INTERNATIONAL Overseas doctors of the NHS: migration, transition, challenges and towards resolution

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ABSTRACT

Overseas doctors are playing an important role in the successful running of the NHS. They represent one-third of the total number of UK doctors and include doctors from the European Economic Area and international medical graduates. The main aim of this review is to explore the challenges that overseas doctors might face when they take up their first job in the UK. We conducted literature search using MEDLINE and EMBASE databases. The inclusion and exclusion criteria were designed to include published literature concerning overseas doctors in the UK and the NHS. Lack of information about the UK health system; language and communication challenges; clinical, educational and work-culture challenges; and discrimination challenges are some of the difficulties that overseas doctors might experience. Understanding these challenges and providing support are important steps in helping overseas doctors to make a smooth transition.

KEYWORDS: Overseas doctors, NHS, IMG, communication challenges, induction programmes

Background

Since its inception in 1948, the NHS has relied heavily on the contribution of overseas doctors in the successful running of its services. The number of medical schools in the UK has increased but medicine, its science and practice, has also expanded.[1] Therefore, the NHS will continue to depend on doctors from overseas to fill the gap.[2] Overseas doctors face challenges entering a new culture, as does the service itself when taking on those who are unfamiliar with medical traditions in Britain. This continuing complex interaction has become more urgent in the face of Brexit.

The purpose of this contribution is to review some of the principal challenges overseas doctors face. All statements are based on the literature, except those which express our personal views.

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Introduction

The term 'overseas doctors' is applied to those who have graduated outside the UK, and embraces two groups: international medical graduates (IMG) and European Economic Area (EEA) graduates.[3] In 1957, overseas doctors represented about 12% of the total medical workforce, the majority having migrated from Europe during or after World War II.[4] The proportion has increased gradually. Recent data indicate non-UK graduates comprise 37% of the total number of doctors: 26% are IMGs and 11% from EEA.[5]

IMGs are required to first pass a set of examinations which will then entitle them to practice in the UK. These comprise the Professional and Linguistic Assessment Board test (PLAB) and the International English Language Test System. EEA and Swiss nationals, however, are exempt from PLAB.[6]

Regulations controlling the entrance of overseas doctors have repeatedly changed.[7] Vacant posts increased during 2001–2006, leading to a rapid influx of overseas doctors, causing some donor countries to struggle to maintain their services.[8] The influx subsequently exceeded demand, causing many doctors to remain unemployed for long periods.[9,10] The work permit visa, introduced in 2006, restricted the entry of IMGs, aiming to achieve a better balance between 'supply and demand'. The struggle to achieve a better supply, however, has continued and the UK decision to leave the European Union is likely to adversely affect recruiting and retaining European doctors.[11] This major issue has been recognised by the UK government which recently announced its decision to remove the restriction on overseas doctors and nurses entering through the Tier 2 visa route.[12]

Methodology

A literature search was conducted using the Ovid search engine. MEDLINE and EMBASE were searched from 1946 and 1974, respectively. The search looked for the following words and synonyms: overseas doctor (foreign doctor, international medical graduate, IMG, European doctor, EU doctor) and United Kingdom (UK, Great Britain, GB) and NHS. The initial search revealed 323 papers. Table 1 shows the inclusion and exclusion criteria. Duplicate papers were removed at the initial review. Titles, abstract and full text were screened to identify relevant articles for full review. The bibliography was supplemented with relevant articles and reports known to the authors. The descriptive findings were pooled and grouped into challenges themes. The initial search was conducted in 2013. Since then, 22 papers and reports have been added to update the manuscript.

