



Maria R Dahm

Patient centred care

Are international medical graduates 'expert novices'?

Background

Depending on their previous training, international medical graduates (IMGs) may be unfamiliar with patient centred care (PCC). This study explores the PCC skills that IMGs demonstrated during observed role play.

Methods

Qualitative observational data were collected during an IMG communication skills course and IMGs' perceptions of PCC were explored in semistructured interviews. Analysis followed principles of grounded theory and focused specifically on the elements of Candlin's (2002) quality of discourse.

Results

Many of the IMGs observed in this study used discourse features that identify them as novices in PCC: they framed consultations as interviews as opposed to conversations, maintained topic control instead of allowing digressions, and focused on achieving simple coherence rather than seeing the consultation as a whole.

Discussion

This study suggests that some IMGs may be novices in PCC while being experts in medical knowledge. A view of IMGs as 'expert novices' may be useful to inform the development of bridging courses.

Keywords: doctor-patient relations, communication, patient centred care, qualitative research

The Australian Medical Council (AMC) asserts that 'good medical practice is patient centred'.¹ Qualitative studies conducted in Canada,² the United States of America³ and Australia,⁴ where international medical graduates (IMGs) represent a crucial part of the healthcare workforce, have shown that some IMGs are unfamiliar with the patient centred model of care. Unfortunately, little is known about how IMGs develop the communication skills required for patient centred care (PCC), a medical model that is new to many of them.³ Assuming that the success of IMGs in gaining access to the workforce is dependent on their master of the communicative norms of the healthcare sector, it is important to explore any issues IMGs have with adapting to the principles of PCC.

The core components of PCC⁵ are summarised in Table 1. This model of care has been adopted by many countries including the United Kingdom, South Africa, Canada and Australia.^{1,6} In Australia, the majority of IMGs applying for assessment of their skills via the AMC standard pathway (ie. multiple choice questions and a clinical exam) come from Asian (Bangladesh, China, India) or Middle Eastern (Iran, Iraq) countries.⁷ While PCC and communication skills training has been introduced at a small number of leading medical schools in some of these countries (eg. China),⁸ they are generally not part of the mostly science focused medical curricula in these countries.^{3,9,10} As a result, some IMGs may be unfamiliar with PCC and may have difficulties adjusting to Western medical contexts or feel threatened in their professional identity by more autonomous patients.¹¹ International medical graduates in the USA were found to have different expectations of what makes a good consultation to local patients and physicians; IMGs exerted

strict topic control over consultations and used predominantly closed questions as a coping mechanism.¹¹ Interestingly, studies of the skills development of domestic American medical students show that novices in this context employ similar strategies, ie. they use generic templates such as checklists, rely on formulaic language and fail to see the consultation as a whole.^{12,13} This suggests that those IMGs who are unfamiliar with PCC could be regarded as novices as far as the practice of PCC is concerned, while being experts in terms of medical knowledge.

This exploratory study applies Candlin's¹⁴ evaluative model of communication skills to observations of an IMG communication skills course to determine which positions IMGs occupied on a 'novice expert' continuum for PCC. Candlin proposed that professional communicative expertise can be measured by three factors that together constitute quality of discourse: framing, topic management, and coherence¹⁴ (Table 2).

While Candlin originally developed this model based on nursing discourse, the concepts of framing,¹⁵⁻¹⁷ topic management^{11,18,19} and coherence^{19,20-22} are also key elements of professional discourse and have each been examined in patient-doctor interactions. Candlin's¹⁴ model synthesises all of these factors and provides a comprehensive framework for this study of the delivery of PCC by IMGs. In order to triangulate the observation findings and further illustrate the challenges IMGs face with understanding and

Table 1. Components of patient centred care⁵

| |
|---------------------------------------------------|
| Exploring both the disease and illness experience |
| Understanding the whole person |
| Finding common ground |
| Incorporating prevention and health promotion |
| Enhancing the patient-doctor relationship |
| Being realistic |

applying the principles of PCC, IMGs’ perceptions of PCC were elicited in qualitative interviews.

