Royal Australian College of General Practitioners

RACGP

A guide to understanding and managing performance concerns in international medical graduates

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The Royal Australian College of General Practitioners Ltd
100 Wellington Parade
East Melbourne, Victoria 3002 Australia

Tel 03 8699 0414
Fax 03 8699 0400
www.racgp.org.au

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Introduction

Presently in Australia, many international medical graduates (IMGs) working in general practice are non–vocationally registered (non-VR), are ineligible to join an Australian General Practice Training (AGPT) Program and are relatively unsupported on their path towards Fellowship of The Royal Australian College of General Practitioners (FRACGP), although the Practice Experience Program (PEP) introduced by the RACGP in 2019 now offers some support.

Many IMGs struggle with Australian general practice and have difficulty passing the Fellowship exam. This can also be the case for IMGs who do manage to join a general practice training program.

This guide provides an understanding of the issues that IMGs contend with and the clinical performance problems that occur. It also provides a framework for managing those performance concerns, including exam support.

This guide is complementary to the RACGP's *A guide to managing performance concerns in general practice registrars.* While the two contexts are different, the principles of performance management and support (remediation) are the same. The performance management that is discussed in both guides is with respect to the attainment of the requisite level of clinical skills for the doctor to be able to practise independently in Australian general practice and attain FRACGP.

IMGs who are underperforming may sometimes come to the attention of the Medical Board of Australia (Medical Board). For information regarding performance management in that context, refer to the RACGP's *A guide to performance management and support for general practitioners.*

Understanding IMGs

IMGs, like other migrants, have to adjust to a different way of life and to a social system and behavioural norms that conflict, to varying degrees, with their personal and ethnic values. Perceptions of IMGs can sometimes be misguided, with prejudice and bias directed against them and their families.

IMGs face significant pressures, perhaps more so than the average migrant. They have constraints placed on them with respect to their medical registration and where they are allowed to practise; consequently, they may feel trapped. Their identity is challenged and their self-esteem may be affected because they have to study and pass exams all over again in order to prove themselves capable and competent. Many lack appropriate support and guidance and find themselves struggling to pass exams and to achieve the requisite standard of practice.

IMGs are often misunderstood and a disservice is done to them when it is rationalised that their difficulties are entirely due to a 'lack of knowledge', 'cultural' factors or 'language' issues. Certainly, these are important considerations, and while generalisations can sometimes be useful, great care needs to be exercised because IMGs are a disparate group.

Hofstede's six dimensions of national culture (Appendix A) is a useful framework for comparing cultures and providing insight into the values and behaviour of IMGs. However, care needs to be exercised because the framework relates to values of ethnic cultures, not individuals.

As regards clinical performance, the issues that IMGs contend with relate primarily to:

- medical training and work experience overseas
- language and communication skills
- migration and displacement issues.

Medical training and work experience overseas

Depending on their circumstances, IMGs may or may not have trained or worked in their home country. Many IMGs have undergone specialty training and may have worked in their specialty field for a number of years before migrating to Australia. IMGs have to adjust to a very different health system and method of practice. Even if they have worked in general practice overseas, that context may be very different from general practice in Australia.

The aspects of general practice that IMGs have particular difficulty with are the:

- different patterns of disease and clinical presentations (especially the early presentation of illness and psychosocial problems)
- patient-centred clinical method, including patient education and shared decision making
- medico-legal system (regulations, legislation, ethical dilemmas, medico-legal aspects of practice).

Language and communication skills

Communication is a fundamental skill in medical practice and difficulties with communication will impact on the outcomes of the consultation.

While IMGs are obliged to pass a proficiency test in English, this doesn't necessarily equate to being able to communicate effectively in the consultation and the broader medical context. Even between English-speaking countries there are differences in the way English is spoken and understood, including differences in meaning, idiom, nuance, verbal and non-verbal cues, what is and isn't appropriate to say in a given context, and social norms. IMGs will frequently identify these aspects of language as being problematic, as opposed to such things as limited vocabulary and difficulties with syntax.

Some IMGs continue to think in their own language, rather than in English. The result is that they continually translate in their mind from one language into the other, which can cause them to lose focus with respect to the task at hand.

