Self assessed learning needs of rurally based IMGs

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Australia has long relied on international medical graduates (IMGs) to provide care in regional, rural and remote communities. They now come from many nations with different health systems and languages to Australia, and with unknown standards of medical education. However, they are willing to work where local graduates will not, forming a relatively invisible, professionally isolated workforce.[1]

The issue of their competence has been a topic of debate. There are no internationally recognised systems for validating medical qualifications (although the World Federation of Medical Education is promoting them[2]). Yet, with support and training, IMGs can adapt and become strong contributors.[3] This small project explored the educational needs of IMGs in rural north Queensland.

Methods

Although it did not include information on duration in Australia, the most current contact database of rural IMGs was held by the Queensland Rural Medical Support Agency. Questionnaires were sent to 45 IMGs, seeking information on their training, experience, language skills and self identified learning needs. Questionnaires were completed by 19 (response rate 42%). Another three questionnaires were 'returned to sender'.

Ethics approval was obtained from the James Cook University Human Research Ethics Committee.

Results

Most respondents came from south Asia (10/19) and spoke a first language other than English (15/19). Only six had been required to demonstrate English language proficiency (eg. the International English Language Test Score [IELTS]) where their modal score was 7.0; less than generally regarded as ideal for medical communication (which is probably above 7.5).

All except one had 5–30 years experience since graduation, most often in primary medical care, general hospital training, paediatrics, or internal medicine. All except one had been working in Australia for less than 5 years. Only 10 had undergone any formal pre-employment assessment of their qualifications, eg. submission of a curriculum vitae, interview with the Medical Board of Queensland, or telephone interview by a medical practitioner.

Only 2/19 had undergone any pre-employment training, comprising a few days under supervision in an emergency department of a regional hospital. Nine had since undergone formal certification assessment: three had passed the Australian Medical Council examination, one had undergone emergency skills training, and five had successfully completed The Royal Australian College of General Practitioners examination. Ten had undergone no formal assessment of their skills or knowledge.

Fourteen listed self perceived strengths and weaknesses. Many claimed broad experience and strengths in a range of medical discipline areas, particularly in emergency, obstetric and anaesthetic procedural skills. Most also listed weaknesses, covering a range of issues typically found in surveys of rural doctors learning needs, including procedural skills. However, the two largest categories of identified weaknesses were English language communication and understanding the Australian health care system (25%). The third most often nominated weakness was in mental health. However, while most respondents felt that addressing these needs could improve their suitability for rural medical practice, only two were prepared to pay for such training.

Discussion

The sample was small and the response rate low (although the sample frame may have been overinclusive). Nevertheless, the findings may inform educators and workforce planners.

In at least one Australian region, despite rural IMGs appearing to be diverse in language, experience and training, levels of experience were often high and apparently appropriate to rural practice.

It was surprising that many participants were employed with so little prior assessment of their knowledge and clinical, or language skills, and without any formal preparation for professionally isolated rural and remote practice. This highlights the need for programs to prepare IMGs for medical practice in Australia, particularly rural primary care. Perhaps training is the responsibility of the employer, rather than the individual. General Practice Education and Training (GPET) regional training providers could provide specifically tailored support programs.

Conflict of interest: none declared.

Acknowledgment

Thanks to Tropical Medical Training for funding.

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