Supervising the International Medical Graduate (IMG) GP registrar

GPSA
GENERAL PRACTICE SUPERVISION AUSTRALIA

About this guide

International medical graduates (IMGs) are defined as those doctors whose medical qualifications are from a medical school outside of Australia. IMGs comprise about one third of the Australian medical workforce, with about 65% of IMGs working in locations outside capital cities.[1] The proportion of IMGs filling general practice training positions in Australia has increased over recent years, particularly in rural areas, and now represents over one quarter of all registrars in training.

International Medical Graduates face multiple challenges to successful passage through, and completion of, GP training. A 2007 systematic review stated that clinicians responsible for supporting and training IMGs need a thorough understanding of the range of communication and other issues confronting this group.[2] More specifically, there has been a call for GP supervisors to better understand and develop strategies to better support IMG GPRs[3].

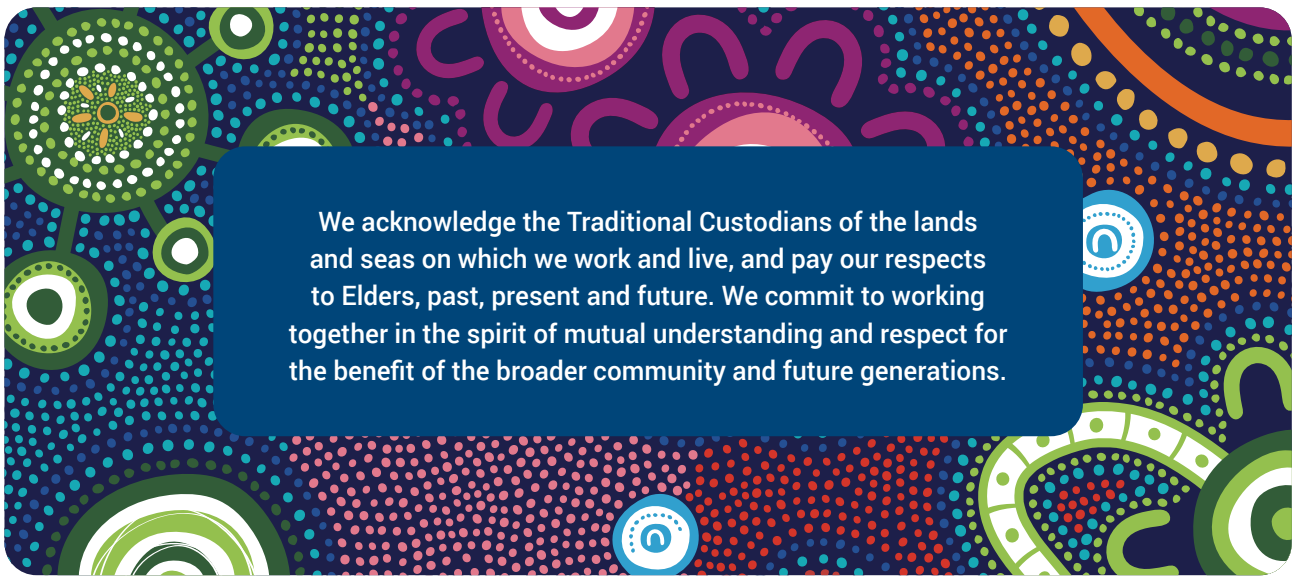
This GPSA guide sets out to address the specific needs for IMG GPRs and support GP supervisors in this aspect of their role. It aims to be a practical resource, giving a brief background to some of the issues facing IMG GPRs and straightforward suggestions on how to prevent and/or address such issues as part of supervision. This guide does not elaborate on the detailed management of specific performance issues in IMG GPRs – appropriate advice should be sought from the relevant College.

This guide is not intended to be used as a definitive reference but should be used in conjunction with the policies and guidelines of your own College, medical defence organisations and regulatory authorities.

Thank you to Dr Simon Morgan for writing this GP supervisor guide. Also, acknowledgements to Drs Gerard Ingham, Hung Nguyen, Jenni Parsons, Rebecca Stewart and Geeta Trehan for their review and input. Thanks too to our supporters. General Practice Supervision Australia (GPSA) is supported by funding from the Australian Government under the Australian General Practice Training (AGPT) program.

GPSA produce a number of relevant guides for GP supervisors and practices, visit www.gpsa.org.au to view additional guides.

Contents



Introduction

Imagine you have just moved from Australia to another country. Everything feels foreign and unfamiliar. The culture is vastly different to where you grew up – people dress differently, speak differently and act differently. You feel that you have a good grasp of the language, but it is second (or third) to what you speak at home and the nuances of colloquial conversation are very often lost on you. Your friends and extended family have remained in Australia, including your aging and frail relatives. You are homesick.

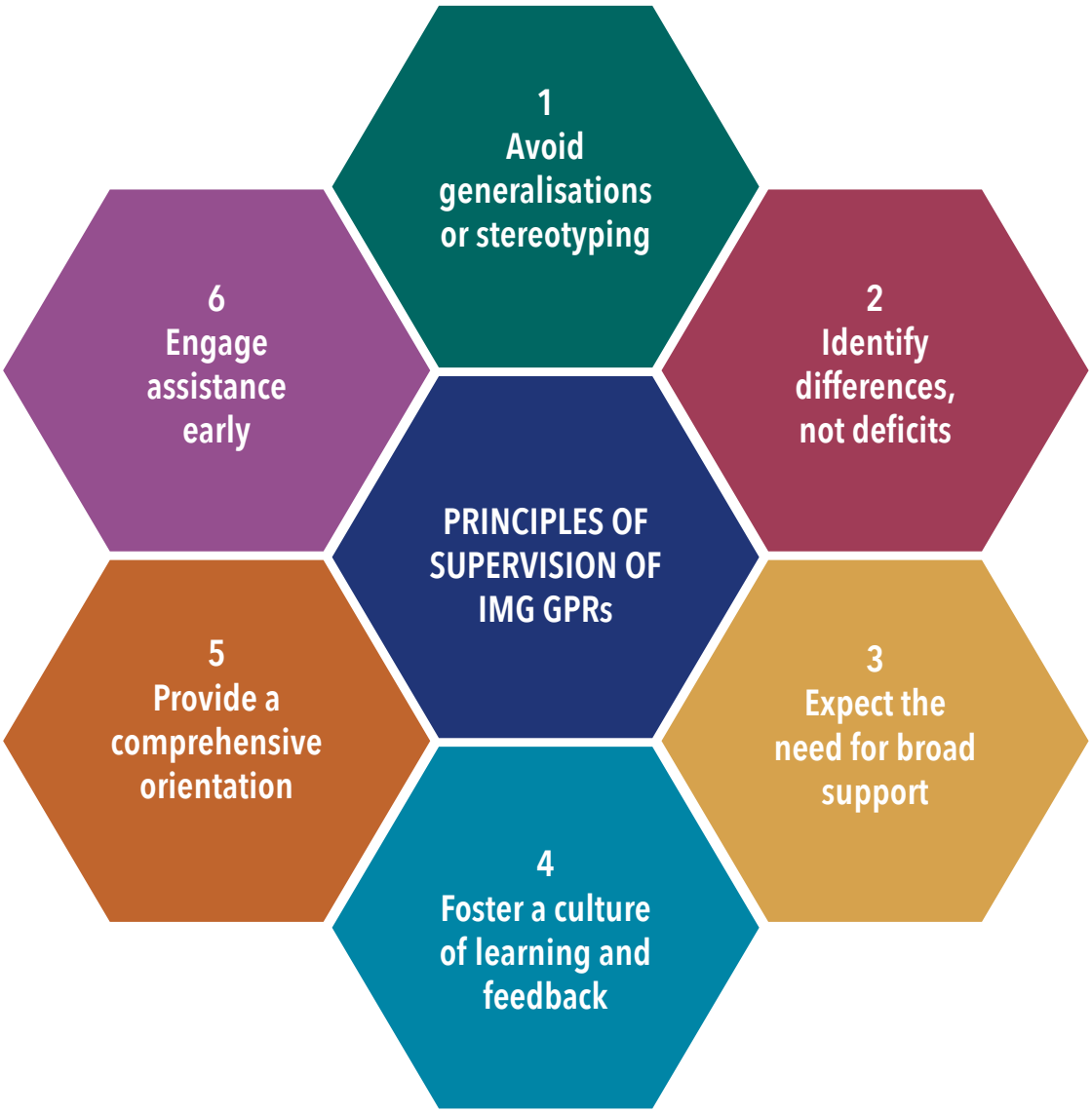
And now you're starting work in this new country as a doctor. The hospital hierarchy feels familiar, but you need to adjust to a new 'medical culture' and health system to that in which you trained back home in Australia. You interact with patients, some of whom have significantly different cultural values and norms to your own, on issues as challenging as gender, sexuality, and religious freedom. Your workplace is generally supportive, but you cannot help feeling that some people dismiss you as coming from another country. You miss your old job, and your family back home in Oz.