Migration and displacement

Migration and displacement issues are not just related to arriving in a new country and having to adjust to a new way of life. The issues have deeper roots and relate to their life circumstances in their home country and the reasons for migration. They may be refugees who have endured hardships, perhaps even trauma, whose lives have been under threat and who have made difficult journeys to get here and who may be lucky to be alive. Having arrived here, their imperative is to work and provide for their families here and/or overseas. Being professionals, they are looked up to by their family and their community and have to meet their expectations. They have to provide for their family, including any particular needs related to health or disability. Moreover, their family may be separated from them. The IMG may be working in a rural location while their family is in the city, or their family may still be overseas.

Understanding the role of the general practitioner in Australia

IMGs have to balance competing pressures: work, family and study to pass exams – the Australian Medical Council (AMC) clinical exam and/or FRACGP. Many struggle to pass the exams, even though in some instances they have received support. There are many reasons for this; fundamentally, IMGs need to understand the role of a general practitioner (GP) in Australia. They need to learn the requisite skills for conducting a patient-centred consultation, managing chronic complex problems and psychosocial problems, and understanding medico-legal issues. Medical educators are certainly able to assist IMGs with these matters, but also need to be cognisant of all the different issues that IMGs contend with, and have strategies for addressing those issues.

Clinical performance concerns

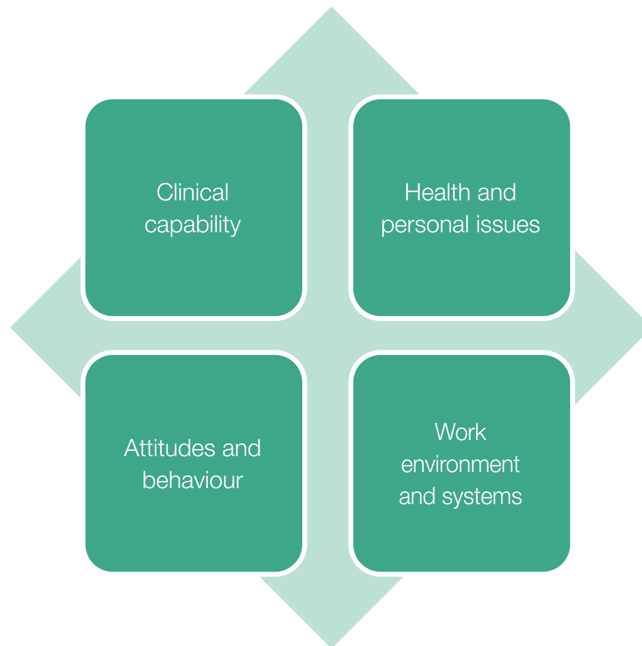

Figure 1. The four broad areas of performance concerns

IMGs have performance concerns, just like any Australian medical graduate. For IMGs, the factors that result in performance concerns – either directly or indirectly – are many, often complex and interrelated. When a concern about performance has been raised, it is important to look more broadly, to identify all the issues as well as the underlying contributing factors.

Performance concerns fall into four broad areas, as presented in Figure 1.

Table 1 summarises the performance concerns that can arise within each area.

Table 1. Performance concerns in IMGs

Performance area	Performance concerns	
Clinical capability	• Medical training • Work experience • Knowledge • Language and communication skills	• General consulting skills • Clinical reasoning • Social and medico-legal issues
Health and personal issues	• Health • Personal issues	• Family commitments • Gender inequality
Attitudes and behaviour	• Identity, self-esteem, self-confidence, expectations of self • Personal cultural factors • Insight, ability to adapt and change	• Motivation • Study and exams
Work environment and systems	• Work conditions • Regulatory requirements	• Navigating social and practice systems • Emotional intelligence in the workplace

Clinical capability

Medical training

Whether the IMG studied medicine in their home country or elsewhere, the education that they received is likely to have been subject-oriented, teacher-centred, discipline-based, lecture-focused and hospital-based.

Work experience

Overseas

The amount of work experience the IMG had before emigrating can be quite variable and it may have been in a different country from the country where they received their training. It may have been minimal, equivalent to internship only, or they may have worked for a number of years. Their work experience is more likely to have been hospital-based.

The IMG may have a specialist qualification in their country, but for various reasons has decided to pursue general practice in Australia. Not uncommonly, general practice is their only option because they are unable to gain registration to practise in their specialty in Australia.

