

Supervising IMGs explained - FAQ

These frequently asked questions have been distilled from the “Supervision of IMGs - Are you speaking the same language?” webinar delivered by Dr George Zaharias on 26 March 2015.

NB: The nature of this webinar and therefore this FAQ is to help GP Supervisors look out for ‘common’ issues and provide strategies of how to address them with their IMG registrar should they arise. Consequently there are generalisations made that may not be the case for the IMG registrar you supervise.

Disclaimer

You will need to make your own assessment of where the IMG registrar you supervise is ‘at’ on their GP training journey in the Australian healthcare system. The webinar recording and this FAQ may be of assistance with this. Generalisations are made to establish ‘commonality,’ not to upset or denigrate, and similar issues to those detailed below can also be associated with Australian Medical Graduates. We hope you find the resource useful.

INDEX

- [1 What are the key characteristics of the IMG group?](#)
- [2 What are the key difficulties that challenge IMGs?](#)
- [3 What are some of the problems IMGs have experienced with AHPRA?](#)
- [4 What are the key teaching strategies that can be utilised to support the IMG?](#)
- [5 What strategies can be suggested to enable better communication from Doctor to patient?](#)
- [6 Are there any tips to help the IMG become more familiar with English language?](#)
- [7 What are the strategies to counter cultural reasons for not doing a physical examination?](#)
- [8 Is a shared supervision model appropriate for the supervision of an IMG?](#)

1 What are the key characteristics of the IMG group?

Generally IMGs are a very disparate group of individuals, and very different to registrars as a broad group.

Many IMGs are very good at what they do and are motivated to learn and become supervisors themselves. However many IMGs face challenges many Australian Medical Graduates do not. The most common of these include;

- **language difficulties**
English pronunciation and fluency issues, understanding meanings, nuanced messaging, the Australian dry sense of humour and slang.
- **communication issues**
Verbal and nonverbal. Clarity of messaging to the patient and understanding boundaries.

- **contextual limitations**
Understanding and appreciation for the Australian context of the doctor/patient relationship can be limited.
- **knowledge and skills**
Variable - depending on country of origin, training and experience.
- **motivation**
Depending on cultural background, motivation to cover all aspects of doctor training and patient care may be influenced and limited by different world-views and belief systems.
- **flexibility**
Different capacities to be flexible in approach - some may be very rigid in their approach and thinking.

2 What are the key difficulties that challenge IMGs?

- **Command of the English language.**
Fluency and structure issues arising from “thinking in their language”.
- **Talking at rather than with the patient**
IMGs sometimes tend to talk at the patient. They will sometimes check to see if the patient has understood – but there is a tendency to do it in a tokenistic way.
- **Communication skills**
 - Difficulty regarding the provision of information.
 - Delivery of the management plan can be:
 - Stilted
 - unstructured
 - not prioritised – lack of focus on the most important problem
 - lack of depth or too much depth
 - they can provide information which is unnecessary – too much – too convoluted therefore causing confusion for the patient.
- **Self-confidence**
The uncertain IMG registrar, often as a result of communication issues or other matters contributing to confidence or lack thereof, can be perceived by the patient as being ‘uncertain’ about a diagnosis or management plan. Whereas to the IMG registrar This can lead the patient to believe the IMG registrar does not have the appropriate knowledge or authority and feel unsure about what they are recommending. This can lead to second opinions and overservicing patients.
- **Boundaries**
 - IMG registrars sometimes speak in an inappropriate manner or have clumsy speech
 - inappropriate touch
 - not obtaining informed consent in a manner which is explained adequately and being sure that the patient has understood.

- **Australian context**
 - The concept of patient centredness is a shift in culture from Dr centredness in many countries.
 - The notion of equality - patient and doctor on a relatively equal footing and that to obtain an outcome is a negotiated process in respect to a range of choices, and it is a shared decision making process.

