Issues for clinicians training international medical graduates: a systematic review

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ABSTRACT

Objective: To ascertain the specialised communication issues clinicians need to understand when preparing international medical graduates (IMGs) for clinical practice in Australia.

Study design: Systematic review.

Data sources: A series of searches using MEDLINE (1990–2006) was conducted with relevant keywords. Literature from countries with experience in the integration of IMGs into their medical workforces was included. All except four articles were published between 1997 and 2006.

Study selection: The initial search identified 748 articles, which reduced to 234 evidence-based English language articles for review. Of these, only articles relating to postgraduate medical training and overseas trained doctors were selected for inclusion.

Data extraction: Titles and abstracts were independently reviewed by two reviewers, with a concordance rate of 0.9. Articles were included if they addressed communication needs of IMGs in training. Any disparities between reviewers about which articles to include were discussed and resolved by consensus.

Data synthesis: Key issues that emerged were the need for IMGs to adjust to a change in status; the need for clinicians to understand the high level of English language proficiency required by IMGs; the need for clinicians to develop IMGs' skills in communicating with patients; the need for clinicians to understand IMGs' expectations about teaching and learning; and the need for IMGs to be able to interact effectively with a range of people.

Conclusion: Training organisations need to ensure that clinicians are aware of the communication issues facing IMGs and equip them with the skills and tools to deal with the problems that may arise.

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The number of international (overseas-trained) medical graduates (IMGs) filling general practice training positions in Australia has been steadily increasing since the end of the 1990s, particularly in rural areas of need.[1] Currently, IMGs occupy more than 25% of the medical workforce, with about 65% of them working in locations outside capital cities.[2,3] Figures presented at the 9th International Medical Workforce Collaborative Conference in Melbourne in 2005 indicated that the largest single group of IMGs practising in Australia was from the United Kingdom, closely followed by the Indian subcontinent, Malaysia and Singapore, followed by the rest of Asia.[2]

IMGs, especially from Asia and the Middle East, are likely to encounter difficulties adjusting to life in a Western culture and reactions to separation from extended family and friends.[4] In addition, IMGs have to cope with practising medicine in an English-language environment and adjusting to the "medical culture" or way that medicine is practised in Australia. IMGs need to quickly grasp the protocols of the medical practices to which they are attached and the organisation of state and federal health systems. In addition, they have to cope with changes in self-esteem,[5,6] differences in learning styles,[4] new patterns of disease, and communication issues.

Clinicians responsible for supporting and training IMGs need a thorough understanding of the range of communication issues confronting IMGs. Trainers should be aware that IMGs are not a homogeneous group and that culturally diverse medical practitioners bring multiple perspectives to issues.[7] Effective communication can help IMGs to successfully attain qualifications and integrate into new communities and lifestyles.[8] There is a need for specific training to improve the skills of trainers, both in local and national training programs. In reviewing some important communication issues, our aim is to help clinicians understand the needs of IMGs.

METHODS

A systematic literature review was conducted using MEDLINE (1990–2006) to identify evidence-based articles on communication-related issues in the training of IMGs. The bibliographies of identified articles were also used to expand the search.

An initial search was conducted using relevant keywords, including "IMGs", "overseas trained doctors", "communication", "training", "teaching", and "education". The search was then narrowed down to evidence-based articles by the use of MEDLINE-defined limiting terms such as "controlled clinical trial", "randomized controlled trial", "comparative study", "evaluation studies" and "consensus development conference". Titles and abstracts were then independently reviewed by two reviewers (L S P and J A). Publications that addressed communication needs of IMGs in training were retained. Organisational reports, training packages, letters, student articles and unreferenced articles were excluded. Any disparities about which articles to include were discussed and resolved by consensus. The concordance rate between reviewers was 0.9. The themes that emerged most frequently were extracted by the two reviewers.

Ethical approval

Our study was approved by the University of New South Wales Human Research Ethics Committee.

RESULTS

The initial search produced 748 publications, which reduced to 234 evidence-based articles for review. Sixty-seven were judged relevant to the communication needs of IMGs, and of these, 49 met the exclusion criteria, leaving 18 for inclusion. These were made up of seven cross-sectional studies (six using qualitative and two using quantitative methods), eight referenced narrative articles and three non-systematic reviews.

Key themes emerging from these articles were:

- *The need for IMGs to adjust to a change in status;*
- *The need for clinicians to understand the high level of English language proficiency required by IMGs;*
- *The need for clinicians to develop IMGs' skills in communicating with patients (skills that include subtle and pragmatic aspects of language interaction);*
- *The need for clinicians to understand IMGs' expectations about teaching and learning; and*
- *The need for IMGs to interact effectively with a range of people.*

DISCUSSION

Change in status

In many cultures the status of medical doctor is highly regarded and the doctor operates from a position of considerable power within the community.[9] Thus, difficulty arises when the IMG changes country to a culture in which the doctor–patient relationship is more equitable. The consumer-oriented view of patient care prevalent in developed countries may pose problems for IMGs, as they are often challenged by patients. The concept of a patient questioning a doctor is quite alien to many IMGs because, in their home countries, the patient's role is one of compliance, trust and cooperation, and any other behaviour is not tolerated.[10]

The IMG is also required to undertake more study to sit for local medical board examinations, and so is relegated to the lower-status role of "student". Remennick and Shtarkshall[5] maintain that one important factor in the successful integration of an IMG into a host medical system is the IMG's ability to maintain "a positive self-image as a professional".