After a few years of navigating the hospital system you successfully apply for GP training. You are required to relocate to a rural town away from your community and social networks in the capital city. And you are immersed into yet another unfamiliar environment, primary care. The general practice systems are different to what you know, and you are uncertain of your role and boundaries with your patients in community practice. You struggle to know how best to fit into the primary care team and the small-town community and wonder if you will ever really feel like a GP.

This story, to varying degrees, is very familiar for many International Medical Graduate GP registrars (IMG GPRs) in Australian GP training.

Principles of supervision of IMG registrars

There are a number of broad principles that should guide the supervision of IMG GPRs. While these are appropriate to all registrars, they have particular importance for IMGs.



1. AVOID GENERALISATIONS OR STEREOTYPING

International Medical Graduates are not a homogenous group, and have a wide range of knowledge, skills, attitudes, experience, and backgrounds, even within the same cultural group. This may sound obvious, but it is critical to avoid generalisations or stereotyping, and for supervisors to regard every IMG as unique. Where issues arise, it is critical to specifically 'diagnose' the problem (educational, personal etc.), rather than generalising it as being 'cultural' or 'language'.

2. IDENTIFY DIFFERENCES, NOT DEFICITS

While often associated with posing educational and training challenges, IMG GPRs can bring a wealth of positive skills, attributes and expertise to GP training and the general practices in which they train. Such positives include:

- A broader world view.
- Experience of alternative health systems (often in disadvantaged communities).
- Specific clinical skills.
- Second (or third) languages.
- Resilience to setbacks.

Reflecting this, a recent paper on supporting IMG GPRs argued that the focus on supervision of IMG GPRs should be on 'difference', not 'deficit'.[3] Furthermore, the authors stated that labelling IMGs as having learning needs was unfair without also acknowledging their unique strengths.

3. EXPECT THE NEED FOR BROAD SUPPORT

The IMG GPR is may need increased support across all facets of training – educational, pastoral, personal and professional. While the transition from the hospital to the general practice setting is potentially highly challenging for all registrars – characterised by a breath of clinical problems, relative independence of decision making, time pressures, management of uncertainty, new practice systems, financial and billing issues – this challenge is likely to be exacerbated for many IMGs. It is essential that the supervisor of IMG GPRs is willing to take on this broad responsibility, and to be overt about their support role in all aspects of the registrar's development.

4. FOSTER A CULTURE OF LEARNING AND FEEDBACK

It is vital to foster an open and honest culture of teaching, learning and feedback in the practice. Supervisors should use a broad range of teaching methods and focus on skill development, rather than clinical knowledge. It may be necessary at times for the supervisor to have challenging conversations with the IMG GPR on sensitive areas like cultural norms and communication issues. Thus, it is critical for both supervisor and registrar to agree on a process for frank feedback, while also maintaining a culture of mutual support.

5. PROVIDE A COMPREHENSIVE ORIENTATION

One of the key planks in effective supervision of the IMG GP registrar is provision of a comprehensive orientation at the commencement of the training term. In addition to the usual clinical and administrative benefits, there is evidence that effective orientation of IMGs can increase their sense of professional identity, morale and belonging.[4] IMG registrars are likely to benefit from discussion of Aboriginal and Torres Strait Islander culture, as well as Australian culture more broadly, and community support. This may also include an orientation to the IMG registrar's partner and family.[4]

6. ENGAGE ASSISTANCE EARLY

Supervisors need to engage appropriate support from their regional training organisation, or elsewhere, when performance issues arise. Performance issues for IMG GPRs are often complex and may require specialist input. Supervisors should therefore have a low threshold for seeking guidance from the registrar's medical educator.[5]

Issues for IMG registrars

Common issues

For clarity, the common issues for IMG GPRs are categorised below. These headings reflect the findings of research work in the area and observations in practice. There is considerable overlap across these categories, for example communication and consultation skills, but hopefully such a categorisation provides a practical list for supervisors to help 'diagnose' and manage issues in their IMG GPRs.

Identification of issues

Issues are most likely to emerge and be identified in the day-to-day interactions of the supervisor and registrar. However, it can also be worthwhile attempting to identify any potential issues early in the placement using a range of tools. These include the 'IMG registrar self-assessment tool' and 'Supervisor assessment tool for IMG registrar' (see appendix).

Cultural issues

A culture is a set of beliefs and customs, rules of behaviour, and collective ideas that belong to a particular group or society. There are multiple definitions of culture, but in essence it is a collective understanding and way of living.

There are multiple issues related to cultural differences that are challenges for IMGs. Those specifically related to communication, the doctor-patient consultation, clinical skills, professionalism and teaching and learning are discussed in separate sections of this guide.

Medical culture and the Australian health care system

The culture of medicine varies enormously from one country to another. Medical culture does not refer only to the practices and processes of the health care system, but also the relationships and behaviours of the people within them. IMGs have previously identified that adapting to the Australian medical culture is a specific challenge and learning need.[6]

The Australian medical system is likely to be vastly different to that in which the IMG trained, in structure, funding and complexity. Adapting to the scope and boundaries of a new system can be bewildering for an IMG. It is important that the supervisor help them to build confidence in working within a new system without feeling overwhelmed.

The medical culture in Australia is also likely to be different. In many countries, the doctor operates from a position of considerable power compared to that of the patient. This is in stark contrast to the relatively equitable doctor-patient relationship common in Australian health care. For example, in many overseas medical cultures, the patient would rarely or never question their doctor. Transition to this non-hierarchical model and adjustment to a change in status can be a significant challenge for some IMG GPRs.

Additionally, many IMGs may need to adjust from being a respected specialist practitioner in their own country to being a trainee again. The need to study and pass exams in the new discipline of general practice can take a toll on self-esteem and confidence. It has been described that one of the important factors in IMGs adjusting to a new medical system is to maintain a positive self-image as a professional.

Another contrasting feature of Australian general practice with many overseas health care systems is the focus on continuity of care. Continuity of care is considered a core feature of both primary care and high-performing healthcare systems, and is associated with improved patient satisfaction, decreased emergency department attendance, decreased hospitalisation, and decreased patient mortality.[7] While it is regarded as integral to Australian general practice, it is often non-existent in many other settings.

TIPS

- Ask your registrar about the nature of the health system in their home country. Discuss the Australian health system and Medicare/PBS.
- Ask your registrar about their previous medical practice. How did they interact with patients? Did they work as part of a team? How did they interact with specialists and other care providers? What was the 'medical culture' in their home country?
- Discuss the 'culture' of Australian general practice, that of first contact, comprehensive, coordinated, continuing care, with an emphasis on longitudinal care.

Australian culture

IMG registrars have described the challenges of understanding Australian culture as a significant training issue, including aspects as diverse as dress codes, sexual practices and alcohol consumption.[6] A lack of understanding of Australian cultural values and norms has been described as contributing to issues with communication, rapport building and empathy for IMG GPRs. For example, it has been found that IMGs may at times impose their own cultural norms during a consultation, which may come across as judgemental. As well, racism and community acceptance has been identified as issues for IMGs.[6] Perceptions of IMGs can sometimes be uninformed or stereotyped, resulting in prejudice directed against them and their families.