- **Knowledge**
 - Many IMGs can be very knowledgeable - where IMG registrars will often come unstuck is in the 'application' of their knowledge - in the Australian context.
 - Their method of study is to learn by heart and wrote learning.
 - Behaving as an adult learner is something that don't quite understand and don't know to approach it;

- **Being reflective**
 - learning how to look inward and examine one's own experiences
 - identifying their needs
 - making a learning plan for themselves

- **Learning style**
 - IMGs may prefer to be told what to study and what to do. If this is their learning style, learning guidelines off by heart is easily done, but applying them can often become problematic.
 - None of us like making mistakes, however typically the fear of making a mistake is even more acute for IMGs - they have to learn that it is ok to make a mistake - that is how we learn.
 - Importantly, in recognising that is it ok to make a mistake as clinicians they must also learn how to own up to mistakes, be honest and seek advice rather than attempting to cover up their errors.

- **Clinical skills**
 - Physical Examination - technique can be poor. IMGs may not be aware of Australian cultural expectations of patients to be examined. If this is the case they may prefer to skip an examination and jump to investigation.
 - IMGs need to understand that patients in Australia expect and appreciate being examined.

- **History taking**
 - History taking can be poor - and if physical examination is not well done, clinical reasoning is not going to be good, and the doctor can jump to a conclusion or make assumptions and go very quickly to investigation, over-relying on others to provide the answer to the problem.
 - When investigation results return, they may therefore have difficulty managing uncertainty and correctly interpreting "shades of grey", requesting more unnecessary investigations.

- **Documentation**

Documentation is sometimes very poor. When clinical notes are reviewed, one doesn't often get a good sense of what has occurred during the consultations. IMGs need to understand that

good note taking is essential – not only for doctor to doctor communication, but to protect themselves.

- **Medicolegal scenarios**

Many IMGs are not confident in this area and don't understand the laws in Australia. Making time to discuss medico-legal issues in relation to consent, privacy, negligence, sexual harassment, etc. whether from personal experience or regularly discussing articles reported in medical observer or Australian Doctor is a good way to build registrar knowledge around medicolegal scenarios.

- **Other difficulties**

- Drivers License
- CentreLink Forms
- Insurance
- Workcover
- TAC

Case examples can be used to help explain filling out forms and dealing with WorkCover/TAC etc.

Perhaps a solicitor who works in this area can explain the requirements and regulations.

If the IMG is moving from state to state he/she has to realise that regulations will vary from state to state.

3 What are some of the problems IMGs have experienced with AHPRA?

Problems with prescribing F8's - narcotics and hypnotics.

- A lot of IMGs have no idea about the regulations – they have not received any training.
- E.g. notifying Health Department about someone who is a drug seeker.
- IMGs also often struggle with the difficult behaviour of the drug seeking patient – comes back to assertiveness – being able to say “No”.
- If withdrawing patient from medication – maintaining the personal authority to set a plan and require the patient to follow the plan.

4 What are the key teaching strategies that can be used to support the IMG?

- **Clinical Experience**

The best way for IMGs to learn is through clinical experience gained from the patients they see from day to day. Textbooks like John Murtagh's *Patient Education* are important. It is very good in terms of how to approach presentations, red flags, yellow flags, what not to miss, the masquerades etc. It provides the registrar with structure in terms of approaching the problem.

- **Direct observation by the Supervisor**

Direct observation of a registrar can occur with you in the room or through video playback and there is much to be learned by the supervisor through such observation. It will help guide you in understanding the registrar's strengths and weaknesses and inform the priorities you place on their dedicated teaching time. However, if you sit in with the registrar, it is important to remember that the registrars relationship with the patient must be preserved. Dr Gerard Ingham's "[Avoiding 'consultation interruptus' - a model for the daily teaching of general practice registrars](#)" explores this very issue and is recommended reading.