Methods

All data were collected and analysed by the author. A corpus of field notes were collected during 33 hours of classroom observation of two groups of IMGs attending a role play based medical language bridging course at The Royal Australian College of General Practitioners (RACGP) (www.racgp.org.au/education/amc). One group contained 15 IMGs and the other 14, a total of 29 ($n=29$). In line with RACGP approval, recordings were not permitted during the course and therefore multiple sources²³ of data were collected in the form of course materials (eg. role play instructions, collections of useful English phrases for consultation stages) and observational field notes.²⁴ During the class, the role of the researcher was restricted to observations (ie. complete observer) but at other times (eg. during breaks) the researcher also interacted with the participants²³ (ie. observer as participant); data were collected using both observation modes. While role play observations can show how IMGs approach PCC in interactions, interview data can offer additional perspectives in exploring what IMGs think about PCC.

At the time of observation, raw notes were recorded under four headings: general description (time, topic, dominant speakers); language (verbatim quotes, content summaries); behaviour (movements, displays of emotion), and comments (researcher’s memos). In the weeks immediately following each period of observation these basic notes were extended to more comprehensive narrative field notes to be used in qualitative analysis.^{23,24}

The observational study presented here is part of a larger, mixed method research project for which physicians and patients from different language backgrounds were interviewed by the author about their general experiences and use of medical terminology in medical encounters in Australia.²⁵ Four of the IMGs interviewed in this larger project were recruited as a convenience sample by an RACGP IMG project officer and had previously completed the same RACGP course. Even though the interviews focused on general experiences, three of these four IMGs addressed challenges concerning PCC and all four interviews were included to allow for triangulation. All interviews were conducted in English, audio recorded and transcribed for analysis.

The study was approved by both the RACGP, and the Macquarie University Human Research Ethics Committee.

Analysis

Observational and interview data were analysed iteratively in NVivo 8²⁶ following the principles of grounded theory.²⁷ Observational data were used to explore the PCC skills exhibited by the IMGs during role plays following a quality of discourse model; interview data were used to describe IMGs’ perception of PCC. Analysis progressed through three stages: open coding – labels were assigned freely to transcripts and field notes; axial coding – initial labels were refined into fixed coding categories, and selective coding – relationships between core concepts and categories were established.^{24,27} The first analytical stage was iterative and overlapped with and continued until the collection of observational data was completed. This enabled comprehensive field notes to be reviewed weekly, allowing new codes or concepts to emerge freely as the course progressed until data saturation was achieved.^{24,27}

Results

Table 3 provides detailed demographic data of observational ($n=29$) and interview participants ($n=4$). All IMGs in this study were non-native English speakers.

Qualitative findings follow. The first section draws on both interview data and observational data

Table 2. The three key elements that constitute quality of discourse¹⁴

| | Concept | Novice | Expert |
|-------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Framing | <ul style="list-style-type: none"> Based on the notion that individuals adopt different (interactive) frames of reference to help them understand and correctly identify the different demands of face-to-face interactions (ie. a sales encounter vs a joke, a fight, or a visit to the physician)¹⁵ Closely related to the concept of ‘knowledge schema’ – the expectations that people develop based on prior experience and which impact on the frames that they associate with particular interactions¹⁵ | <ul style="list-style-type: none"> Interview Highly structured Physician centred Restricts opportunities to explore the patient’s illness experiences or to understand the whole person by eliciting patient narratives Has detrimental effects on the establishment of a good patient-doctor relationship | <ul style="list-style-type: none"> Conversation Loosely structured interview Participants take equal shares and have equal opportunities to contribute |
| Topic management | <ul style="list-style-type: none"> Relates to the flexibility of the approach to topic management and the ability to allow patients to introduce their own topics | <ul style="list-style-type: none"> Question ‘checklist’ Closely follows structured lists of questions Leaves little room for patients to introduce their own topics | <ul style="list-style-type: none"> Flexibility for digression Able to take risks and explore (un-)important topics raised by patients |
| Coherence | <ul style="list-style-type: none"> Relates to the ability to perceive links between different topics and gathered information and to see the consultation as a whole Sometimes referred to as conversational coherence or responsiveness to patient cues | <ul style="list-style-type: none"> Simple coherence Leaves little room for patients to introduce their own topics Results in failure to establish causal links between the itemised information collected | <ul style="list-style-type: none"> Comprehensive coherence Pursues to incorporate all (potentially) crucial facts to see the bigger picture in patient assessment |

to give an overview of the general challenges of IMGs concerning PCC. The remaining three sections relate to the elements of the quality of discourse model and draw only on the observational data.

