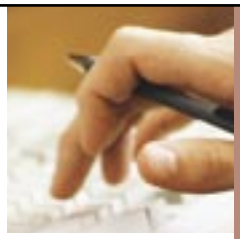

# Orientation of IMGs

## *A rural evaluation*

**Neville Carlier,** MBBS, FRACGP, MPH, is Medical Director, Eyre Peninsula Division of General Practice, Port Lincoln, South Australia.

**Meredith Carlier,** BEd, MEdSt, GradDipHealthEd, is Workforce Support Officer, Eyre Peninsula Division of General Practice, Port Lincoln, South Australia. mcarlier@epdgp.org.au

**Glenys Bisset,** is Executive Officer, Eyre Peninsula Division of General Practice, Port Lincoln, South Australia.

Successful orientation and continued support for international medical graduates (IMGs) and their families might improve the retention of doctors in the rural medical workforce to the benefit of rural communities. Divisions of general practice are in an ideal position to coordinate orientation and continued support for new rural IMGs, as they are familiar with the local medical scene and with existing supports for families of doctors living in the area. The Eyre Peninsula Division of General Practice in South Australia evaluated the orientation received by new IMGs who had come to work in this division between 1998 and 2003, to find ways of improving orientation for future IMGs.

Due to a shortage of Australian medical graduates to meet the needs of rural Australia,[1–6] Australia has been recruiting international medical graduates (IMGs) to the rural medical workforce. The Eyre Peninsula Division of General Practice (EPDGP) in rural South Australia supports general practitioners in 11 rural towns varying in population size from 1000 to 24 000. Seven of the towns are served by a solo GP. In 2003, 47% of the 44 GPs in this division had been recruited from overseas, and 76% of these had arrived in the past 5 years.

International medical graduates have usually trained and practised in settings where disease patterns, levels of technology, treatment options, forms of health care delivery, workplace hierarchies, and social mores differ from Australia.[7] Orientation aims to help these doctors understand and integrate into their new working environment.[8] Other studies have found that orientation of new IMGs resulted in a more integrated, confident and functional workforce,[7] and increased the sense of professional identity, morale and feeling of belonging.[9]

While larger practices tend to orientate their own new doctors, smaller practices have asked for help from the larger practices and more recently, the EPDGP. The Rural Doctors Workforce Agency (RDWA) meets new IMGs on arrival in South Australia, helping with introductions to the Medical Board and the Health Insurance Commission, and also funds the Rural Family Medical Network (RMFN) to provide support for the IMG's family.

## The survey

A self administered questionnaire was posted to 20 of the 22 IMGs who had arrived to work in this division between 1998 and 2003. Two doctors who had left the division were excluded. A covering letter explained the purpose of the survey and offered $65 for completing the questionnaire. Steps were taken to preserve confidentiality.

The questionnaire asked about the doctor's broad age group, place of medical training, years of experience and any special skills they had before arriving in Australia. Respondents were then asked to rate the importance of various orientation topics (*Table 1*) and their confidence in these topics at the end of their orientation on a scale of 0 to 4. Other questions about orientation concerned its duration (actual and preferred), who provided it, and satisfaction with it. Doctors were also asked about the difficulties (on a scale of 0 to 4) they and their family experienced while settling into a rural Australian town, and who their supports were. Suggestions on how orientation could be improved were invited.

Occupational orientation was defined as starting when the new doctor was able to spend time each day with another person who taught and answered questions regarding the orientation topics in *Table 1*, and ending when they were consulting without using or accessing this support on a daily basis.

The questionnaire was developed in consultation with PHCRED staff and with the Flinders and Far North Division of General Practice. The University of South Australia's Human Research Ethics Committee approved the study. EpiInfo™ was used for data entry and analysis.[10]

## Results

All 20 doctors completed and returned the questionnaire. Most (75%) had arrived in Australia in the past 4 years, with only 20% arriving 5–6 years ago. Africa was the most common place of primary medical training (65%) compared with Asia (15%) and Europe

(15%). Most doctors were in the 30–49 years age group (85%) with only 10% over 50 years and 5% under 30 years of age. The majority (70%) had more than 10 years experience, with 20% having 5–10 years, and 10% having less than 5 years. While 45% had obstetric skills before arrival, only 30% were still using these skills. Similarly, 45% had anaesthetic skills before arrival, but only 25% were still using these skills. Ten percent were working in solo GP towns, 20% in towns without specialists. Intended length of stay varied from 1–4 years (25%) through 5–9 years (30%) to 10 or more years (20%), while 20% were unsure.

