice. Taking each of these scenarios and discussing them with trainees in an open forum would immediately show to the doctors what the standard of practice is expected from a Medical General practitioner
* I believe the MDU/MDUS and MPS may well run such workshops ? also involve GMC with their Education hat
* Understand what the medical ethics are of doctors from different countries and different medical systems. Explore these differences in groups perhaps with people presenting briefly what they think the main ethical frameworks are for doctors from their background. The traditional autonomy/beneficence/non-malificence derives from a particular philosophical culture.
* Acknowledge and actively seek discussions about these areas of dissonance
* Medical Ethics / Ethical Dilemmas teaching
* Understand what the medical ethics are of doctors from different countries and different medical systems, and how UK law affects this (so, knowledge of important principles, such as abortion act, mental capacity, Fraser competence etc)
* The different cultural and faith beliefs – recognise and have a flexible response
* Treatment plans – to meet all the needs of the patient?
* Dealing with conflicting priorities of ‘need’
* Case analysis involving the four ethical principles and how these can be used to solve dilemmas needs to be demonstrated shared and discussed in detail where questions can be answered and attitudes dissected Could be taught by the GP School or faculties who have local expertise In VTS there should be regular opportunity for actual cases to be shared This probably is happening now
* Ethical dilemma HDR workshop every quarter ( useful for all not just IMG’s)
* Ask the Doctors to discuss ethical dilemmas experienced in their own countries and then share scenarios from UK Compare and contrast .Well facilitated workshops with compare /contrast/learn ethos

**Patient -centeredness**

* Develop educational plans and strategies to learn about why shared management with the patient is important and how this is done in practice
* British trainees also at first can struggle with the idea of a patient centred approach and asking patients to be involved in management plans – I don’t think it’s unique to IMGs. A summary of the evidence for the effectiveness of patient involvement in decision making in terms of compliance etc would be a good exercise and present back to VTS group.
* This will only really come with experience-the doctor has to be aware of their own limitations though.
* Sit in with your trainer and see how they do it (we do not see enough of how local doctors do it)
* Doctor centred approach is common in IMGs . Trainer needs to address this issue. (it will be much better if trainer understand trainees cultural back ground). We need to provide trainers with more formal education
* Consider how you feel as a patient / with your family / with partner when seeing a British GP…what differences and advantages might there being involved
* Use Shared Decision Making Module (Tim Norfolk)
* Reversal of role play with doctors acting as patients and demonstrate patient-centred and doctor-centred consultation
* Definitely agree the ability to share management options is vital in British GP, and something many IMG find very difficult , make use of videos , role play and be very explicit from start of year that this is very important
* Read all the evidence in Silverman & Kurtz about the effects of autonomy, satisfaction etc
* Differences in how men and women treat being ill this, like several issues, applies to all trainees
* The uniqueness of the individual- tailor the treatment plan to the individual – not the other way round
* Ability to say ‘no’ to a patient
* Be aware of forcing own views onto a patient

**Teaching methods**

**Teaching methods**

**Observations and comments based on the survey**

* The student-teacher relationship is markedly different in some cultures. In Eastern cultures, for instance, the teacher may be accorded unconditional respect and may not be openly challenged as a result. This should not be interpreted as a lack of critical ability on the part of the student.
* Trainees brought up with more didactic approaches may feel frustrated if told to self-direct their learning. At best this feels frustrating but at worst the trainee may feel lost or abandoned.
* The concept of self-directed learning is valued in the East as well as the West, but the skills, i.e. knowing how to clarify the problem, investigate it, learn and reflect are not intuitive to students from any culture and need to be taught.
* In addition, didactic ‘telling’ methods may be necessary particularly when the trainee is not yet confident with learning independently.
* Providing regular and specific feedback on performance can help trainees to see the gaps and gauge their progress. This is particularly helpful when new to the GP curriculum.
* Trainees from abroad have their individual learning styles and preferences, just like students in the UK. A blanket approach to educating IMG doctors is therefore inappropriate.