In summary, IMGs need:
- *The ability to deal with an equitable doctor–patient relationship; and*
- *The ability to maintain a positive image of themselves as professionals.*

English language proficiency

For the majority of overseas-trained doctors entering Australia, English is not a first language, but many IMGs will have completed their undergraduate medical training using English as the medium of instruction. They will also be familiar with medical textbooks and journal articles printed in English.[4] The language requirement for IMG entry into Australia specified by the Department of Education, Science and Training is a minimum International English Language Testing System score of 7. The descriptor for Band 7 is:

> Good user — has operational command of the language, though with *occasional inaccuracies, inappropriacies and misunderstandings in some situations*. Generally handles complex language well and understands detailed reasoning. (Emphasis added.)

Accordingly, some IMGs entering practice in Australia may experience language difficulties when communicating with patients, colleagues, medical educators and allied health professionals. Sharif[4] acknowledges that language is the vehicle of communication and that weaknesses in language can act as a barrier to learning. Other studies[6,10-13] have demonstrated that the language barrier is of real concern to IMG registrars and their trainers.

In summary:
Clinicians need to understand the language and communication problems associated with learning and patient care and recognise the associated concerns for IMGs.

Communication with patients

Initial communication training programs for IMGs focus on remediation of the more overt features of communication, such as accent, speech inflection, understanding of regional dialects, and colloquial speech and language.[12-14] IMGs articulated their need for a better understanding of the English language, particularly the use of idiom, nuances and vernacular terms.[12]

Communication problems also exist at a more subtle level, even for overseas-trained doctors who are proficient in English.[13] IMGs need to be able to read the non-verbal cues in an interaction and respond with cultural appropriateness. Establishing rapport with patients and responding to patients' emotions can be challenging for medical graduates trained in non-Western countries. Many IMGs expressed frustration with their inability to show caring and empathy towards patients and did not know how to express empathy in a different culture, both by word choice and non-verbal actions.[6] This resulted in IMGs feeling they had been unable to support the patients and their families in a caring way. IMGs reported they received little or no training in specific doctor–patient communication skills and experienced difficulties with question formation, understanding informal colloquial language and negotiating treatment plans.[10,12-15] For most IMG residents, formal training in medical interviewing outside Australia was delivered by observation of clinical faculty and senior students, with the emphasis on content and information gathering rather than on interpersonal factors.

IMGs participating in Hawken's[11] New Zealand study of a course in professional development experienced difficulty offering emotional support for fear of violating gender and/or cultural boundaries. Awareness of communication deficiencies increased after IMGs had begun consulting, when they requested further assistance on communication issues, including "empathy, reflective listening, dealing with difficult situations, open questions, and rapport-building".[11]

Case history-taking was also deemed difficult by IMG doctors, as the language barrier and inability to make concise word choices caused difficulty in understanding for the patient, possibly compromising the accuracy of the case history. IMGs are often trained in a more interrogative form of history-taking[16] and may encounter difficulties in using open-ended questions.[11] Sometimes they do not know how to phrase questions appropriately, as they are fearful of offending the patient, particularly in cases where psychosocial issues need to be explored.

Clinicians should:
- *Explore IMGs' understanding of cultural boundaries;*
- *Teach the use of open-ended questions;*
- *Encourage reflective listening skills; and*
- *Develop IMGs' ability to explore psychosocial issues.*

Understanding IMGs' expectations about teaching and learning

Differences in medical education exist between Asian countries and Western countries.[17] Majumder and colleagues describe medical training in Asia as "colonial-biased, subject-oriented, teacher-centred, discipline-based, lecture-focused and hospital-based".[18] Clinicians working with IMGs in Australia need to have an understanding of the system from which IMGs have graduated, as this has an impact on their communicative interactions.[10]

Clinicians have remarked on the "lack of responsiveness" of foreign graduates, even when asked direct questions. The position of teacher is held in great esteem by Asian cultures and the student is not encouraged to question or challenge.[4,16] The student must appear not to know too much or to challenge the teacher's knowledge of a subject. The reluctance of IMGs to answer questions or give opinions in Western teaching sessions can be misinterpreted as a lack of knowledge.[12]

There is also a perception by IMGs that the teacher's role is to provide the students with all the material and information required and the student's role is to memorise it. When faced with differences in teaching style in Australian medical training, such as experiential learning, problem-based learning and discussions, IMGs are at a loss as to how to participate effectively.[4,19]