General challenges

From both data sets it emerged that IMGs encounter several challenges with adapting to PCC. Three of the interviewed IMGs raised challenges concerning PCC that they had experienced in Australian medical encounters. One IMG stated that she was initially unaware of the communication and interpersonal demands of PCC and expressed her need for specific training.

‘... nowadays it is completely different. Everything should be explained and asked and do this and like a conversation and communication and everything. [...] So this is the problem. That’s why we are here and we do some courses. [...] We don’t know anything. They have to uhm prepare us. They have to like uh to encourage us to be ready for the system otherwise we don’t. [...] Because I just passed my MCQ, I don’t know anything about the relation of the patient, communication and these things. [...] How approach to the patient. How you should ask question.’

Another IMG identified patients’ hidden agendas as her greatest difficulty. She was surprised by this aspect of her role as a physician because she was used to more paternalistic role patterns where patients tend to be submissive and provide all the requested information.

‘I think yeah if uh some sometimes you should read into the context. Like some people have problems that they don’t talk about it but you should guess them. That’s the difficult part. [...]

sort of like a detective work. You have to know what they expect to – from you.’

A third IMG stressed that her unfamiliarity with Australian culture contributed to her communication difficulties and made it difficult for her to fulfil all demands of patient centred interviewing, such as addressing delicate personal matters:

‘So that is – it is a different country and the culture is also very different from my home country. And I haven’t been that much involved with people to know the culture. [...] you don’t know if what way you ask the people. Some question are very difficult – to uh ask the patient. Which involved the sex or something. [...] Something is taboo like that in our culture. So maybe I find it even myself difficult to ask it from my patients.’

Three of the four IMGs interviewed acknowledged the differences between PCC and the consultation styles they were trained in, however the behaviour of many IMGs in the role plays showed that despite their awareness they struggled to adopt PCC. They often gave blunt, insensitive statements to enforce treatment plans or appeared judgmental instead of acknowledging and normalising patient concerns or negotiating treatment options with the patient to facilitate shared decision making:

‘You are obese! You have to lose weight!’

‘You had only one partner? No, you had multiple partner!’

Yet others tried to accommodate patients in every possible way, to the extent that they appeared to give up their own [equal] role as a physician. In some role plays, IMGs overly acknowledged patient concerns, constantly provided reassurance

using formulaic constructions, and did not correct misconceptions:

IMG: ‘I understand.’

‘I understand your concern.’

‘I understand your concern and your situation.’

SP*: ‘But I heard [immunisation] can cause autism.’

IMG: ‘Right.’

SP: ‘I read about on the internet.’

IMG: ‘Yes.’

(* Standardised patient. In this course, the language educator also occupied the role of ‘patient’ in the role plays.)

Framing

The IMGs in this study predominantly framed role plays as highly structured and physician centred interviews, offering the patient little chance to express their concerns beyond the initial presenting complaints. Common phrases to control turn taking and to set up the consultation as an interview rather than a conversation included:

‘I would like to ask you a few questions.’

‘Can I ask you some question?’

‘I will ask some question to find out what’s wrong.’

During the course, the IMGs studied communication strategies that could be used to express empathy, offer reassurance or preface particularly sensitive topics. Sometimes they used a few of these communication strategies, therefore breaking their close adherence to the question-answer pattern of interviews. Unfortunately, in the majority of instances such expressions were used clumsily and appeared out of place in the dominant and overarching interview frame, which focused on crossing questions off a checklist.

IMG: ‘What about your family? How is at home?’

SP: ‘My father is very demanding.’

IMG: ‘I see. I’m very sorry to hear that. And how about things at school and with your friends?’

IMG: ‘I can understand it is really difficult. Are you on any medication?’

IMG: ‘Do you mind if I ask a personal question?’

SP: ‘No, that’s okay.’