TIPS

- Ask your registrar whether any aspects of the Australian culture are particularly challenging for them in their interaction with patients.
- Ask your registrar whether they have ever been subjected to racism and how they dealt with it.
- Encourage the registrar to watch popular Australian TV shows e.g. 'Home and Away' to gain an insight into Australian culture.

Cultural capability

Australia is a multicultural society, with almost half of Australians either born overseas or had one or both parents who were born overseas. In addition to adjusting to the cultural norms of mainstream Australia, IMG GPRs also need to develop cultural competence in managing patients from multiple cultural groups. Additionally, IMG GPRs need specific cultural competency skills in managing Aboriginal and Torres Strait Islander people, where cultural competency has been described as key strategy for reducing inequalities in health care access and improving the quality of care for this population.[8]

TIPS

- Ask your registrar to reflect on their own 'cultural lens' i.e., their own unique personal worldview influenced by the cultures that nurtured them. How might that impact on the approach to patients from other cultures?
- Discuss Aboriginal and Torres Strait Islander people as a population with specific cultural needs. The GPSA guide Aboriginal and Torres Strait Islander Health in General Practice is an excellent resource.

"A lack of understanding of Australian cultural values and norms has been described as contributing to issues with communication, rapport building and empathy for IMG GPRs."

Communication issues

Effective communication is a critical skill in general practice. There is strong evidence linking good communication with improved outcomes for both patients and doctors. The 'art of communication' has been described as applying the most appropriate skills to suit each unique patient-doctor interaction.[9]

Communication has been described as the most prominent issue impacting IMGs during GP training.[6] Most obviously, this can be related to language, accent, comprehension, and written English, but communication issues also include non-verbal and other subtle aspects of communication. Additionally, many overseas medical schools prioritise clinical knowledge acquisition over skills in doctor-patient communication in their training.

Communication issues can manifest in multiple ways and impact significantly on the effectiveness of the consultation. Importantly however, communication skills can be taught, and supervisors can play a vital role in this aspect of training. We recommend review of the GPSA Consultation Skills toolbox for communication skill resources.

Language and verbal communication

The Medical Board of Australia requires all doctors to demonstrate satisfactory English language skills for registration. However, it is well known that some IMG registrars have significant language issues that may impact on satisfactory communication, both with patients and peers. This has clear consequences for clinical outcomes, examination performance and confidence.

Most IMGs will have English as their second (or third or fourth!) language, even though they may have been exposed to English as the language of instruction. IMG GPRs may struggle with fluency and structure, and comprehension of colloquial English. As a result, IMGs may have problems:

- Picking up patient cues
- Demonstrating empathy
- Establishing rapport
- Appropriately responding to difficult situations
- Translating medical jargon into lay language.[6]

IMGs have also specifically identified that understanding Australian slang, idioms and mannerisms can be a challenge.

Giving appropriate feedback on language and verbal communication can be difficult. It has been described in the literature that commenting on an IMG's language skills could potentially be misperceived as racism, thus making any efforts to address perceived issues challenging.[10] However, such discussions are necessary, especially in the context of a possible impact on patient care.

Non-verbal communication

Communication is also heavily influenced by non-verbal cues, such as smiling, eye contact, body language, silence, and expressive touch. Non-verbal cues may have different meanings in different cultures – for example, smiling by the patient may mean embarrassment, maintaining sustained eye contact could be construed as disrespectful, and insufficient eye contact may be perceived as inattention or rudeness.

Written communication

Written English is an issue for many IMGs who have English as a second language. Difficulties with written communication can include comprehensiveness, organisation and clarity of documentation like referrals and clinical notes.

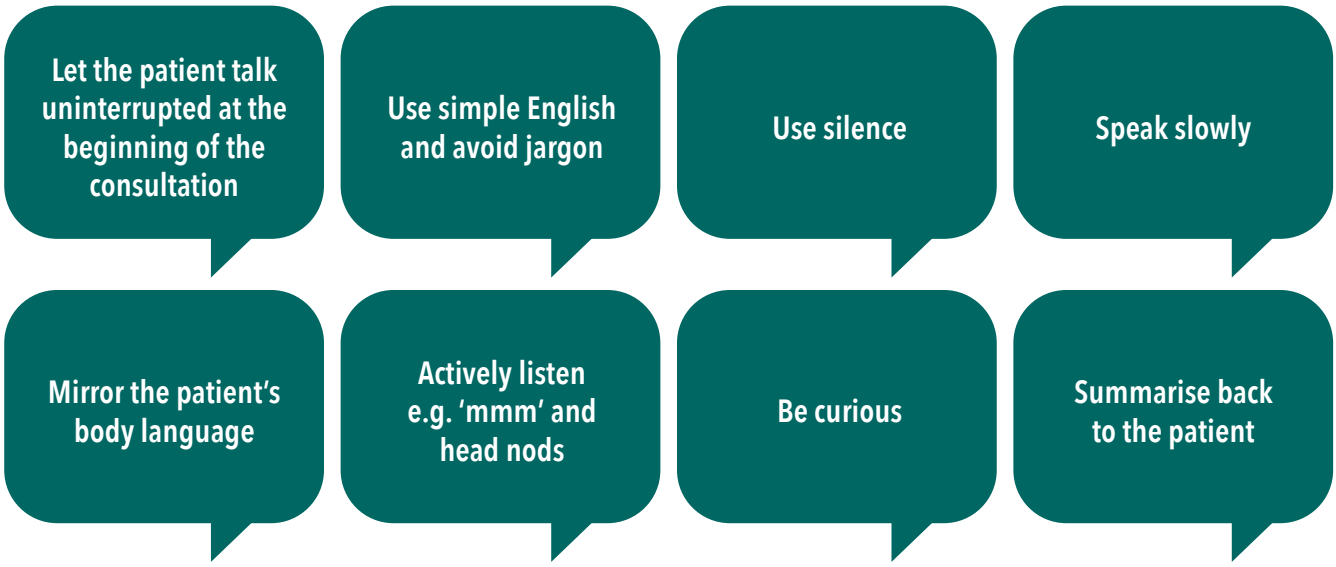
Specific scenarios

There are a number of general practice encounters that require the use of specific communication skills, for example communicating with children, managing the angry patient, saying no, breaking bad news[11], motivational interviewing[12], palliative care, and grief counselling. IMG registrars may not have been taught specific skills for managing such scenarios.

TIPS

- Ask your registrar what communication skills training they have done in the past, if any.
- Employ a broad range of teaching methods to focus on communication skill development e.g. direct observation, role play, random case analysis.
- Give explicit feedback on communication skill issues, including written English, even though it might be challenging.
- Demonstrate your 'spiel' for explanation and management of common clinical conditions.
- Encourage your registrar to use simple communication strategies in the consultation (see diagram 1).
- Discuss non-verbal cues and their likely meanings in Australian general practice.
- Discuss and role play situations where specific communication strategies may be required (as above).
- Encourage reflective practice in your registrar i.e. 'How well did I communicate in that consultation?'
- Encourage your registrar to watch local TV shows, read newspapers, see Australian films, attend local venues e.g. sports clubs or RSL (if comfortable) etc. to help refine their everyday English language skills.
- Consider online learning courses e.g. Doctors Speak Up website[13] or assistance from professional linguists/language teachers.
- Ask your registrar what their preferred style of communication is, direct v indirect - Erin Meyer's Culture Map
- Consider the cultural challenges of "saying no" to specific groups including boss, community elders etc and discuss strategies to deal with this - Lost in Translation webinar
- Provide useful phrases (see Table 1).

Diagram 1 - Basic communication skills



Clinical knowledge

As previously stated, the pass rate for Fellowship examinations is lower for IMGs, including in those assessments of applied clinical knowledge. There are likely to be many factors underpinning this, including cultural, English language comprehension, study techniques, and previous medical training. Knowledge gaps can be particularly prominent where the IMG has previously trained and worked as a specialist in their home country, and/or where they have worked in a narrow field of practice prior to starting GP training. Even where knowledge may be reasonable, it has been observed that the application of clinical knowledge can be an issue for some IMGs.