If the IMG worked in general practice overseas, this would have been different to how it is practised in Australia (particularly in relation to GP autonomy, the scope of practice, different presentations, the patient-centred method, communication, gender relations and other sociocultural factors).

In Australia

Before being able to practise in Australia, IMGs have to obtain medical registration and comply with certain conditions. At the very minimum, they have to have passed the AMC Part I (multiple-choice questions paper) and an English proficiency test. This will allow them to work in a hospital or in general practice in an area of need or district workforce shortage.

IMGs who have passed the AMC Part II (clinical exam) will probably have completed their intern year, as well as a year of residency, and then entered an AGPT Program. For various reasons, some do not complete their general practice training and are then in the same predicament as those who have only completed the AMC Part I.

IMGs may be working in a narrow field of practice and so their clinical experience is constrained. One example is after-hours or locum work, where the range of presentations is limited. Another example is when IMGs choose to work in a location where most of their patients are from their own community. While this has its advantages (eg common language, a closer understanding of the needs of their patients, the ability to address patient concerns more readily), it constrains IMGs from gaining broader experience and a better understanding of Australian general practice. This becomes problematic when IMGs find themselves in a different context and have to adapt to mainstream general practice and meet the expectations of AMC and RACGP examinations.

Knowledge

Generally speaking, IMGs have very good book knowledge, but some have knowledge deficits that impact on clinical capability. Factors that contribute to those knowledge deficits include:

- limited clinical exposure
- the individual's motivation to study (inability to pass exams can be one of many reasons behind the lack of motivation)
- family concerns, which may take precedence, distracting the IMG from studying or creating difficulty in allocating regular study time
- the individual's ability to learn:
  - being older and having difficulty studying efficiently, and memory not being as sharp
  - being more inclined to learn facts than develop problem-solving skills
  - relying on limited study methods (eg rote learning, preference for instructional teaching and direction)
  - using limited learning resources (eg preference for factual sources, such as textbooks)
  - finding it difficult to form study groups (eg not knowing who to connect with, remoteness of location and consequently limited access to study partners, internet connectivity issues).

Language and communication skills

Language refers to both the spoken and written word. It is the ability to express oneself as well as the ability to be understood. In the clinical context, communication skills refers precisely to those skills required to communicate effectively in conducting a consultation. It is important to delineate what constitutes difficulty with language and difficulty with communication skills.

Language difficulties include:

- verbal skills:
  - command of English – pronunciation, accent, vocabulary, fluency, contextual meaning
  - thinking–translation processes – 'thinking in their language', translating the language and science of medicine into lay language
  - understanding – the Australian accent; the patient's pronunciation, intonation and use of idiom, slang and humour; nuances and cues
- non-verbal skills:
  - body language
  - written fluency (clarity with medical records, including referral letters).

Language skills may sometimes be observed to be weak in the clinical setting but not in a different context. Any difficulty with language will contribute to communication skills difficulties. This will generally manifest in the manner of communication – for example, the ability to choose the right words; knowing what is appropriate to say and do, without offending; and providing the necessary information clearly and succinctly.

These concerns about communication are not confined to IMGs. All doctors have to bridge the 'cultural divide' between doctor and patient. IMGs, however, have to contend additionally with the divide between their culture and the Australian culture. In other words, they need to accommodate the differing expectations about what constitutes appropriate communication, the roles of the doctor and patient in the consultation, and what is appropriate in the consultation. In some countries, for example, the practice is not to inform the patient about a fatal diagnosis or prognosis. This sits at odds with the Australian context, where the patient has a right to know. Medico-legal and ethical problems present significant dilemmas to IMGs regarding what is and isn't appropriate.

General consulting skills

It is frequently observed that the IMG consultation is not well structured and time management is poor. This will generally be due to difficulties with one or more of the elements of the consultation:

- history-taking
- physical examination
- investigations (ordering of and interpretation)
- management.

History-taking

Reasons for inadequate history-taking include:

- lack of attention to history-taking or inability to take a focused history
- language-related
  - inability to make precise word choices so that the patient may understand the doctor's intentions
  - having been trained in a more interrogative form of history-taking and therefore having difficulty using open-ended questions
  - not knowing how to phrase a question out of fear of offending
- knowledge-related – for example, being unfamiliar with psychosocial issues, and consequently not knowing how they might relate to the presentation or how to explore those issues.

Physical examination

Difficulties with physical examination include incomplete examination or poor examination technique.