- **Video recording and feedback**
A great way to engage the registrar in reflective practice is to have the registrar record consults with patients, with the patient's consent. As a supervisor, you can replay the consults during dedicated teaching time and provide advice about what was done well and where opportunities for improvement are identified.
- **Role-play and discussion of difficult situations**
As their supervisor, you may also consider engaging the registrar in a reverse role-play - where the supervisor takes the lead as the clinician. Replication of what a registrar's behaviour (eg. invading personal space, engaging in consent in a tokenistic way, etc.) and asking the registrar to critique you can highlight what you have observed in their consultation, that they may not be aware of themselves until they experience it as "the patient". Role-playing clinical scenarios with emphasis on clinical reasoning, problem formulation and consult structure is another great development application of role-play as part of the supervisor toolkit.
- **Sitting in with an experienced doctor**
There is no substitute for learning professional behaviours through observation. The apprenticeship model is all about learning to put knowledge into practice. This occurs during clinical placement during undergraduate years, during their intern years and importantly must also occur during their vocational training. However you should also remember that bad habits may also be learned through direct observation.
- **Overall structure of consultation**
Where the structure for a consultation becomes second nature for a fellowed GP, registrars are relatively junior and IMGs may have learnt an entirely different approach to structuring a consultation. It should not be taken as given that a registrar or IMG knows how to structure a consult. Having a registrar explain to their supervisor at, or shortly after orientation, how they structure their consults or even sitting in on their first consult will flag any adjustments that need to be made.
- **Improving history taking**
It is important that an IMG learns that through history taking a lot of information is obtained, and by the end of the history taking the IMG should have a reasonable idea about what is going on for the patient. As a supervisor you can gain a good understanding about where a registrar's history taking skill is at by sitting in on a consult or completing a [random case analysis](#) of their patient notes. Registrars will gain a lot from the time you spend questioning them about the notes they have recorded and or by sitting in on their consultations or vice versa having them sit in on your own consults to observe.
- **Physical examination**
Registrars need to understand that patients expect to be examined in some way regardless of whether the presenting concern or patient history requires it. Failure to complete any physical examination can result in the patient leaving the practice feeling that they have not received adequate care. This can be as simple as taking a blood pressure and recording the result in the patient notes.
- **Creating structured management plans.**

There is a very good section in John Murtagh's book – Patient Education. The author sets out 10 steps for structural management plans, the first five of which should be done in every consultation.

IMG's need to learn how to tailor management plans to the individual including negotiation with the patient regarding agreed outcomes. They need to focus on what is more important for this particular patient.

- **How to deliver management plans effectively and confidently**

IMGs may be perceived by the patient as without authority, and the patient may feel that the doctor does not know what they are talking about or recommending.

IMG's need to develop self-confidence and take control of the consultation, particularly during the delivery of the management plan and negotiating agreed outcomes.

5 What strategies can be suggested to enable better communication from Doctor to patient?

- **Ask the IMG to "say it simply".**

IMGs may often explain something in a convoluted way. Ask the IMG to "say it simply". Often, when asked to explain what they mean, a registrar will explain it in vastly simpler language. If they have achieved a simpler explanation than their first attempt, this should be highlighted with them. If the registrar fails to deliver a less complex way of explaining something, supervisors can suggest: "Do you mean...(insert simpler way to explain it to the patient)".

- **Phraseology may not be understood**

Try explaining in a different way. IMG's need to understand their patient has a lot going on in the mind and may not be concentrating on what is being said. Checking with the patient what their understanding of what has just been explained to them is therefore essential.

- **IMG needs to speak clearly**

If your registrar has a strong accent, a repeat of what has been said may be required. Registrars with strong accents need to learn to ask the patient if they have understood the explanation and if it is critically important, for the patient to repeat back what they have heard. As a supervisor, you need to be aware that just as you would not consider your own accent to be a strong one or even notice that you have an accent, the IMG registrar may not be aware of how strong their accent is to their patients. If you are aware that this may become an issue for the registrar and or their patients, it is worth having this discussion early on during the registrar's orientation and putting in place a strategy for the registrar to employ during their consults.