Table 3. Demographic data of participants

| Participant characteristics | Observation 1 (n=15) | Observation 2 (n=14) | Interview (n=4) |
|------------------------------------|----------------------|----------------------|-----------------|
| Female, n (%) | 11 (73.3) | 5 (35.7) | 4 (100%) |
| Mean age in years (SD) | 41.5 (6.3) | 36.7 (8.6) | 46 (2.4) |
| Mean years spent in Australia (SD) | 8.5 (4.6) | 4.6 (2.8) | 12.3 (5.3) |
| Region of origin, n (%) | | | |
| Northeast Asia | 2 (13.3) | 2 (14.3) | 1 (25) |
| Southern Central Asia | 7 (46.7) | 7 (50) | 2 (50) |
| Southeast Asia | 3 (20) | | |
| Middle East | 1 (6.7) | 4 (28.6) | 1 (25) |
| Southern and Eastern Europe | 2 (13.3) | 1 (7.1) | |

Immediately adjacent questions included:

‘Have you had myalgia? Any muscle pain?’

‘Any family history of hypertension?’

‘Any allergies?’

‘What are your eating habits?’

The ‘unwarranted’ use of empathic or prefacing strategies in an interview frame also points toward systemic problems in topic management and coherence.

Topic management

In the vast majority of the observed role plays, IMGs approached patients by working through a fixed set of questions, allowing only limited digression to patients or themselves. Despite being advised otherwise, IMGs often attempted to take a full medical history within the 10 minutes allotted for most role plays.

‘Remember you don’t have to ask every question or do all the system reviews. It’s better to tailor your questions to the patient so you have more time to ask his opinion and explain.’ (Language educator)

In IMG role plays, the interview frame sometimes bordered on an interrogation in which questions were fired in close succession, allowing the patient only to respond with ‘yes’ or ‘no’:

‘And do you have other pain?’

‘Do you have any chest pain?’

‘Any back pain?’

‘Any other problems?’

‘Do you have heart problems?’

‘And problems with your blood pressure?’

‘Any allergy?’

‘How about in your family?’

‘Are you on any medication?’

Occasionally, the topic controlling behaviour also extended to how explanations were offered to patients. In a number of cases, IMGs tried to present all possible information using strategies similar to checking off items on a list.

IMG: ‘Your test results tell us you have diabetes
2. What do you know about diabetes?’

SP: ‘It’s too much sugar in the blood right? The sugar level.’

IMG: ‘Yes your glucose in the blood is too high. Your BSL is 13.1 millimol per litre. Glucose and insulin is related to your liver and pancreas. We did another blood test. The BSL was 10.1 millimol per litre. The creatine kinase is 5.5 millimol per litre and the cholesterol level is 6.4 millimol per litre. Such level can damage

your arteries and kidney. We also have to look at your blood pressure.’

Although the IMG briefly enquired about the patient’s knowledge of diabetes, an excessively technical biomedical account of the patient’s metabolic state and related problems followed. While a lot of information has been offered, the interaction cannot be considered as patient centred, because the physician does not take the patient’s likely level of understanding into account.

Coherence

The preoccupation of the IMGs in this study with topic control and itemised information collection also affected their ability to perceive links between different topics and gathered information and to see the consultation as a whole. Consequently, they sometimes missed patient cues because they were so entrenched in a structured question-answer pattern.

IMG: ‘How are things at school? How about home?’

SP: ‘Good, my boyfriend is at school.’

IMG: ‘What about your study?’

IMG: ‘Do you ever have a drink of alcohol?’

SP: ‘I don’t drink alcohol. It has too many calories.’

IMG: ‘How about coffee?’

In these role plays the reason for the visit has been made explicit at the beginning of the encounter: a minor’s request for the contraceptive pill; a young female with body mass index of 15.1 who was pushed to see the physician by her mother. Both cases illustrate how patients often offer information that IMGs could use to their advantage in exploring the patient’s feelings, ideas and social circumstances. However, the IMGs did not deviate from the interview frame and thus missed opportunities to become more patient centred and understand the patient as a whole. Language proficiency difficulties can further exacerbate the problems of leaving patient cues unattended. In particular, everyday language and idioms such as ‘tossing and turning’ might be difficult to understand for a non-native English speaking person:

SP: ‘My girlfriend says I’m always tossing and turning.’