The epidemiology of many diseases is very different in Australia compared to other countries. Furthermore, GP supervisors have previously identified that IMGs may be unfamiliar with some common Australian general practice presentations, such as childhood asthma and psychosocial problems. This may have a cultural dimension – for example, in some countries, depression may not even be considered an illness. Additionally, patients in Australia may present much earlier in the course of their illness compared to patients in other settings, leading to a higher proportion of undifferentiated presentations. In many countries, the focus of clinical practice is on assessment and management of acute problems, and preventive care is a luxury only available to a small proportion of the population. Hence, understanding of screening and preventive health practice is a recognised knowledge gap for many IMGs.

TIPS

- Ask your registrar about the nature of their past clinical experience i.e. range of demographics, presentations etc.
- Help your registrar identify their learning needs and clinical knowledge gaps using appropriate methods e.g. clinical self-assessment tool, random case analysis
- Discuss local and national disease epidemiology
- Encourage use of appropriate clinical resources and guidelines e.g. RACGP Red Book, Therapeutic Guidelines, Health Pathways
- Use the GPSA teaching plans for in-practice teaching on identified knowledge deficits.

"Knowledge gaps can be particularly prominent where the IMG has previously trained and worked as a specialist in their home country, and/or where they have worked in a narrow field of practice prior to starting GP training."

Consultation issues

At the heart of general practice is the consultation, and it is the consultation that provides the context for the entirety of general practice education. The consultation can be viewed most simply as the sharing of information between patient and doctor, in order to develop both a common understanding and a plan of management. Consultation skills can be considered as the range of skills that underpin the effective doctor-patient encounter. They include core clinical skills and communication skills (as discussed in previous sections), but also a range of skills unique to the general practice encounter, like shared decision making.[14]

While a structured consultation is second nature for an experienced GP, registrars often struggle to facilitate an effective, organised, and time-efficient consultation with their patients. This is particularly the case for many IMG registrars, where the primacy of the general practice consultation may not have been a feature of their past training or experience.

Consultation models

Over the years, there have been several formal models of the consultation described in the international literature. One of the most enduring is Neighbour's 'The Inner Consultation'15, in which he proposed that the general practice consultation was 'a journey, not a destination', and described five 'checkpoints' along the way.

- Connecting – Have we got rapport?
- Summarising – Do I know why the patient that has come today?
- Handing over – Have we agreed on a management plan?
- Safety netting – Have I covered the 'what ifs'?
- Housekeeping – Am I in good shape for the next patient?

Closer to home, Murtagh stated that the objectives of the general practice consultation are to:

A. Determine the exact reason for the presentation.

B. Achieve a good therapeutic outcome.

C. Develop a strong doctor-patient relationship.[16]

TIPS

- Invite your registrar to sit in and observe your consultations, and then afterwards specifically discuss consultation structure.
- Use various consultation models as frameworks to teach IMG GPRs about the importance of a structured, patient-centred and safe consultation. Focus on specific areas which IMG registrars may find challenging, like connecting with the patient and handing over.
- Watch example consultations with your registrar and specifically discuss consultation structure.

Consultation skills

HISTORY TAKING

History taking can be compromised by language barriers, communication issues and cultural differences. As well, history taking is taught very differently in many international medical schools – often as an interview with a series of questions, rather than a dialogue with the patient (see section on patient centred care). IMGs may thus undertake history taking using a very biomedical approach, without the communication techniques commonly used to facilitate the patient's agenda (like the use of silence).

Additionally, there may be some aspects of history taking that are regarded as culturally unacceptable to perform, especially on patients of the opposite gender – for example, sexual history taking, discussing urogenital symptoms, or exploring social circumstances like intimate partner violence.

TIPS

- Ask your registrar whether there are any specific areas of history taking they are uncomfortable with e.g. sexual history taking etc. and focus on these areas during teaching
- Encourage the use of simple communication strategies for effective history taking – see Diagram 1
- Encourage the use of effective strategies for identifying the patient's agenda – see section on patient-centred care
- Use the GPSA teaching plan on history taking
- Practice psychosocial history taking.

PHYSICAL EXAMINATION

There are a number of recognised differences in the approach of IMGs to physical examination. There is a widely held cultural expectation in Australian health care that patients should be examined when they visit the doctor. However, in some cultures, physical examination is less commonly performed, or it may not be appropriate for a male to examine a female (or vice versa). As well, more intimate examinations like a pelvic examination may be deemed culturally unacceptable.

TIPS

- Ask your registrar whether there are any specific areas of physical examination they are uncomfortable with e.g. pelvic examination etc.
- Encourage your registrar to consider a focused examination as a fundamental element of the consultation unless there is justification to omit it – this may be as simple as BP check
- Discuss the role of the chaperone in general practice
- Use the GPSA teaching plan on physical examination

MANAGEMENT PLANNING

Another core clinical skill is formulation of a management plan, ideally one that genuinely includes the patient's input (see section on patient centred care and shared decision making). This is another potential area of consultation skill development for IMG GPRs. The role of the allied health practitioner might be unfamiliar to many IMGs, reflecting the medical culture and access to resources in which they trained.

INVESTIGATIONS

Another clinical skill which may be particularly challenging for IMG GPRs is the rational use of investigations. A number of factors may underpin this, including challenges in effective history taking and examination, lack of a patient-centred approach, intolerance of uncertainty, and the influence of past training or clinical practice.

TIPS

- Explicitly discuss the rational use of tests with your registrar, including the potential for harm in over-testing.
- Discuss approaches to avoid overtesting like seeking appropriate advice, using guidance, safety netting.
- Use inbox review as a teaching method
- Use the GPSA teaching plan on rational testing

PRESCRIBING

Prescribing is another recognised area of clinical skill development for IMG GPRs, with similar factors underpinning it.

TIPS

- Explicitly discuss the rational use of medicines
- Discuss appropriate guidance for prescribing like Therapeutic Guidelines
- Discuss the approach to interacting with pharmaceutical representatives.

Consultation tasks

Another useful framework for considering the range of consultation issues for IMGs is the Kalamazoo consensus statement, a widely adopted model for assessing communication skills.[17] The Kalamazoo statement describes seven essential sets of consultation tasks, namely:

1. Building the doctor-patient relationship.
2. Opening the discussion.
3. Gathering information.
4. Understanding the patient's perspective.
5. Sharing information.
6. Reaching agreement.
7. Providing closure.

These are elaborated below. Suggested phrases for each task are listed in Table 1.

BUILDING THE DOCTOR-PATIENT RELATIONSHIP

Establishing rapport with a patient is a critical step in best practice patient care. Rapport is positively established through a series of verbal and non-verbal communication strategies, as previously discussed. On the other hand, previous studies have shown that inappropriate use of the computer can negatively impact on rapport building.[18] Establishing and building the doctor-patient relationship is not a focus of medical training and medical practice in many countries. But while the registrar's background, confidence and personality will influence how well they can establish rapport, this skill can also be learnt.

TIPS

- Teach your registrar the micro-skills of how to build rapport, including appropriate social 'chit-chat', using the patient's preferred name, and putting the patient at ease
- Discuss the negative impact of the computer on building rapport

OPENING THE DISCUSSION

Opening the consultation is a critical skill that sets the tone for the rest of the encounter.

GATHERING INFORMATION

This comprises history taking and examination skills and is covered in the section on clinical skills.

UNDERSTANDING THE PATIENT'S PERSPECTIVE

Patient-centred care (PCC) is a model of care that is defined by understanding the whole person, respecting patient preferences and engaging patients fully in the process of care.[19] In practical terms, it involves establishing rapport and a connection with the patient, identifying the patient agenda, and sharing decision making. McWhinney, an academic GP from Canada, stated that patient-centred care is an approach where 'the health care provider tries to enter the patient's world to see illness through the patient's eyes'.[20] Patient-centred communication is positively associated with patient satisfaction, adherence and better health outcomes.21 It is rightly regarded as the foundation of good medical practice.