Investigations

Issues with investigations are generally with respect to:

- over-reliance on investigations in the problem-solving process, because of inadequate history-taking and/or physical examination
- difficulty with the interpretation of test results – a factor may be that terminology and interpretation of results can differ between countries
- not knowing what to do with abnormal results (especially false positives).

Management

In the management phase of the consultation, difficulties will generally occur with:

- developing an individualised, holistic management plan
- a tendency to be concerned with management of the presentation and not looking more broadly for associated issues or, if they have been identified, not addressing them
- long-term management plans being formulaic rather than tailored to the individual and the context
- delivering the management plan and providing information and explanations clearly and succinctly
- involving the patient in the management (shared decision making, negotiation).

Clinical reasoning

Clinical reasoning occurs in all phases of the consultation. This fundamental skill is frequently a weak point for IMGs. There are several contributory factors:

- jumping to conclusions
- a tendency to think in ‘black and white’ and consequently struggling with managing uncertainty
- a tendency to focus on making a diagnosis
- discomfort with problems where the diagnosis and/or solutions are not clear-cut or do not fit ‘what the textbook says’
- difficulties in problem solving.

Even though their knowledge base may be good, IMGs may have difficulties with their application of knowledge. This usually manifests as a mismatch between demonstrated clinical skills and knowledge and/or difficulties with clinical reasoning.

Social and medico-legal issues

Social and medico-legal issues include being unfamiliar with ethical practices, the law and other regulations, which may result in patient complaints and reporting to the Australian Health Practitioner Regulation Agency (AHPRA). They can manifest in:

- crossing doctor–patient boundaries because of unwittingly using inappropriate language or inappropriately touching (not knowing the right words, not knowing the social norms, not knowing what is appropriate in a particular context)
- not knowing what constitutes informed consent
- not complying with the regulations regarding patient confidentiality

- inappropriately prescribing drugs of dependence because of not knowing the regulations around them
- having inadequate documentation (medical records).

Health and personal issues

Like any other individual, and particularly with increasing age, IMGs may become ill or have a disability. When a performance concern has been identified, it is important to consider the possibility of an underlying health issue. Any significant illness (physical or mental, acute or ongoing) has the potential to:

- affect judgement or performance
- impact on patient care
- impact on self, family and friends, colleagues and work capability.

Personal and family issues can also affect health and work performance.

Of particular note as regards personal issues:

- discrimination in society and in their professional practice can impact the IMG
- IMGs who are older, having spent a substantial part of their working life overseas, may be less adaptable and open to change, may struggle more with their learning (memory issues, health issues that impact on study time) and have a rigid or doctor-centred consultation style.

Family issues that occur commonly include:

- having to provide for family (which may be in Australia and/or overseas) and attending to family and their needs – commitment to the family's needs generally takes precedence over other things, particularly when there are young children and/or elderly parents to take care of
- female IMGs, even if they are working part time, struggling to manage their daily responsibilities – situations of gender inequality only add to their difficulties.

Attitudes and behaviour

Identity, self-esteem, self-confidence, expectations of self

Like any other migrant, there may be conflict for the IMG between their aspirations and expectations before coming to Australia and what they find and what they are able to achieve. A common scenario is the IMG who trained and worked as a specialist in their home country, and, having migrated, expects to work in that specialty. For many, the reality is that they have no other option but to work as a GP and this affects their identity and self-esteem.

Identify and self-esteem are also impacted by being a migrant in a foreign country, having inadequate English language skills, having to study and pass exams again when they are already qualified as a doctor and having restrictions placed on practice.

There may be conflicting notions regarding the role of the doctor and the role of the patient and how the interaction between them is conducted. This may manifest as difficulties with the patient-centred clinical method (as opposed to a doctor-centred model) and the notion of 'equality' in the consultation. This can have flow-on effects on such things as the provision of information and explanations, shared decision making and negotiation with the patient.

There may also be conflicting notions regarding the role of the doctor and the role of other staff. Problems can arise if, for example, the IMG adopts a position of superiority with respect to nurses and non-medical staff. If the IMG believes that their authority is being questioned, friction may arise, with the potential to create a hostile work environment.

The IMG may lack self-confidence and assertiveness in the clinical setting, which may manifest as difficulties with:

- interpersonal skills generally
- decision making
- managing difficult patient behaviour (especially drug-seeking behaviour)
- teamwork.