IMG: ‘Mmh.’

SP: ‘I sometimes wake up with a jolt.’

IMG: ‘Do you smoke?’

Discussion

From the interview data it emerged that IMGs encounter problems when trying to reconcile the relatively unfamiliar patient centred model of care with their own, mostly culturally determined, ideas about medical visits. In addition, the role play data showed that IMGs predominantly adopted an interview style approach to patients, exerted strict topic control, and established only simple coherence in their interactions.

Previous research has established that some IMGs rely more on a paternalistic rather than patient centred consultation style due to culturally different expectations and medical socialisation during their training.^{28,29} Moreover, many of the IMGs participating in this study received their training in countries that follow science focused medical curricula.^{3,9,10} However, some native English speaking physicians trained in Western settings have also been found to exhibit individual communication styles which lack PCC related communication skills and can cause significant problems such as increased malpractice claims.^{30,31} Therefore, the difficulties faced by IMGs in adopting PCC may also relate to their personal communication styles and their perceived status as biomedical experts.

The IMGs in this study had already worked as fully qualified physicians in their country of origin. Consequently, it can be argued that these IMGs are biomedical experts in their own right and that they (like all medical graduates) have progressed through the various developmental stages during their medical training.^{12,32} Nevertheless, with regard to PCC, these IMGs are now faced with a mismatch in competencies: while they might be biomedical experts, they are just starting out in PCC. They have to master the complex and systemic demands of PCC and successfully combine the theoretical (medical) knowledge and communication skills components of a consultation. They are, in a sense, nontraditional novices or expert novices.

Training programs introducing IMGs to PCC should acknowledge IMGs’ unique developmental status (as ‘expert novices’) and address common novice errors^{12,13,32} in addition to providing PCC theory and useful phrases for IMGs seeking to apply this theory to actual medical practice. Training modules could involve conversations with educators and peers from other cultural

backgrounds to allow IMGs to explore different expectations in approaching patients in a range of situations. More importantly, the use of clinically focused practice role plays may actually exacerbate the tendency to adopt repetitive and formulaic communicative strategies,¹³ particularly if they are not coupled with opportunities for reflection and feedback.

Despite having received some instruction in PCC during the course, all IMG participants struggled with the practical application of their theoretical knowledge beyond tending to the superficial manifestations of PCC. On the whole, IMGs seemed to be primarily interested in learning the skills necessary to pass their upcoming AMC clinical exam, with acquisition of PCC skills that would serve them well in practice appearing to be only a secondary goal. In this sense, the use of superficial empathic statements and prefacing could also be interpreted as the IMGs' attempt to tick 'being patient centred' off their interview checklist and receive marks in their clinical exams.

No differences regarding use of PCC emerged among IMGs in the observational groups relating to the time they had spent in Australia. However, for the interview group, time and local experience appeared to influence whether or not they identified aspects of PCC as a challenge that they faced. The three IMGs for whom PCC posed difficulties lacked relevant medical experience in Australia, while the fourth IMG, who did not mention PCC at all, had lived in Australia for 18 years, obtained an Australian nursing degree in addition to her foreign medical qualification and was working as nurse in a metropolitan hospital. A previous interview study suggested that the communicative difficulties experienced by IMG participants who had received at least 6 months practical supervised training persisted although the IMGs had resided in Australia for 11 years or more.⁴ The data from IMGs who were interviewed in the present study also supports this finding but unfortunately, no information about practical experience was collected from the observed IMGs, thus limiting this aspect of the interpretation of the observational data.

This study is further limited in that it focuses on one particular IMG medical language bridging course and is the first to apply Candlin's¹⁴ quality of discourse model to physician centred rather than nursing discourse. Moreover, the fact that

the language educator also acted as the simulated patient in role plays might have further affected the IMGs performance.

Conclusion

Despite the limitations outlined above, these findings offer an additional dimension to the complex barriers IMGs have to overcome. While IMGs may arrive in Australia as biomedical experts, they may be unfamiliar with PCC. When trying to follow PCC principles with simulated patients in role played interactions, the IMGs observed in the present study exhibited novice-like communication strategies. In developing specialised training programs, providers should take into account this unique status of IMGs as 'expert novices'.

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