However, it has been found that many IMGs are unfamiliar with the model of PCC.[22] Previous research has established that some IMGs rely more on a paternalistic rather than patient-centred consultation style. This may reflect an absence of PCC training in the curricula of many international medical schools, or the hierarchical model of patient care in many countries. In contrast to the PCC model, features of the consultation with IMGs have been found to include:

- Framing consultations as interviews rather than conversations e.g. *'I will ask some questions to find out what's wrong.'*, with minimal scope for the patient to contribute or express their concerns
- Maintaining 'topic control' instead of allowing digressions, characterised by a checklist of questions, and a more structured, inflexible encounter
- Focusing on achieving 'simple coherence' rather than seeing the consultation as a whole – so called 'comprehensive coherence' or 'seeing the bigger picture'.[22]

IMGs can therefore encounter problems when trying to reconcile the relatively unfamiliar PCC model with their own understanding of the consultation.

In this regard, IMGs have been described as 'expert novices' - biomedical experts but novices in PCC.[22] The potential consequences of this non-PCC approach are multiple, including negatively impacting on the doctor-patient relationship; failing to identify the patient's agenda; failing to consider hidden agendas[23]; missing patient cues; sounding blunt, judgemental or unemphatic; failing to involve patients in decision making; and failing to negotiate the doctor and patient agendas.

Supervisors play a critical role in facilitating a more PCC approach to consultations in the IMG registrars. This goes beyond simply educating registrars on the need to consider the patient more or include some appropriate phrasing – indeed, the latter may exacerbate the tendency to adopt formulaic and ultimately ineffective communicative strategies. IMGs need the opportunity to receive feedback on patient encounters and reflect on practice to embed these skills.

TIPS

- Ask your registrar their definition and understanding of PCC and whether this was taught at medical school
- Use a range of teaching methods e.g. direct observation, role play and feedback, to teach PCC
- Explicitly discuss the patient-centred care model and encourage your registrar to read about further about it
- Discuss the specific areas of framing, topic control and coherence
- Discuss hidden agendas, and patient groups where they may be more common - teenagers, middle-aged men and the elderly.
- Discuss the use of ICE – ideas, concerns, and expectations – to help elicit the patient agenda.

SHARING INFORMATION

Murtagh lists as the first point in patient management 'Tell the patient the diagnosis'.[16] It is critical to

formulate and deliver a simple and clear explanation, including the provisional and differential diagnosis and the evidence supporting this, before discussing management. As appropriate, this explanation should also specifically refer to the patient's ideas, concerns and expectations. It is also essential to check the patients understanding. Sharing information in this way is a common skill gap for many registrars, and may be more prevalent in some IMGs.

Another essential skill for general practitioners is the management of uncertainty. There is conflicting evidence on whether IMGs have a different level of harm avoidance and tolerance of uncertainty to Australian trained doctors.[24] But in many countries, patients are less accepting of uncertainty and as a result many IMGs have been trained to 'make the diagnosis' and may be uncomfortable managing undifferentiated presentations. Management of uncertainty is an important area for which supervisors can support their IMG GPRs using appropriate strategies.

"It is critical to formulate and deliver a simple and clear explanation, including the provisional and differential diagnosis and the evidence supporting this, before discussing management. As appropriate, this explanation should also specifically refer to the patient's ideas, concerns and expectations."

TIPS

- Use mini-role play as a method to practice delivery of brief explanations.
- Discuss approaches to discussing uncertainty with the patient – a useful resource is the GPSA guide to Managing Uncertainty.
- Emphasise the frequency of undifferentiated presentations in general practice and that making a diagnosis is not always required.

REACHING AGREEMENT

Development of a management plan is another key consultation skill. While this requires satisfactory clinical knowledge and skills, it also requires understanding and application of shared decision making. Shared decision making is an approach where patients are genuinely involved in decisions around their care.[25] As above, it is a core feature of PCC.

TIPS

- Explicitly discuss the shared decision making approach and encourage your IMG registrar to read about further about it.

PROVIDING CLOSURE

Closing the consultation is an important step but one that IMGs may struggle with. This includes plans for follow-up and effective safety netting.

Table 1: Communication tasks and example phrases

Communication task	Example phrases
Builds the doctor-patient relationship Greets patient. Builds rapport. Shows concern.	*We haven't met before.* *Tell me a bit about yourself...* *I'm really sorry to hear that.* *That must be really tough.* *Just excuse me while I use the computer to take some notes.*
Opens the discussion Allows the patient to talk uninterrupted.	*How can I help you today?* *What can I do for you today?* *What would you like to talk about today?*
Gathers information Uses open ended questions. Screens for other problems. Clarifies issues. Actively listens.	*Start at the beginning and tell me what has been happening.* *Tell me more about that.* *I see. (active listening)* *So, before we explore that issue, can I ask whether there is something else you wanted to cover today?*
Understands the patient's perspective Identifies the patient agenda. Elicits ideas, concerns and expectations. Acknowledges and respond to the patients concerns.	*I have got a few thoughts about what might be going on, but before I share these, I wanted to ask what you thought might be causing this…* *A lot of people worry about serious causes. Do you have any particular concerns about what is going on?* *You have come today with concerns and expectations from the visit. Do you feel that these have been addressed?* *How were you hoping I could help you today?* *What is the most troubling thing for you?*
Shares information Gives clear explanation. Shares uncertainty. Checks patient's understanding.	*I have heard your story and examined you, and what I am thinking is…* *I am not entirely sure what to make of this…* *So, I think what I have heard is…*
Reaches agreement Shares decision making. Clarifies the patient's willingness and ability to follow the management plan.	*If you were to go home and tell your family what was the plan was, what would you tell them?* *Where do you think we should go from here?*
Provides closure Summarises and affirms agreement on the plan. Discusses follow up.	*Has this visit addressed your problems?* *When should we next meet to follow this up?*

Clinical reasoning

Clinical reasoning encompasses skills in effective data gathering (history, examination and investigation), data synthesis and interpretation, communication, managing uncertainty, patient-centred care, and evidence-based medicine. It is a core element of high-quality general practice.

Many of the core skills of clinical reasoning, and the reasons that these might be problematic for IMGs, have already been discussed. Additionally, IMG registrars may never have been introduced to some of the core concepts of clinical reasoning – the diagnostic process, cognitive biases, models for differential diagnosis generation e.g. Murtagh's model[16]; VITAMINSABCDEK.[26]

Clinical reasoning has been identified as a specific area of skill development for IMGs in its own right.[2] While clinical reasoning skills develop with experience, reflection and exposure to multiple patient presentations, they can also be taught. GP supervisors can therefore play an explicit role in the development of clinical reasoning skills in their IMG registrar, in particular to 'think like a GP'.

TIPS

- Explicitly focus on clinical reasoning skill development in your registrar teaching – a good resource is the GPSA Guide Teaching Clinical Reasoning
- Use a range of teaching methods e.g. direct observation, random case analysis, to support development of clinical reasoning skills
- Try to facilitate a broad clinical exposure for your registrar
- Discuss the diagnostic process and cognitive biases with your registrar
- Encourage the use of Murtagh's model[16]
- Encourage your registrar to use a diagnostic pause, consider gut feelings, think out aloud, and be reflective

Professional, ethical and medicolegal issues

Professional and ethical practice

Medical professionalism is regarded as one of the core factors in providing high-quality patient care.[27] Professionalism is closely associated with improvements in doctor-patient relationships, patient satisfaction, and healthcare outcomes.[28] A good doctor is intrinsically a professional doctor.

However, professionalism, and more specifically medical professionalism, is culturally determined and varies widely across countries and contexts. Perhaps not surprisingly therefore, professionalism is another area which has been identified as a focus for skill development for IMGs.[2] This includes issues such as setting boundaries, difficulties obtaining consent, reluctance to disclose errors, and interpersonal communication.

Medicolegal

There is evidence that IMGs from some countries have a higher risk of malpractice claims and adverse findings than Australian trained doctors.[29] Common themes of 'at risk' countries of training include English as a second language, and different medical education and health systems to Australia. Specific areas include opiate prescribing and managing drug seekers (including being able to 'say no'). For example, some drug seeking patients see IMGs as a 'soft target' and will sometimes be aggressive to get their way. Many IMGs may struggle with how to decline prescription requests.