Personal cultural factors

The IMG's personal values, attitudes and beliefs can sometimes create tensions, particularly as regards interactions with medical educators, supervisors and generally those who they perceive to be their superiors by virtue of learning, experience or social status:

- The educator is generally held in great esteem and the learner is not encouraged to question or challenge or in any way appear that they know more. The reluctance of IMGs to answer questions or give opinions in teaching sessions can therefore be interpreted as a lack of knowledge, interest or confidence, or an unwillingness to engage.
- From an IMG's perspective, the educator's role is to provide learners with all the material and information they require. When faced with differences in teaching style – such as experiential learning, problem-based learning and discussions – IMGs are at a loss as to how to participate effectively.
- Feedback, and especially negative feedback, may be perceived as criticism and may be accompanied by feelings of shame and loss of face.

Insight, ability to adapt and change

For IMGs, there may be difficulties with self-awareness, self-reflection, and recognising their limitations and learning needs. Consequently, the IMG may be unwilling or reticent to engage with supervision and remediation programs.

In general practice, the IMG's ability to adapt and change is evidenced by the degree of adaptability to the different social norms and work culture, as opposed to the degree of fixedness to the traditional systems/methods to which they have been accustomed.

Difficulties with integration, socially and professionally, may impact on:

- quality of life
- education (experience and outcomes)
- professional and community networks (ability to communicate and interact with a range of people in different roles)
- workplace culture, interaction with colleagues and other health professionals.

Motivation

Motivation to learn, improve skills, and integrate in the workplace and the community is a personal thing. While for many IMGs the will may be there, the imperative to work and provide for family tends to take precedence.

Study and exams

Study can present many problems for IMGs, including:

- unfamiliarity with adult learning principles (textbook as opposed to experiential learning, being used to being told what to do and consequently not always being proactive with learning)
- limited time to study because of having to balance work and family commitments – commitment to family generally takes precedence over the need to study, particularly when there is lack of support with caring for children
- limited opportunities to attend continuing professional development (CPD) and exam preparation sessions, form study groups and engage with and learn from more-experienced GPs
- lack of mentoring/guidance (knowing what is expected and how to do it)
- lack of access to peer support, such as supervisors and mentors.

Work environment and systems

Work environment and systems are areas sometimes not considered as having an impact on clinical capability, but they are nevertheless important.

'Work environment' includes:

- employment contracts and conditions, such as working in an unsupported, high-demand clinical environment where IMG needs (in order to develop their skills and to study and pass exams) are not met
- practice systems, such as understanding and navigating the social, healthcare and medico-legal systems – these are of particular concern, given potential difficulties with understanding the Pharmaceutical Benefits Scheme, the Medicare Benefits Schedule and Schedule 8 regulations
- emotional intelligence, or lack thereof, in the workplace (which may also be related to notions regarding the role of the doctor and the role of others).

'Systems' include:

- various regulatory requirements, such as medical registration and limitations on practice (as imposed by the government and Medical Board)
- the requirements of the AMC and RACGP (including exam requirements).

Principles for managing performance concerns

A well-formulated, tailored management plan will improve the likelihood of engagement by the IMG and, consequently, the likelihood of the learning objectives being achieved. The following principles for formulating and executing a management plan provide a suitable framework for enhancing the performance management process:

1. Approach to the IMG
2. Educational considerations (learning preferences)
3. Language skills
4. Clinical skills
5. Educational strategies
6. Giving feedback

1. Approach to the IMG

It is important for the IMG to be engaged, from the outset, when concerns are first identified, and certainly in the formulation of a management plan. It is helpful to:

- try to understand the IMG, their background, and their personal and life issues
- consider their side of the story: What do they perceive are the issues/difficulties? What do they believe they need help with?
- maintain awareness for any issues or needs that are unspoken.

It may be necessary to conduct an assessment (direct observation and/or video with feedback) when it is not clear what the precise concerns are. All issues at play should be identified, not just the clinical skills concerns. Remember, it's not all 'knowledge gaps' and 'cultural'. There may be underlying contributing factors, such as personal health, family or even industrial relations problems. Only once these have been considered and explored can the fundamental issues (causative factors) be truly discerned.