**What do IMGs and others say?**

**Teaching methods**:

* Back home, I'm used to being taught mostly through being told
* I look up to my teachers (who are also my elders) and would not be expected to challenge them. It makes me really uncomfortable when expected to do so. This shouldn't be misinterpreted as meaning that I am not ‘tough’ or lack the ability to think for myself. I'm simply trying not to be rude or disrespectful.
* When I'm ‘lost’, I expect my teacher to guide me. Therefore, when I get non-directive feedback which tries to help me find my own way by using my own experience, I feel confused and frustrated.
* For my UK colleagues, they have the culture and communication that allows them to engage in this form of discussion much more easily than myself. For me, it just adds another layer of confusion when I'm already grappling with understanding a new culture and it feels very de-motivating not to be able to live up to what my teachers expect of me.
* I therefore prefer feedback to be more explicit and targeted, allowing me to clearly see the problem. Also, I need more opportunities to practice and be informally reassessed so that I can boost my confidence by actually seeing that I'm improving.
* I definitely don't feel empowered by having autonomy and being told to be self-directed. Back home autonomy comes when you are older, not at my stage of life. There, I am not expected to be independent, which includes being self-directed in my learning.
* At home, I receive guidance on what to learn, not how to learn. In addition, my programme of learning is planned and timetabled for me. My job is to turn up and to diligently apply myself to learning what my teachers require of me.
* People expect me to exercise autonomy and self-direction over here, but I need help with getting over the cultural barrier to doing this. I also need practical help/facilitation on how to do it.
* Maybe more than my UK colleagues, I feel very vulnerable especially early on in training and there is a real need to boost confidence at this stage. Criticism needs to be balanced so that I can see that I have some strength as well. Maybe in some ways, my own culture is an asset? I certainly feel so, but people haven't in the past tried to understand me so that they can see this.
* When challenged they are more likely to say that they do it this way because another doctor they respect has told them that it should be in such a way or because “it was in the guidelines” (though these may be now out of date). There is more reliance on the advice of their senior doctors than on evidence-based medicine.
* IMG doctors can be confused when given conflicting advice on how to manage the same problem by different partners – can be frustrating for them when one doctor questions an approach recommended to them by another doctor in the practice.
* I am not an IMG so do not have full understanding of the problem. However I have a few comments regarding VTS teaching. I notice when we split up into groups to prepare presentations often Trainees can split up into groups with people they know. (often for UK graduates you join groups with friends from medical school). This can also mean that IMGs join together in a group. Sometimes you find the focus of the presentation can then be different between the groups.
* IMGs sometimes concentrate on detailed medical knowledge on specific conditions whilst UK graduates may focus more on communication / self- awareness / practical management issues.
* Also there can be differences in some cases between the styles of presentations - UK graduates can sometimes be more audience interactive and less didactic. Perhaps mixing of the groups deliberately by scheme organisers / trainers could ensure better mixing between trainees and transfer of skill to more self-directed learning / better presentation skills.

**Ideas on how to address this**

**Teaching issues**

* This feeling of strangeness and out of water is very common to initial arrived IMGs
* To have a discussion early on as to what style of teaching GPST is used to and how it is likely to differ in this country. In half -day release to encourage GPST to discuss how they learn . Often notice IMGs very keen on books and need to be encouraged to DO more than read. It is by seeing patients you learn these skills
* Introduction of Educational assessment and on line education through e portfolio---IT competent teachers required for this.
* Induction courses for vulnerable doctors Good explanation of workplace assessment and educational portfolios and the stress of what is reflection and how this leads to change. Regular review of Portfolio by Educators
* What’s wrong with a bit of formal teaching? – I think “self-directed learning” can go a bit far – why not use the Trainer as an information resource sometimes.
* Teaching Trainee and Trainer (using Gerald Grow’s stages of self-directed learning as a way of developing the learning trajectory)
* Teaching of Trainers by appropriate Teachers within the GP School, including linguistic and communication experts and CSA practice/feedback.
* These doctors may need better clinical supervisor support especially in hospital posts. In general practice one always has a trainer nearby-however in hospital there is never that close association with a senior colleague-would these doctors be helped by a similar relationship in hospital posts?
* We have tried trainer sitting in to directly observe consultations so can give immediate feedback – mixed feelings about this myself as it alters the dynamics of the consultation but has been welcomed by IMG’s who are struggling to pass CSA.
* Undertake increased numbers of CbD and COTs to gain additional practice and feedback