The international literature on teaching skills in professionalism describes two complementary approaches. The first is teaching of the so-called 'cognitive base' of professionalism, that is the specific knowledge and skills in professional practice e.g. gaining consent, discussing confidentiality and dealing with error. The second approach is the teaching of professional attributes through role modelling and experiential learning.

TIPS

- Ensure your registrar has read the Medical Board of Australia Code of Conduct
- Explicitly encourage your registrar to disclose any mistakes or near misses and reassure them that they will be dealt with in a supportive and blame-free manner
- Discuss S8 prescribing as part of orientation
- Read the GPSA Guide Teaching Professionalism
- Use the GPSA teaching plan on professionalism
- Use the GPSA Flash Cards to discuss and/or role play challenging professional and ethical scenarios

"...medical professionalism is culturally determined and varies widely across countries and contexts. Perhaps not surprisingly therefore, professionalism is another area which has been identified as a focus for skill development for IMGs."

Teaching and learning issues

Successful completion of GP training requires high level skills not only in clinical general practice, but also effective learning. This includes effective knowledge and skill acquisition and application, efficient study practice, the ability to receive and act on feedback, and reflective practice.

As previously described, IMG registrars are known to have lower pass rates in Australian GP training.[31] One of the many potential factors underpinning this relates to the approach to learning.

Cultural perceptions of learning

There are well recognised cultural differences in the nature of teaching and learning across different contexts. Many cultures embrace a strong hierarchy in the educational process, in which the teacher is seen as an expert, rather than a facilitator of knowledge. In such settings, there is often much less emphasis on identification of the learners individual learning needs and self-directed learning. The IMG registrar may be less comfortable speaking up or challenging their teacher. Furthermore, the style of learning is often focussed on rote learning and fact memorisation, rather than applied or problem based. As a result, the approach to teaching and learning in many international medical schools is very different to that in Australia. This may impact significantly on an IMG GPRs ability to learn in Australian general practice training.

"...the approach to teaching and learning in many international medical schools is very different to that in Australia. This may impact significantly on an IMG GPRs ability to learn in Australian general practice training."

TIPS

Explore your registrar's previous experiences in education and training.

- Where did they train in medical school?
- What was the format of that training e.g. large or small group learning? How did they view the role of the teacher in their training? What was their role as learner?
- Ask your registrar how they identify their own learning needs. Help them identify their learning needs using appropriate tools e.g. a self-assessment tool.
- Discuss 'two-way' learning in the practice, where your role as supervisor is not as an expert but facilitator of knowledge and skills.
- Don't assume that lack of responsiveness is lack of interest, under-confidence or disengagement – it may be a cultural approach to learning.
- Overall, encourage your registrar to take control of their own learning.

Study techniques

Over recent years there has been an increasingly strong focus on study skills and techniques in GP training, especially for those registrars unsuccessful in Fellowship examinations. It has been described that many IMGs use outdated study techniques such as rote learning, and utilise a limited range of resources, rather than more evidence-based approaches like spaced practice. Furthermore, many IMGs are older and may have difficulties with efficient studying and recall, as well as juggling work and family commitments.

TIPS

- Explore your registrar's approach to study and the techniques they use
- Refer to best practice study techniques
- Explicitly discuss the need to develop skills and apply knowledge, rather than just learning factual information
- Encourage a range of learning resources e.g. video, podcasts etc.
- Encourage the registrar to join a study group – the value of group discussion is very high
- Recommend that the registrar read the GPSA Study Skills guide

Exam preparation

Passing the Fellowship barrier examinations is the goal of every registrar in training and can be the source of significant anxiety and stress. Unfortunately, IMGs are known to have lower pass rates in postgraduate examinations than local doctors, including in Australian GP training.[2] There are likely to be many factors underpinning lack of exam success – cultural issues, communication and English language skills, clinical skills, study techniques – which are described in the sections above.

One particular difference between Australia and many overseas countries is the approach to oral examinations. IMGs may be more familiar with an examination style of interrogation and identification of knowledge gaps, rather than facilitating the demonstration of what a candidate knows. In many settings oral examinations are traditionally examiner-led, rather than candidate-led, and IMGs may need to change their approach from passivity and be encouraged to speak confidently about what they know.

While there is a wealth of literature on the reasons underpinning exam failure, it is also of value to reflect on the factors for exam success in this cohort.[32] A paper from the UK described six main themes for success, including:

- Insight into challenges – cultural, communication etc.
- Proactive approach – planning learning, early preparation, study techniques
- Refining consultation skills – consultation structure, consultation skills
- Learning with local graduates – especially communication skill development
- Valuing feedback – seeking feedback from multiple sources
- Supportive relationships – practice, community

Supervisors can foster and encourage these broad approaches and attitudes in their IMG GPRs to maximise the chances of success in the exams.

TIPS

- Ask your registrar to complete the self-assessment tool to help identify potential barriers to exam success
- Dedicate in-practice teaching time to specific exam preparation, especially in the areas of communication and consultation skills
- Facilitate peer support and group learning

Reflective practice

Reflection in medical education has been defined as '*a metacognitive process that occurs before, during and after situations with the purpose of developing greater understanding of both the self and the situation so that future encounters with the situation are informed from previous encounters.*'[33] There is an increasing emphasis on reflective practice in medical education. Reflective practice can improve skills in professionalism and clinical reasoning, and lead to better patient management.

Genuine reflective practice may be a new concept to many IMGs – they may simply never have been encouraged to stop and reflect on their practice and performance in the past. But self-reflection is a skill that can be fostered during a registrar's training.[34]

TIPS

- Encourage reflective practice using discomfort logs, journaling, case discussions etc.

Feedback

While delivery of feedback can be challenging in any circumstance, there are specific issues for IMGs that can make this even more challenging. These include the perceived power dynamics between teacher and learner, communication issues, attitudes towards critique, and potential vulnerability in evaluation. In many cultures, critique is not a usual part of day-to-day practice and can therefore be misconstrued as evidence of a serious failure. Indeed, feedback has been more often associated with loss of face, shame and embarrassment in IMGs than other registrars.[2]

"In many cultures, critique is not a usual part of day-to-day practice and can therefore be misconstrued as evidence of a serious failure."

TIPS

- Ask your registrar about their previous education and training and how feedback was given. How has their performance been evaluated in previous learning situations? What type of feedback are they familiar with? How do they find receiving feedback?
- Explicitly discuss the nature and process for feedback in the practice (regular, frank, supportive)
- Establish a good relationship with your registrar based on respect, trust, transparency and openness at the beginning of the placement to provide a sound base for constructive feedback
- Invite feedback on your own performance as a supervisor to help normalise this in the practice
- Consider cultural experiences and expectations with feedback and explain usual processes in Australia

Help seeking

Recognising one's limitations and appropriate help-seeking is a core general practice skill, and a fundamental aspect of safe practice. It is also essential for effective learning. However, it is known that the approach to help seeking varies between cultures and can impact on learning. IMG registrars may not ask for assistance directly, but may instead more subtly 'hint' at problems. This may be overlooked or misinterpreted by the supervisor.

TIPS

- Ask your registrar about their comfort with calling for help.
- Explicitly discuss the nature and process for help-seeking in the practice i.e. when to call, how to call.
- Review a 'call for help' list at the commencement of the practice.

Personal issues

General practice training is a demanding and potentially stressful experience for all registrars. It requires them to balance work, family, study and other demands. However, for many IMGs, the personal stressors are magnified. Migration and displacement may mean the absence of family and community supports. IMGs have described relocation to rural areas as a particularly stressful time, commonly associated with separation from partners and isolation. Family concerns are thus common. As previously discussed, IMGs may be subject to prejudice or racism, which understandably can have a major impact on wellbeing. As well, IMG GPRs may have to adapt to a sudden change in status (specialist to trainees).

Personal issues may impact significantly on a registrar's performance and motivation to study. Supervisors should therefore explore such issues with their IMG registrar at the commencement of term and regularly throughout.