Lastly, in discussion with the IMG, it is important to agree on the management plan:

- issues that need to be addressed and the objectives
- medical educator and supervisor support
- educational strategies/activities – help the IMG understand that didactic teaching is not always the best method
- time frame for implementing the plan
- how progress during implementation of the plan will be assessed
- how outcomes will be evaluated upon completion of the plan.

2. Educational considerations

In formulating a management plan, including a learning plan, it is important to consider conflicts that may occur between educator and learner expectations. Generally, the learning methods preferred by IMGs are:

- procedural teaching
- case-based discussion
- exam-oriented teaching
- interactive lectures/tutorials
- Applied Knowledge Test/Key Feature Problem (AKT/KFP) quiz sessions.

The methods of learning least preferred by IMGs are:

- reflective writing
- small group learning (webinar format)
- role-play
- critical analysis
- random case analysis/discussion
- direct observation and videorecording of consultations

IMGs may feel threatened by direct observation, videorecording of consultations and role-play. Rather than seeing these as learning opportunities, they may perceive them as tests of their capability that may result in them being unable to practise or, possibly, being reported to AHPRA.

In regard to learning, educators place emphasis on:

- depth of learning and understanding
- learning that lasts (that is retained and built on)
- lifelong learning (CPD).

Educators also have expectations that the learner be motivated to learn and put what is learnt into practice.

Learners, however, may appear to be more concerned with:

- surface learning
- wanting to pass exams
- learning to the test.

On face value, therefore, there is a mismatch between what the educator believes is good for the learner and what the learner wants. It is important not to lose sight of the 'greater picture', which is to develop clinical skills and become a competent GP with the capability to practise safely and independently anywhere in Australia (which is the assessment standard for the FRACGP exam). Study that focuses purely on passing the exam is unlikely to bring the desired results.

In all instances, the following factors are key for habits to change and improvement to occur:

- attitude (willingness to change)
- motivation (desire to change)
- discipline and determination
- a well-considered study plan.

3. Language skills

Even though IMGs are required to pass an English language test before working in Australia, some, in varying degrees, experience language difficulty quite separate to any difficulties with communication skills. Strategies for improving language skills include:

- formal English lessons
- English language coaching from a speech therapist or linguist – this is useful when the IMG has a strong accent, difficulties with pronunciation or makes syntactical errors
- self-help:
  - speaking a little more slowly, loudly and clearly
  - support from family and friends
  - networking and speaking English with other IMGs
  - more contact with everyday spoken English (listening to radio and news, reading newspapers, watching Australian TV programs where everyday language is used, watching English-language medical programs)
- practice, practice, practice!

Support from family and friends may be in the form of encouragement to improve language skills but it could be as simple as talking to the children at home or trying to explain something medical to a family member or friend. Children pick up language a lot more easily than adults and they can be very good at correcting errors in vocabulary, use of idiom and even the nuances of language. Someone who doesn't have medical knowledge is best placed to give feedback on whether they clearly understood medical information that was conveyed to them and whether the manner in which it was conveyed was engaging.

4. Clinical skills

It is important for the IMG to understand the fundamentals of Australian general practice. Generally, this teaching can be incorporated in clinical skills tutorials. However, when the IMG does not have a good understanding, it may be necessary to conduct specific sessions on:

- the general practice environment and culture
- the doctor–patient relationship and patient-centred care
- teamwork and interpersonal skills within general practice.

When teaching clinical skills, the following are important aspects of these skills to be mindful of.

- Communication skills:
  - using verbal, non-verbal and written communication
  - ensuring two-way communication between doctor and patient
  - building rapport
  - understanding the patient and being understood by the patient

- Having a structured consultation
- History-taking:
  - regularly checking the accuracy of gathered information with the patient
  - summarising, so as to ensure all the relevant information has been gathered and understood
  - gathering sufficient evidence that supports/refutes the working hypothesis
  - considering the possibility of any serious underlying issues (red and yellow flags, Murtagh's 'masquerades')
- Physical examination:
  - conducting a focused physical examination
  - gathering evidence that supports/refutes the working hypothesis
  - considering new/unexpected findings in relation to the presentation
- Clinical reasoning (problem solving and formulation of hypotheses):
  - not relying on illness scripts alone
  - understanding the difference between a diagnosis and a working hypothesis
  - keeping an open mind and creating a shortlist of working hypotheses, rather than focusing too quickly on a single hypothesis or diagnosis
  - giving due weight to findings, relative to the presentation and relative to the working hypothesis
- Management:
  - prioritising the problem list and thinking in terms of short-, medium- and long-term management
  - considering the urgency of certain situations and responding to that urgency
  - creating structured management plans
  - tailoring management plans to the individual, including negotiation with the patient to agreed outcomes
  - delivering management plans effectively and confidently and giving clear instructions
  - providing information and explanations in a clear and concise manner and tailoring to the patient context
  - using shared decision making
  - safety netting