**Raising awareness**

* To facilitate the culture shift from formal teaching to self-directed learning.
* Trainers to think when they last felt like fish out of water and how they handled it.
* Trying to teach badly.
* Trainer showing vulnerability (Dr X is good at this, my IMG trainee said that she often started a VTS afternoon by talking about her difficulties and asking the trainees for advice).
* Understand Learning Styles, Discuss teaching methods that you have been subjected to or become familiar with.
* Identify learning style and understand the pros and cons of different learning style
* Again, I think this is suited to be incorporated into induction course, so everyone does it.
* The need for continuous learning and review.
* The need for own professional development plan.
* Maintaining the balance between self-enquiry and knowing when to ask for help
* Being pro-active in own training.
* Earning the respect as a member of a team.
* Learning to be a team player.
* Need to plan and organise for myself.
* It is alright to ask questions.
* This is by far the hardest competence to address. There is no doubt that outside of the United Kingdom, teachers and elders are shown respect. Respect comes in the form of a non-challenging behaviour and accepting that what is said is gospel and need not to be challenged. Rather than trying to change an IMG’s inherent value, I think that this aspect could be built upon by asking the trainer to self-analyse himself in front of the registrar and therein showing/talking aloud to the registrar what his thought processes were to justify his action. Often IMGs knowledge base is outstanding. By giving the IMGs confidence, by asking them to list out their potential differential diagnoses, the trainer can go through each of his diagnosis one by one with a view to assessing and teaching him which is the most likely in the setting that he is in. With experience, I would anticipate that the registrar would be able to reduce his listed possible causes or systems involved for a presenting system. Using the apprentice model to show how to look up a problem would be beneficial here. For example, what the latest guidelines are on CKD would, if the trainer went about looking them up, providing the candidate an insight as to how a problem is looked at when probably he already knows the answer. It is more about teaching a method and showing them the reason why it has to be taught.
* Perhaps discussion / mentor with another more senior IMG – not wanting to set up them/us but these specifics are obviously difficult to overcome.
* Get trainee to discuss how they have resolved other challenges they have had in coming to a new place – for instance how did they find out how trains, buses work in this country, where did they go to find out about regulations in the law for driving etc and illustrate this is a form of self-directed learning and get them to gain insight into how they are able to find out answers for themselves and work out what it is they need to know
* I think I’ve touched on this but educators do need to be more aware that their actions may be seen as being very different from what’s expected – and I’m sure a lot of us enjoy being “different” – but that may not be very helpful – so an effort at raising awareness of how trainees have been taught to date would appear very apposite.
* We often do a learning styles questionnaire with trainees but maybe an educational history would be more useful – how have you been taught, what do you see as the role of trainer etc.

**Dr Amar Rughani**

General Practitioner, Sheffield

RCGP Blueprint lead and examiner

Associate Postgraduate Dean

**Dr Arun Davangere**

General Practitioner Meden vale Nottinghamshire (IMG graduate)

**Acknowledgments**

First and foremost we would like to thank those who responded to the questionnaire and for doing so honestly and constructively.

The project has been supported by the GP School and we would like to thank the many colleagues who advocated the need for this work and helped to refine the interpretation. We are especially grateful to Dr Jon Chadwick for his work on the ‘educational possibilities’ document which accompanies this evaluation and to Dr Maggie Eisner.