TIPS

- Get to know the story behind your registrar – their background and life
- Let the registrar know that you 'have their back' at all times
- Encourage participation in community events
- Encourage your registrar to have their own GP

Case study

David Zhang is a 38-year-old GP registrar who is currently three weeks into his first GP term. David grew up and undertook his medical training in China, and then worked there for many years as an ophthalmologist before moving to Australia seven years ago. After completing his AMC, David worked in the emergency department of one of the large capital city hospitals for a couple of years. He then successfully applied for GP training and did another hospital year as a RMO in general medicine and surgery as part of his training.

David is a rural pathway registrar and is on the ten year moratorium. Three weeks ago, David started working at a practice in a rural town, four hours from the capital city, under the supervision of an experienced supervisor Maria Fiolli. His wife and two children, aged ten and seven, have remained in the family home, and David has relocated to a small flat in the town. He plans to return home every weekend to see his family if not on call.

In the lead up to the placement, Maria was in close communication with David about securing accommodation and relocation to the town. Having supervised many IMG registrars in the past, she was acutely aware of the need for support in the weeks before and after commencing the placement, especially as David was leaving his family behind. Having interviewed him and read his application letter, Maria already had a bit of an idea about David's communication skills – she was aware that he had a strong accent and was softly spoken, and at times was hard to understand.

Maria's practice took pride in the comprehensiveness of their orientation for new registrars. Not only did they use an orientation checklist, they also personally introduced their new registrars to key people like the local pharmacist, the senior nurses at the local nursing home and the physio team. They had recently become aware of the GPSA resources for IMG registrars and asked David to complete the self-assessment tool.

At their first formal teaching session, Maria talked with David about a several issues. She firstly said how much she enjoyed having IMG registrars in the practice, and really valued the unique skills and experience they brought. She was particularly looking forward to getting his advice on any worrying eye presentations! She flagged that in her observation, IMGs often faced issues navigating training and was explicit about her availability for support.

Maria then reviewed David's self-assessment form and used the supervisor tool to further explore a few specific issues.

Cultural

David identified that he had no past experience of Australian general practice, and even though he had lived in the country for seven years, found many aspects of the Australian culture hard to understand. He thought he had a reasonable grasp of Australian slang. Maria recommended David review the online MBS and PBS modules and to read a resource on Australian general practice.

Communication

David identified that his spoken English had been flagged as a communication issue in the past and that he was keen to improve this while in general practice. He also felt this his language and cultural background could impact on his communication in sensitive situations like breaking bad news. Maria suggested the Doctors Speak Up website which she had referred other IMG registrars to and found to be excellent.

Clinical

David was hopeful that his ED experience and recent experience in medicine and surgery would be good background for general practice. He recognised that he was underconfident in paediatrics. He said that there were no particular areas of clinical practice that he felt uncomfortable about, but had identified women's health as a knowledge gap. David was aware of a clinical learning needs assessment tool through the College and planned to complete it once he had settled in.

Consultation

David flagged that there was very limited focus on 'the consultation' as part of his medical training and past practice in China. He had not really come across the notion of 'patient-centred care' but was very keen to learn. Maria flagged that this was a core element of her teaching and she help him develop these skills.

Clinical reasoning

Again, this was an area David said that he had limited understanding of.

Professional, ethical and medicolegal

David said that he really did not know whether he had gaps in these areas. As part of the practice orientation, David had been given the Medical Board of Australia Code of Conduct resource which he had not yet read. Maria confirmed that they would dedicate a teaching session to this in the next couple of months.

Teaching and learning

On discussion, Maria confirmed her belief that David's medical training was very hierarchical and didactic, and discussed the approach she would take in the practice – learner-centred and problem-based. She also explicitly discussed the approach to help-seeking and established that David was comfortable always seeking her assistance. Together, they reviewed a 'call for help' list and flagged a number of presentations warranting Maria's review. Maria also reinforced her strong belief in 'two-way' feedback.

Personal

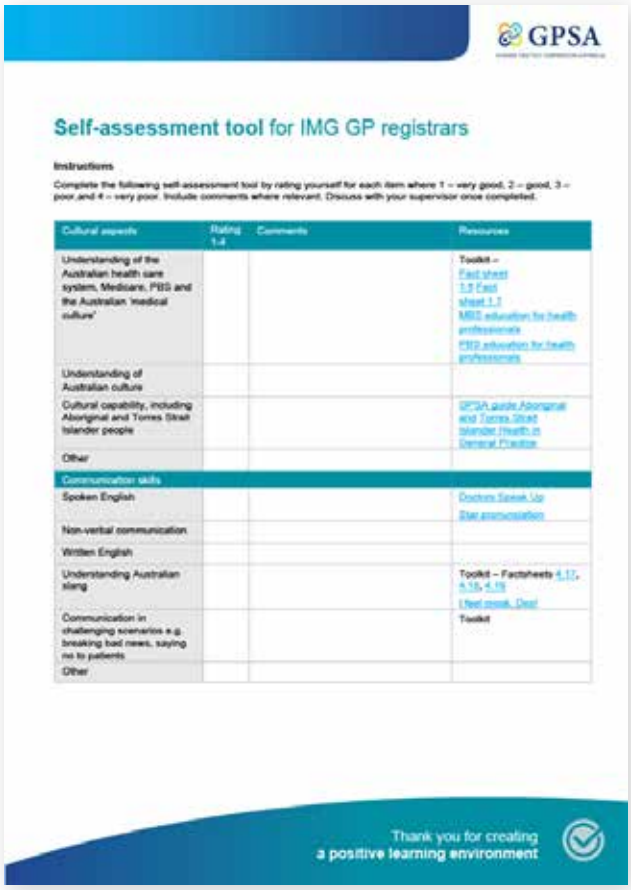
'So far, so good' was David's reply in relation to how he was settling into the town, but he certainly was missing his family. David's family have a GP in the city, but David thinks it might be difficult to get there for his own health. Maria suggests telehealth may be an option for David to contact his GP if necessary, and tells David there are a couple of GPs in a nearby town who have an interest in doctor's health.

Maria and David developed a brief learning plan as a result of this discussion. In the subsequent couple of weeks, they undertook direct and reverse direct observation, and a brief session on random case analysis. Maria referred David to a few other resources, including the GPSA Aboriginal and Torres Strait Islander guide, the RACGP Red Book, the most recent BEACH report on Australian general practice activity, and a brief paper on identifying the patient agenda. And they also set up a time for David to come to Maria's house for dinner and meet her horses!

Appendices

Appendix 1 -

Self-assessment tool for IMG GP registrars



GPSA

Self-assessment tool for IMG GP registrars

Instructions

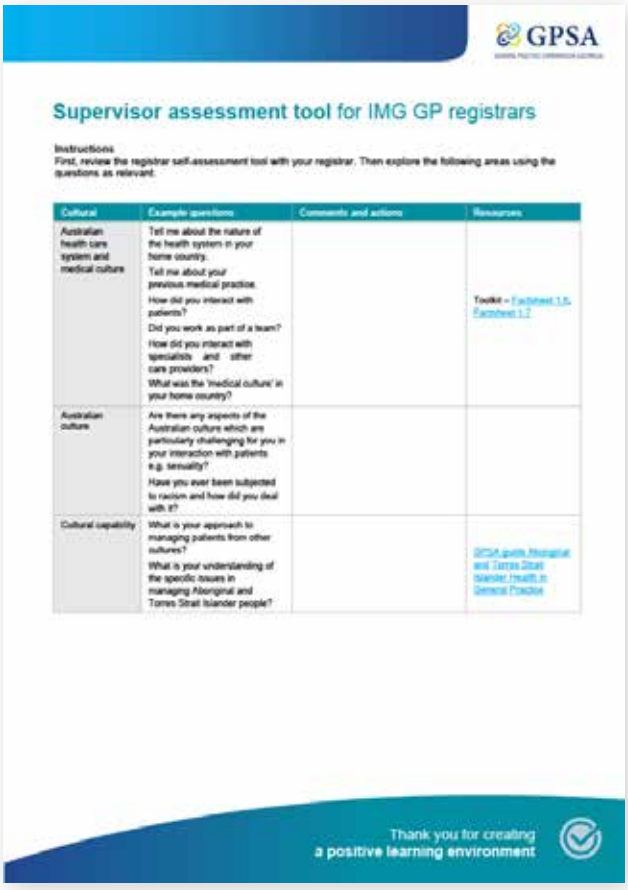
Complete the following self-assessment tool by rating yourself for each item where 1 – very good, 2 – good, 3 – poor,and 4 – very poor. Include comments where relevant. Discuss with your supervisor once completed.