Table 1. Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Papers covered overseas, European or IMG doctors	Papers covered overseas doctors in other countries
In the NHS or in the UK	Not in English
In English	

IMG = international medical graduates

From inquiry to PLAB: The Merrison inquiry (1975)

Concerns on performance of some overseas doctors triggered this landmark inquiry. Its conclusion highlighted major issues, one being that the performance of a 'significant number' of overseas doctors fell below expectations.[13] The following extract summarises the problem well:

> *It would be surprising if doctors from overseas did not lack knowledge of the operation of the NHS, did not find difficulty in understanding the significance of the euphemisms and colloquialisms which for many patients are their most accurate means of expression, and even more surprising if they could easily come to grips with the variety of dialects they may encounter.*[14]

This led to the introduction of a new method to assess clinical and language skills, the Temporary Registration Assessments Board, which finally developed into the PLAB test in 1978.[15]

Overseas doctors gain their primary medical qualification from about 150 diverse countries,[16] with inherent variability of medical regulations between country of origin and the UK.[17] Coupled with this is the frequently inadequate information about the NHS and its structure,[16,18,19] the reality often differs from expectations.[20] There may be lack of information on individual posts, particularly for competitive specialties.[21,22] A further issue for overseas doctors is that they may not be made aware of the new regulations requiring them to obtain medico-legal insurance during clinical practice in the UK, hence may miss this important support when most needed.[23]

Language and knowledge of 'local euphemism and colloquialism'

As the satisfactory practice of medicine requires knowledge of language and culture, overseas graduates require time to become familiar with practice in the UK, particularly when their training in medical school was not in English. Even when English is the medium of instruction, the language learnt may vary from its day-to-day use by reasons of grammar, phrases and idioms.[24–26] The General Medical Council (GMC) report neatly summarises the issues as ranged from 'difficulties with subtleties of language and dialect to misunderstandings of the nuances of non-verbal communication and social and behavioural norms'.[16]

Communication, a two-way process, is affected by the patient's understanding, which in turn is influenced by his/her social and educational background and local dialect – subtleties which the overseas doctor may not be in a position to fully understand.[25,27,28]

The corollary is that the patient, too, needs to be aware of a non-UK graduate's own limitations in this area. Shortcomings on either side lead to weaknesses in how a doctor takes a patient's history, explains management plans, and when handing over care to another doctor.[26]

Yet more complexities arise when non-verbal gestures matter, such as eye contact, facial expression or body language, which hold cultural clues which may be misinterpreted.[21] A particular difficulty is when discussing sensitive issues such as a sexual history, and problems of a different sort when breaking bad news.[28]

Clinical, educational and work-culture challenges

Recognised training posts are ideal for they should provide continuing structured training and graded exposure to responsibilities. In reality, however, a disproportionate number of overseas doctors have to either wait for a long period to secure such a post or, in desperation, accept a non-training post.[29–31] An example is the out-of-hours service. Such positions often provide care during unsociable hours,[32] which local graduates avoid or are reluctant to fill because they lack working time restrictions or because the workload is excessive.[33] The mismatch was accentuated when priority for higher specialty training posts was given to UK and EEA graduates.[21] Further examples included lack of study leave and professional development opportunities. Worst of all, the time spent in such posts did not count towards specialist training when a post is finally secured.[30] The overseas doctors may not be aware in advance of the 'negative' aspects of non-training posts.

Disease patterns may vary markedly between a doctor's country of origin and the UK, as might clinical practice,[25,28,34] the medications available and how these are best used.[25]

Mental capacity, end-of-life decisions, confidentiality and consent are some of the many issues encountered,[21,25,28,35,36] complex as they are interwoven with morality, culture, and perception. These are encountered by health professionals worldwide but their resolution varies from country to country, guided by local culture and law. In the UK, decisions are shaped by the ethical and professional frameworks set out by the GMC.[21] In such grey areas it is understandable why overseas doctors have experienced difficulties, which sometimes have led to unsatisfactory outcomes.[21,37,38] Sharing clinical information with a patient and family and taking consent may vary between countries and cultures, shaped by laws and need to be addressed early in a doctor's career.[39]

Working effectively within teams, now an almost universal practice, is more complex than it at first appears. Decisions are best made when all necessary information is available, which in turn is possible only when the consultant invites even the most junior members to contribute. Such subtleties may not be apparent to an overseas doctor if they have previously worked in a more rigid, hierarchical 'top-down' structure, where the most junior speaks 'only when spoken to', otherwise remains silent which, in the UK context, may be perceived as being a poor team player.[28]