With respect to providing information and explanations fluently and effectively, one useful way of becoming more practised is for the IMG to pick a topic from Murtagh's *Patient education*, learn it and then say it out loud using their own words. There are several ways in which this may be done:

- talking to a mirror
- audio recording and playing back, and repeating this until they not only 'get it right' but feel more comfortable saying it
- saying it to a relative or friend who can give them feedback on how it was said but also on whether they understood the information.

5. Educational strategies

Educational strategies include:

- creating opportunities to engage with mentors, coaches and supervisors, wherever possible
- direct observation and feedback (it is important for the educator to clarify that their role is supportive and the aim is to assist the IMG's learning and improve their skills)
- videorecording and feedback (as with the direct observation, it is important for the educator to clarify what their role is)
- sitting in with an experienced doctor to observe their clinical skills but also to obtain a clear picture of Australian general practice
- role-playing and discussion of a variety of clinical presentations, including more challenging ones, to:
  - develop self-confidence and assertiveness (taking control of the consultation and being decisive)
  - improve the overall structure of consultation, information gathering and management plans
- case discussion (including random case analysis) with emphasis on clinical reasoning
- case presentation with emphasis on presenting the information in a structured way, using language that is appropriate for peer-to-peer interactions.

6. Giving feedback

The general principles of giving effective feedback should always be followed, no matter the context. The following points merit highlighting:

- be mindful of the IMG's perceptions of feedback, address any misconceptions and be clear about your intentions
- be mindful of the IMG's reactions to the feedback
- give specific examples of what was done well and what requires improvement
- give clear explanations as to why something should be done differently or requires improvement
- suggest alternative ways of saying/doing something.

Appendix A. Hofstede's six dimensions of national culture

Based on his own research and that of others, Geert Hofstede identified six dimensions of national culture. These dimensions represent 'value orientations' and are a framework for quantifying the particular values of a society or culture as well as the difference in values between societies and cultures. These dimensions have been investigated considerably at the collective level. They refer therefore to collective values and great care should be exercised when considering:

- IMGs as a group – IMGs do not form a homogeneous group because they come from different countries and different cultures
- Individuals – an individual's values are not necessarily the same as the values of their ethnicity or the cultural group that they come from.

Nevertheless, Hofstede's dimensions are useful in considering the possible motivations to an IMG's behaviour in the workplace or in the educational setting.

Six dimensions of culture (as identified by Hofstede):

1. Power Distance
2. Uncertainty Avoidance
3. Individualism versus Collectivism
4. Masculinity versus Femininity
5. Long-term versus Short-term Orientation
6. Indulgence versus Restraint

1. Power Distance

Power Distance relates to the power differential that exists within a society (how power is used by those more powerful and how inequality is accepted by those less powerful).

Large Power Distance societies

These societies are authoritarian and inequality is accepted as a 'fact of life'. Roles in the society are hierarchically structured. This manifests as:

- parents teach their children obedience
- older people are respected and feared
- education is teacher-centred
- subordinates expect to be told what to do.

Small Power Distance societies

Those in power are held to account and there is a striving for greater equality within roles. This manifests as:

- parents treat children as equals
- older people are neither respected nor feared

- education is learner-centred
- subordinates expect to be consulted.

According to Hofstede

- Large Power Distance is found in East European, Latin, Asian and African countries.
- Smaller Power Distance is found in Germanic and English-speaking (Western) countries.

In general practice

In general practice the Power Distance dimension is evidenced in the interpersonal relationships in the workplace, with educators, staff in organisations, etc. Interactions in these settings may be perceived as being with equals (small power differential) or as being with superiors and subordinates (high power differential).

2. Uncertainty versus Avoidance

This dimension relates to a society's tolerance for uncertainty and ambiguity and the degree of comfort that individuals experience in unstructured situations (novel, unknown, surprising, different from usual).