- **Front desk staff may assist**

Reception staff can inform patients that the doctor has a strong accent, and to feel okay about asking for clarification if they are unclear about what is being said. Patients should be encouraged to ask - what do you actually mean, I didn't quite understand that? or, what are you trying to say?

- **IMG's need to practice giving explanations.**

Registrars can be encouraged to use John Murtagh's *Patient Education* – go to a particular page e.g. diarrhoea, read it and not memorise it, and then explain in their own words. A really

great strategy for registrars to practice their explanations is to record the explanation on their phone and then listen back, and/or provide the explanation to a friend/relative and ask them if they have understood. Note it is important for them to ask their friend or family to be critical of them, otherwise the exercise is pointless.

6 Are there any tips to help the IMG become more familiar with English language?

- **Engagement with media**

To help the IMG become more familiar with the English language they can be encouraged to watch TV shows, the news, read newspapers, read books, or even children's books are good. It is important to do this on a regular basis.

- **Online Learning**

English pronunciation can be assisted by online learning courses such as that offered by Star Pronunciation www.starpronunciation.com

- **Professional assistance**

Assistance from professional linguists may also be helpful.

7 What are the strategies to counter cultural reasons for not doing a physical examination?

- **Examination of opposite sex**

For some cultures it is not appropriate for a male to examine a female or vice versa. If a doctor is in training, they need to learn how to do all sorts of examinations which includes rectal and pelvic examinations and pap smears, etc. It is likely that they will come across a situation which requires that examination, and if they have never done it before they may get themselves into trouble. As a supervisor you need to be aware of cultural beliefs, values and how they will come into play with these types of experiences. Having the conversation up front will guide both the supervisor and the registrar in relation to how this learning experience is managed and likely result in a vastly better experience for the patient and the registrar.

- **Breadth of experience required**

It is not appropriate for the IMG to say that they will end up working in their own community so they don't need to learn particular procedures. GP registrars need breadth of experience and knowledge. They need to be comfortable with examining the opposite gender, talking about sexual history, talking about intimate body parts, talking about what is going on at home. In this regard, the registrar can decide where, what and how they practice after they have followed, but it is not their prerogative to carve out a niche area of practice for themselves during their training.

- **Assertiveness**

Registrars need to learn to be assertive whilst still being respectful of the needs and rights of the patient. Sometimes finding the right balance of assertiveness is a challenge for registrars. Cultural gender roles may be deeply ingrained. Regardless of where your registrar is 'at' on the assertiveness continuum, an appropriate balance between assertiveness, respect and consent must and can be learned. Encourage your registrar to structure their communication to:

- **prepare** the patient for the examination to follow
- **explain** what the examination will involve
- **seek the patient's consent** prior to performing the examination

An example of how this can be described is: "I need to examine you – I need to listen to your chest – I need to feel your tummy – are you okay with that"? Getting that specific consent is important.

- ***Use of gloves for examination***

In some cultures it is not appropriate for females to touch somebody else. The answer to this issue is simply the use of gloves. Similarly, doctors who have trained in another country may not have been exposed to the infection control procedures (i.e. the use of gloves during examination) that Australian Medical Graduates have been throughout their training. Although the use of gloves for examination is second nature for most doctors (IMGs included), it is recommended that this is covered during your orientation with any registrar.

8 Is a shared supervision model appropriate for the supervision of an IMG?

IMGs like any registrar can be supervised by a group of supervisors. Each supervisor has his or her own gifts to offer. It is good for a registrar to see differing styles of how we consult and problem solve while they are learning their own style.

When they sit in with you to observe your consult style encourage them to ask questions:

- Why did you make that diagnosis?
- How did you arrive at it?
- Did you think of the this?
- Why did you exclude that?

They need to become more comfortable in asking those types of questions - afterall, most of us don't know what we don't know... the acquisition of this knowledge requires a registrar to be inquisitive.