The median duration of orientation was 1 week, ceasing when consultation began. Preference was for a longer duration (median 2 weeks), continuing for 1 week after consultation began. The most common provider of orientation was the recruiting practice (60%) while other practices (30%), people in the capital city (20%) and local divisions (5%) also contributed. Twenty-five percent said they had no formal orientation. Just over half (55%) were satisfied with their orientation, 35% dissatisfied, and 10% undecided. There was a higher level of dissatisfaction (60%) among doctors with no formal orientation.

Respondents gave the highest importance ratings to clinical and financial topics such as prescribing, medicolegal issues, clinical support, enhanced Medicare items and billing. The lowest importance ratings were given to social topics such as Australian and Aboriginal culture, community services and divisions of general practice. After orientation, the greatest confidence ratings were in clinical topics and lowest confidence ratings were in special Medicare payments, medicolegal issues and Aboriginal issues.

The suggested improvement to orientation that received the most support was, '...

**Table 1. Orientation topics by importance and confidence (n=20)**

| Topic | Importance* | Confidence* |
|---|---|---|
| Prescribing: basic script writing (hand, computer), Pharmaceutical Benefits Scheme (authorities, restrictions), pharmacies, dispensing | 100% | 59% |
| Medicolegal issues: privacy, risk management, follow up abnormal results, consent, mandatory reporting of sexual abuse, compulsory requirements for blood alcohol | 100% | 29% |
| Clinical support: specialist referral and access to urgent advice (poisons, psychiatric, trauma), retrievals, reference books, internet sources, evidence based medicine | 95% | 50% |
| Enhanced Medicare items: aged health assessments, care plans, home medicine reviews, SIP payments for Pap tests, asthma, diabetic reviews, mental health plans | 95% | 24% |
| Billing: Medicare item numbers (how to use), private fee setting, repatriation benefits, work injury insurance, medicals | 90% | 35% |
| Local hospital issues: admission policies, procedure restrictions, after hours responsibilities, palliative care, nurse educators for women's health and diabetes, item numbers and payments for in patient care | 85% | 41% |
| Practice incentive payments: enrolment, how to maximise (continuity of care, practice accreditation, practice nurse) | 85% | 12% |
| Pathology, radiology: ordering and ensuring all results are back, checked and followed up | 85% | 53% |
| Australian disease patterns: common causes of mortality and morbidity | 85% | 47% |
| Form filling: disability and sickness benefits, work injury insurance, sick certificates, housing trust support letters | 80% | 53% |
| Childhood immunisations: guidelines, national register, incentives, using practice nurses | 75% | 35% |
| Divisions and workforce support agencies: support for IT, illness, spouse, practice management, locums, clinical updates, collaboration to improve community health | 75% | 38% |
| Community services: carer supports, meals on wheels, nursing homes, private allied health (eg. physiotherapists, podiatrists), support groups (weight loss, stopping smoking), home nursing | 75% | 35% |
| Aboriginal issues: Aboriginal culture, dispossession and health consequences | 75% | 31% |
| Australian culture: differences in morality, defacto families, multi-culturalism, discipline issues in schools, drug use, colloquialisms | 70% | 41% |
| Drug names: Australian names of common drugs that may have different names in other countries | 50% | 53% |

*percentage of respondents who rated importance and confidence with high scores

income not being compromised during orientation' (65%). 'Visiting several practices' (60%) was preferred to 'spending more time in one practice' (45%), and 'more consulting with question opportunities' (50%) was preferred to 'less consulting with more formal teaching' (20%). Forty percent wanted an emergency medicine update included. There was some support for a GP mentor (30%) and the availability of telephone support 24 hours a day (35%), but not for weekly visits by a support GP. There were additional comments about the need for an orientation manual, more support for doctors in solo practices, Australian graduate involvement, and a more structured orientation provided by practices. Other suggested topics were tax issues and advice on preparation for The Royal Australian College of General Practitioners Fellowship examination.

Problems that were most likely to be encountered by IMGs and their families when settling into a rural Australian town could have been made easier by 'more information on the community and its facilities' (55%), 'information on job for spouse' (45%), a 'vehicle on arrival' (40%), 'family orientation to the community' (30%), 'developing local contacts before arrival' (25%), 'support from another medical family' (25%) and 'assistance with loans' (20%). Sources of support on arrival in descending order of helpfulness were practice staff, division, local families, schools, community groups and churches.