Recognising and admitting a mistake, thereby learning from it, is now becoming much more conventional in the NHS. *The professional duty of candour* published by the GMC and Nursing and Midwifery Council advocates an open and transparent environment and encourages healthcare professionals to be honest when mistakes happen.[40] Availability of similar guidance may vary across countries and therefore some overseas doctors may be unfamiliar with the actions they should take if mistakes occur.[28] The consequence is missing a real opportunity to 'learn on the job'. Other important abilities like time management,

prioritisation and IT skills may be inadequate or not freely available, compared to local graduates.[28,41]

Communication skills are tested for in postgraduate examinations, such as MRCP(UK), at which an overseas doctor may yet again be disadvantaged for all the reasons explained above.[42]

Finally, revalidation was introduced in the UK in 2012 by the GMC to ensure that all doctors continue to be up to date and fit to practice,[43] a process employed in only a limited number of countries.[17,25]

Discrimination challenges

Bullying, harassment and bias

Bullying was reported to be experienced equally by UK graduates and overseas doctors, the difference being the latter were less likely to take appropriate action, for example reporting the incident to the human resources department.[44,45] Bullying led to increased stress, anxiety and depression, and decreased self-confidence. For the hospital, such problems impact functioning as they lead to decreased productivity, increased absence from sickness and loss of staff.[44,45]

Esmail and Everington (1992) carried out an unusual study. As a pilot, they developed *curriculum vitae* for 'six equivalent applicants – three with Asian names and three with English names. All applicants were male, of the same age, educated and trained in Britain, and with a similar length of experience in district general or teaching hospitals. All were at the same stage of their career, applying for their first senior house officer post in a non-teaching hospital.'[46] Based on the pilot, forty-six applications (23 English names, 23 Asian names) were created and sent to 23 different posts covering a range of specialties. Twelve of the 18 applications shortlisted had English names. The authors repeated their investigation using the same methods five years later and obtained similar findings with preference to English names.[47]

Referral to GMC

The National Clinical Assessment Service (NCAS) was launched in 2001 after recommendations made by the chief medical officer for England in 1999.[48] One in 190 doctors had been referred to NCAS but only one in 17 led to formal assessment.[49] In its analysis of case referrals 2001–2009, NCAS concluded that the likelihood of a non-UK graduate being referred for malpractice is higher than that of the UK counterpart and white practitioners qualified in the UK are at lower risk of exclusion.

In a separate investigation, Humphrey and colleagues[19] examined the outcome of 7526 inquiries made to the GMC until April 2009: 62% were doctors qualified in the UK, 8% in Europe, and 29% were IMG. Most of the UK-qualified referrals were categorised as 'complaints', whilst the majority for overseas doctors were 'referrals', a stage higher (a term which in the authors' view seems counterintuitive for it gives no indication of severity). Overseas doctors were more likely to receive harsh decisions, for example suspension or erasure, when 'fitness to practice' was assessed.[19]

Current methods of integration into the NHS

The most common approaches were through clinical attachments and induction programmes.[18,33,50,51] There is overlap between them but induction programmes have the advantage of structure, and other relevant courses such as communication skills. The history of clinical attachment goes back to 1966 and since then it has remained the main route of entry for overseas doctors to the NHS. Most hospitals now encourage this approach.[51] The GMC has recently launched a half-day induction programme for doctors who are new to the country ('Welcome to UK practice'). The programme runs repeatedly through the year, is free of charge and covers topics that are important in day-to-day practice. Examples are good medical practice guidance and common ethical challenges, with an additional complementary online scenario tool.[52] In addition, many hospitals and trusts have started to offer help for overseas doctors, noticeably for the last few years, ranging from completing computer-based modules to specific induction programmes.

Towards resolution

These suggestions stem from reviewing the literature and from working in the NHS. We recognise these ambitious suggestions will need to be modified in the light of experience, will need resources, time and patience to develop and implement. Nevertheless, these may prove to be important steps in the right direction.

Making the necessary information available in advance

A single website in plain language dedicated to overseas doctors would help to provide guidance in several areas. Examples include: GMC registration, medico-legal insurance, the degree of competition for training posts in each specialty and revalidation. Helpful notes on UK customs and culture would complete the picture.