Cultural aspects	Rating 1-4	Comments	Resources
Understanding of the Australian health care system, Medicare, PBS and the Australian 'medical culture'			Toolkit – Fact sheet 1.5 Fact sheet 1.7 MBS education for health professionals PBS education for health professionals
Understanding of Australian culture			
Cultural capability, including Aboriginal and Torres Strait Islander people			GPSA guide Aboriginal and Torres Strait Islander Health in General Practice
Other			
Communication skills			
Spoken English			Doctors Speak Up Star pronunciation
Non-verbal communication			
Written English			
Understanding Australian slang			Toolkit – Factsheets 4.17, 4.18, 4.19 I feel myself, Dad
Communication in challenging scenarios e.g. breaking bad news, saying no to patients			Toolkit
Other			

Thank you for creating a positive learning environment

Appendix 2 -

Supervisor assessment tool for IMG GP registrars



GPSA

Supervisor assessment tool for IMG GP registrars

Instructions
First, review the registrar self-assessment tool with your registrar. Then explore the following areas using the questions as relevant.

Cultural	Example questions	Comments and actions	Resources
Australian health care system and medical culture	Tell me about the nature of the health system in your home country. Tell me about your previous medical practice. How did you interact with patients? Did you work as part of a team? How did you interact with specialists and other care providers? What was the 'medical culture' in your home country?		Toolkit – Factsheet 1.5, Factsheet 1.7
Australian culture	Are there any aspects of the Australian culture which are particularly challenging for you in your interaction with patients e.g. sexuality? Have you ever been subjected to racism and how did you deal with it?		
Cultural capability	What is your approach to managing patients from other cultures? What is your understanding of the specific issues in managing Aboriginal and Torres Strait Islander people?		GPSA guide Aboriginal and Torres Strait Islander Health in General Practice

Thank you for creating a positive learning environment

References

1. Australian Institute of Health and Welfare. Medical practitioners workforce 2015. Canberra: Australian Institute of Health and Welfare; 2016. Available from: https://www.aihw.gov.au/reports/workforce/medical-practitioners-workforce-2015.
2. Pilotto L, Duncan G, Anderson-Wurf J. Issues for clinicians training international medical graduates: a systematic review. Med J Aust. 2007;187(4):225-8.
3. Wearne SM, Brown JB, Kirby C, Snadden D. International medical graduates and general practice training: How do educational leaders facilitate the transition from new migrant to local family doctor? Med Teach. 2019;41(9):1065-72.
4. Carlier N, Carlier M, Bisset G. Orientation of IMGs: A rural evaluation. Aust Fam Physician. 2005 Jun;34(6):485-7.
5. The Royal Australian College of General Practitioners. A guide to understanding and managing performance concerns in international medical graduates. East Melbourne, Vic: RACGP; 2020. Available from: www.racgp.org.au/education/gps/a-guide-to-understanding-and-managing-performance/introduction.
6. McDonnell L, Usherwood T. International medical graduates. Challenges faced in the Australian training program. Aust Fam Physician. 2008 Jun;37(6):481-484.
7. Wright M, Mainous GA. Can continuity of care in primary care be sustained in the modern health system? AJGP. 2018; 47(10):667-9.
8. Bainbridge R, McCalman J, Clifford A, Tsey K. Cultural competency in the delivery of health services for Indigenous people. Issues paper no. 13. Produced for the Closing the Gap Clearinghouse. Canberra: Australian Institute of Health and Welfare & Melbourne: Australian Institute of Family Studies. 2015.
9. Warnecke E. The art of communication. Aust Fam Physician. 2014; 43(3):156-8.
10. McGrath P, Henderson D, Holewa H. Language issues: An important professional practice dimension of Australian International Medical Graduates. Comm and Med. 2013; 10(3):191-200.
11. Buckman RA. Breaking bad news: the SPIKES strategy. Comm Oncology. 2005; 2:138–42.
12. Sim M, Wain T, Khong E. Influencing behaviour change in general practice Part 1 – brief intervention and motivational interviewing. Aust Fam Physician. 2009; 38: 885-888.
13. Woodward-Kron R, Fraser C, Pill J, Flynn E. How we developed Doctors Speak Up: an evidence-based language and communication skills open access resource for International Medical Graduates. Med Teach. 2015; 37:31-3.
14. Morgan S, Chan M, Starling C. Starting off in general practice – consultation skill tips for new GP registrars. Aust Fam Physician. 2014; 43: 645-8.
15. Neighbour R. The inner consultation: how to develop an effective and intuitive consulting style. 2nd edn. Oxford: Radcliffe Medical Press; 2004.

16. Murtagh J. John Murtagh's General Practice. 5th edn. Sydney: McGraw-Hill; 2010.
17. Makoul G. Essential elements of communication in medical encounters: the Kalamazoo consensus statement. Academic Medicine. 2001; 76(4):390-3.
18. Booth N, Robinson P, Kohannejad J. Identification of high-quality consultation practice in primary care: the effects of computer use on doctor–patient rapport. Inform Prim Care. 2004;12:75–83.
19. Stewart M, Brown J, Weston W, et al. Patient-Centred Medicine: Transforming the Clinical Method. 2nd edition Oxford: Radcliffe Medical Press, 2003.
20. McWhinney I. The need for a transformed clinical method. Communicating with Medical Patients. 1989; Vol. 9, pp. 25-40.
21. Stewart M. Effective physician-patient communication and health outcomes: a review. Can Med Assoc J. 1995; 152: 1423–33.
22. Dahm M. Patient centred care: Are international medical graduates 'expert novices'? Aust Fam Physician. 2011; 40: 895-900.
23. Hannay DR. The iceberg of illness and trivial consultations. J R Coll Gen Pract. 1980; 30:551–54.
24. Eley D, Laurence C, Cloninger CR, Walters L. Who attracts whom to rural general practice? Variation in temperament and character profiles of GP registrars across different vocational training pathways. Rural and Remote Health. 2015; 15: 3426.
25. Charles C, Gafni A, Whelan T. Shared decision making in the medical encounter: what does it mean? (or it takes at least two to tango). Soc Sci Med. 1997 Mar; 44(5):681-92.
26. Zabidi-Hussin ZA. Practical way of creating differential diagnoses through an expanded VITAMINSABCDEK mnemonic. Adv Med Educ Pract. 2016;7:247-248. Published 2016 Apr 22. doi:10.2147/AMEP.S106507.
27. Project MP. Medical professionalism in the new millennium: a physicians' charter. The Lancet. 2002; 359: 520–522.
28. Lesser CS, Lucey CR, Egener B, Braddock CH 3rd, Linas SL, Levinson W. A behavioral and systems view of professionalism. JAMA. 2010; 304: 2732–2737.
29. Elkin K, Spittal M, Studdert D. Risks of complaints and adverse disciplinary findings against international medical graduates in Victoria and Western Australia. Med J Aust. 2012;197; 448-452.
30. Birdon H, et al. Teaching professionalism in medical education: A Best Evidence Medical Education (BEME) systematic review. Medical Teacher. 2013; 35:7.
31. Harris A, Delany C. International medical graduates in transition. Clin Teach. 2013; 10:328–332.
32. Ragg E, O'Rourke J, MacVicar R. International medical graduates: a qualitative exploration of factors associated with success in the clinical skills assessment. Ed Prim Care. 2015; 26(6):378-85.
33. Sandars J. The use of reflection in medical education: AMEE Guide 44. Med Teach. 2009; 31:685-695.
34. Robertson. K. Reflection in professional practice and education. Aust Fam Physician. 2005; 34: 781-783.

GPSA

GENERAL PRACTICE SUPERVISION AUSTRALIA

gpsa.org.au

facebook.com/GPSupervision

twitter.com/GPSupervision