## Discussion

This survey represents the views of IMGs in this division at this time. The results could be different in other divisions, depending on their local context. Rural Australia is privileged to have the skilled doctors it is recruiting from overseas. Most had more than 10 years of medical experience on arrival and nearly half had the procedural skills much desired in rural areas. Some of the IMGs were no longer using the procedural skills they arrived with, but several Australian trained GPs in this division have also ceased obstetrics and/or anaesthetics in the past 6 years for reasons such as the presence of resident specialists, insufficient caseload to maintain confidence or concerns about medical indemnity.[11] Half of the IMGs planned to stay more than 5 years – which is more than their contractual obligation – suggesting that their satisfaction is high.

*Table 1* provides a useful checklist for providing orientation to IMGs. The EPDGP now sends copies of this list to the Rural Doctors Workforce Agency and the practice recruiting a new IMG, asking which topics they wish to cover themselves and which ones they would like the division to cover. Visits to several practices (including an Aboriginal health service) are arranged where the IMG can observe different consulting styles and ask questions about clinical, practice management or cultural issues. Division staff provide information and resources on issues such as chronic disease management, immunisations, computer use in general practice, continuing medical education and the role of practice nurses. This process takes about a week. A formal workshop involving a group of new IMGs might address issues such as cultural sensitivity more effectively,[12] but due to the sporadic arrival of new IMGs this has not occurred.

New doctors' families also benefit from orientation. The provision of furnished housing and a vehicle (with child restraints if needed) can do much to ease the difficulties of adjusting to the new community. Information on how to obtain food peculiar to the IMG's country of origin, arranging links with families in other towns from the same ethnic/religious background, and support from a local mentor family can also help. This division aims to contact and welcome new IMGs and their family on arrival (even before arrival if possible) to provide information about facilities and resources in the new town such as schools, employment possibilities for the partner, and shopping. Opportunities to meet locals and forge new friendships – such as invitations to meals and other community activities – need to be fostered. The doctor's partner (and older children) may also benefit from cultural sensitivity training.

Conflict of interest: none declared.

## References

1. Australian Medical Workforce Advisory Committee. The general practice workforce in Australia: supply and requirements 1999–2010. Canberra: AMWAC Report August 2000.
2. Pezzullo L. Modelling of the general practice workforce. Proceedings of the Third National Australian Rural & Remote Workforce Agency Group Conference. April 2002 Adelaide, Australia.
3. Kamien M. The viability of general practice in rural Australia. Med J Aust 2004;180:318–9.
4. Hawthorne L, Birrell B, Young D. The retention of overseas trained doctors in general practice in regional Australia. Faculty of Medicine, Dentistry and Health Sciences University of Melbourne: November 2003. Available at: www.vurhc.org.au/vurhcpublications/default.asp. Accessed March 2004.
5. Humphreys JS, Jones MP, Jones JA, Mara PR. Workforce retention in rural and remote Australia: determining the factors that influence length of practice. Med J Aust 2002;176:472–6.
6. Brooks PM, Lapsley HM, Butt DB. Medical workforce issues in Australia: 'tomorrow's doctors – too few, too far'. Med J Aust 2003;179:206–8.
7. Ong YL, McFadden G, Gayen GA. Induction of overseas qualified doctors. Hosp Med 2002;63:558–60.
8. Sullivan EA, Willcock S, Ardzejewska K, Slaytor EK. A pre-employment programme for overseas trained doctors entering the Australian workforce. Med Educ 2002;36:614–21.
9. Wood J, Margison F, Allen D. Workforce planning. Of one mind. Health Serv J 2001;111:26–7.
10. EPI Info Version 3: A word processing, database and statistics program for epidemiology on microcomputers. Atlanta Center for Disease Control and Prevention.
11. Carlier ND. GP obstetrics survey. Eyre Peninsula Division of General Practice 2004; June/July:5–6. Available at: www.epdgp.org.au/Download%20documents/pplus%20july%2004.pdf. Accessed July 2004.
12. Majumdar B, Keystone JS, Cuttress LA. Cultural sensitivity training among foreign medical graduates. Med Educ 1999;33:177–84.

AFP

**Correspondence**
Email: afp@racgp.org.au