The way students request assistance also varies between cultures and can have an impact on the IMG registrar–supervisor interaction. IMG registrars may not ask for help directly but instead hint at problems, with the expectation that their supervisors will recognise their difficulties and render assistance. This may be overlooked or misinterpreted by the educators. The proficiency levels of daily conversational English among IMGs may also pose a barrier to asking for help. Although IMGs can use and converse in medical English, the standard of their everyday English to meet their own needs may be less developed.[8] If an IMG registrar is constantly asked to repeat his or her contributions to a discussion, it may result in the IMG becoming increasingly reluctant to participate in such learning situations.[8]

The presentation of feedback to student learners also varies between cultures. In Western-style teaching and learning sessions, feedback is often presented via group discussion, but overseas-trained doctors find this situation very uncomfortable.[4] If an IMG is the target of negative criticism, it can often be perceived as personal and result in "loss of face" and lowered self-esteem.[8]

IMGs often experience difficulty in dealing with failure.[4,8] They come to Australia with a successful academic history and from a position of high status in their home country and find themselves in a situation in which they have to learn new patterns of patient care. The prospect of failure and subsequent lowering of social status can result in anxiety and loss of self-esteem. Admitting to feelings of anxiety, stress or depression may also be a cultural taboo in the home culture of the IMG.[8] Underlying anxiety or depression in an IMG can present as uncommunicative and unresponsive behaviour, which could be interpreted by some as "lack of knowledge, diffidence about the programme, or arrogance".[8]

In summary, clinicians need to:

- *Understand the impact that the teaching system from which IMGs come has on the communication process;*
- *Differentiate IMG cultural silence from lack of interest or underconfidence;*
- *Deal with IMGs' expectation of didactic teaching;*
- *Recognise the unspoken requirements of IMGs; and*
- *Guard against negative feedback being perceived as criticism.*

Communication with a range of people

IMGs, like all doctors, need to be able to communicate with a range of people, including patients, relatives/friends of patients, nursing staff, medical practitioners (including general practitioners), hospital medical officers, registrars, consultants, allied and diagnostic health professionals, supervisors, directors of training, medical education officers and other people involved in community services.[20]

Some IMGs may not have had prior experience in dealing with such a range of people and may lack the communication skills to deal with all people meaningfully and effectively. Every communicative interaction requires a change in the choice of medical terminology (eg, limiting the use of jargon); the way of explaining; the register (ie, appropriate tone and word choice to match the audience and situation); the amount of information given; and the element of empathy. IMGs need to be made more conscious of the subtle and pragmatic changes within a communicative interaction.[21]

Communication problems between IMGs and practice personnel or allied health workers can easily arise. These problems can be mitigated if (a) IMGs are made aware of relevant protocols; and (b) practice personnel/allied health workers provide continual feedback to IMGs about their respective roles, check that messages have been received clearly, and realise that this may be an ongoing process.[21] Recently arrived IMGs are learning and absorbing huge amounts of information, so it is necessary to continually clarify whether information has been interpreted accurately.

In summary, IMGs need:

- *The ability to communicate with a range of people;*
- *The ability to choose the appropriate terminology, register, and amount of information for different audiences;*
- *An element of empathy;*
- *The skills to interact with nursing staff, and a clear understanding of the role of support staff in clinical care; and*
- *An understanding of practice protocols, with ongoing monitoring of whether information is being interpreted accurately.*

CONCLUSIONS

Clinicians play an important role in the successful integration of IMGs into the Australian medical workforce. The question arises as to how clinicians can be best supported in this role, given the time constraints of a busy medical practice, the need to develop teaching skills and the problems of distance.

Training organisations need to ensure that clinicians are cognisant of communication issues facing IMGs and equip them with the skills to deal with problems that may arise. At present in Australia, few training resources have been developed to help clinicians train IMGs. The Association of Faculties of Medicine of Canada has produced a series of online modules to assist educators to work effectively and collaboratively with IMGs to enhance their learning and practice experiences. A similar training module for Australian clinicians could provide clinicians with a toolbox of ideas to consider and avenues to pursue for greater support.

Clinicians need factual information to explain the Australian health care systems and the work practices of the local clinic, including the role of personnel within the practice and the role of allied health professionals. An awareness of the "medical culture" of the IMGs' countries of origin can promote discussion of similarities and differences between countries.

Differences in perceptions of the role of teacher and learner need to be explored by discussion about effective ways to learn, including the delivery of feedback. There is a need for cultural sensitivity training to allow both IMGs and clinicians to discuss cultural differences that impinge on attitudes to health care delivery. Clinicians need access to training in the form of workshops, and training modules with role-plays, case studies, patient scenarios and current research. Training digital video disks and

online resources demonstrating effective communicative interactions are also needed.

Clinicians need to become aware of the needs of IMGs in order to develop ways of dealing with sensitive communication issues among colleagues from diverse cultures.

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COMPETING INTERESTS

None identified.

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