Bridging the culture gap

Healthcare professionals and organisations need to understand the clinical and cultural differences, which in turn can enhance overseas doctors' performance and their retention.[22] Supervisors and mentors, too, benefit from such knowledge allowing them to understand cultural differences and help overseas doctors fit within the NHS, with its own distinctive ethos.[22] The deficit in expertise in the field of integrating overseas doctors and the financial burden on organisations will continue to lead to a shortfall in providing individualised and on-going support.[22,53]

The work of the social psychologist, Geert Hofstede, on cultural dimensions may help to understand variations across countries. The Hofstede theory states the culture of a country is supported mainly by four domains: power distance, uncertainty avoidance, individualism vs collectivism and masculinity vs femininity.[54] Every national culture has its unique profile, according to strength or weakness of these domains.

Morrow *et al* (2013)[37] have 'fine-tuned' the domains to pick up subtle differences and have provided several examples how the intermix varies from country to country and its impact on their clinical practice (Table 2).

A point of contact 'responsible officer'

It is reassuring to meet a specified officer in each deanery, the 'point of contact person', who would offer guidance and help. Such

Table 2. The Hofstede theory model with examples of its application in clinical practice in different cultures

Hofstede theory domain	Explanation	Examples of countries	Example in clinical practice
Power distance	In large organisations, which commonly have hierarchical structures, authority and power, actual or perceived, is almost by definition distributed unequally, those at the top having most. Such inequality is accepted by the leaders and the led.	High 'power distance' countries are France and India. Low 'power distance' countries are Austria and Israel.	In a societal culture of high 'power distance', the patient perceives the doctor to be in a superior position; the doctor in turn accepts this, directs the consultation, which then becomes unidirectional.[37] In a culture of low 'power distance', however, the patient and doctor regard themselves as equals, hence consultation becomes a bidirectional discussion.[37]
Uncertainty avoidance	Members of a group commonly react, or as perceived to an outsider to react, to unexpected or unforeseen situations in accordance with prevailing culture.	Strong 'uncertainty avoidance' countries are Japan and Greece. Weak 'uncertainty avoidance' countries are Denmark and Hong Kong.	An example of 'uncertainty avoidance' is time made available per patient during clinics or ward rounds. In a strong 'uncertainty avoidance' culture, a rigid time management structure prevails, thus each patient is given precisely the same time and approached in the same manner. Doctors from countries with a high 'uncertainty avoidance' profile may find building a relation with a patient through empathy and non-verbal communication, such as eye contact, difficult.[37]
Individualism versus collectivism	Cultures where 'individualism' is the norm are characterised by loose connections, thus allowing a person to act on his/her own initiative. In 'collectivism', in contrast, individuals in the group prefer to be instructed on what they can and cannot do. The emphasis in individualism is on being a good leader, while in 'collectivism' culture it is about being a good member.	'Individualistic' cultures are found in the USA and UK, while 'collectivism' is found in Peru and Iran.	Doctors from countries with high 'collectivism' may appear to be less assertive, which may become obvious when working in a country like the UK.[37]
Masculinity versus femininity	This dimension reflects less the gender *per se* and more the culture associated with it. In 'masculine' countries assertiveness and competitiveness are acceptable, whereas in 'feminine' cultures the preferences are more on caring and improving the quality of life. The 'feminine' society treat male and female gender equally.	'Masculine' countries are Japan and USA. 'Feminine' countries are the Netherlands and the Nordic countries.	Consultation and communication with patients and relatives is guided by societal perception of the role of men and women – whether both are treated equally or differently.

Statements are referenced, except those which are the authors' personal views.

support should ideally be available before the doctor starts their first post and the contact maintained throughout the post.

A national induction programme

A mandatory national induction programme for overseas doctors complemented by existing local hospital inductions will help.

The curriculum could include sessions on 'culture', both that of the British way of life and, more specifically, of the NHS, as well as clinical skills.

The subtleties of the English language, subconscious in those who have grown up in the UK, may be unfamiliar to doctors from overseas. The induction programme would be a good forum to provide insights.

Conclusion

Overseas doctors continue to contribute significantly to the UK NHS but coming from a different culture and healthcare system creates certain challenges. The doctors need to understand the differences, whilse the host can help by making important information about the NHS and British culture readily accessible. Combined, these steps have the potential to lead to resolution, and smoothen the doctors' entry into the NHS. ■

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