Greater Uncertainty Avoidance societies

These societies believe that uncertainty in life is a continuous threat that must be fought. They try to minimise unstructured situations by putting in place strict behavioural codes, laws and rules. Deviant opinions and behaviour are not tolerated. This manifests as:

- higher stress, emotionality, anxiety, neuroticism
- need for clarity and structure
- emotional need for rules
- expecting that educators have all the answers
- remaining in a job even if it is disliked.

Lesser Uncertainty Avoidance societies

These societies accept the inherent uncertainty in life and live each day as it comes. This manifests as:

- more relaxed, lower stress and anxiety, self-control
- tolerance of 'deviant' ideas and behaviours
- comfortable with ambiguity and chaos
- dislike of rules
- teachers may say 'I don't know'.

According to Hofstede

- Greater Uncertainty Avoidance countries include East and Central European countries, Latin countries, Japan and German-speaking countries.
- Lesser Uncertainty Avoidance countries include English-speaking and Nordic countries and Chinese cultures.

In general practice

In general practice, where uncertainty in the clinical context frequently occurs, the Uncertainty Avoidance dimension may be evidenced in the way uncertainty is perceived and managed. In the educational context, the dimension is evidenced in the expectations that the educator has of the learner and the learner of the educator.

3. Individualism versus Collectivism

This relates to the degree to which people in a society are integrated into groups, as a societal characteristic rather than an individual characteristic.

Individualist societies

These societies have loose ties between individuals. Everyone is expected to look after themselves and their immediate family. This manifests as:

- 'I' consciousness, right to privacy
- speaking one's mind and personal opinion
- seeing others as individuals
- transgression leading to guilt feelings
- believing the purpose of education is learning how to learn
- believing task prevails over relationship.

Collectivist societies

People in these societies are, from birth, integrated into strong, cohesive groups (eg extended families) that provide protection in exchange for unquestioned loyalty to the group. This manifests as:

- 'we' consciousness
- emphasising belonging and harmony of the group
- seeing others as either belonging or not belonging to the group
- transgression leading to feelings of shame
- believing the purpose of education is to learn how to do something
- believing relationship prevails over task.

According to Hofstede

- Individualism prevails in Western countries.
- Collectivism prevails in less developed and Eastern countries.
- Japan has a middle position.

In general practice

This dimension is evidenced in the relationship between the patient and the various societal groups to which they belong (family, work, community), the responsibilities of one to the other, and the doctor's beliefs with respect to all these. Problems occur when a person's values are not considered and assumptions made, resulting in inappropriate judgements and actions.

4. Masculinity versus Femininity

This dimension relates to the distribution of values between the genders as a societal, rather than individual, characteristic. Women's values vary less between societies as compared to men's values. Men's values range from very assertive and competitive ('masculine') on the one hand, to modest and caring ('feminine'), similar to women's values, on the other.

Masculine societies

These societies have maximum emotional and social differentiation between the genders, with men expected to be (while women might be) assertive and ambitious. This manifests as:

- admiration for the strong
- work prevailing over family
- fathers dealing with facts, mothers with feelings
- 'boys don't cry and should fight back'; 'girls cry and shouldn't fight'
- moralistic attitude towards sex; sex is functional.

Feminine societies

These societies have minimum emotional and social differentiation between the genders, and both men and women are expected to be modest and caring. This manifests as:

- balance between family and work
- sympathy for the weak
- both mothers and fathers dealing with facts and feelings
- 'boys and girls cry and neither should fight'
- matter-of fact-attitudes about sexuality; sex is a way of relating.

According to Hofstede

Masculinity is:

- high in Japan, German-speaking countries and some Latin countries (Italy, Mexico)
- moderately high in English-speaking (Western) countries
- moderately low in France, Spain, Portugal, Chile, Korea and Thailand
- low in Nordic countries and the Netherlands.

In general practice

This dimension is evidenced in the doctor–patient interaction, as well as in views on sex and gender roles.

5. Long-term versus Short-term Orientation

Long-term Orientation

This orientation is associated with hard work and the belief that the most important events in life will occur in the future. Its values include perseverance, thrift, ordering relationships by status and having a sense of shame. This manifests as believing:

- a person should adapt to circumstances
- good and evil occur as a result of circumstances
- traditions are adaptable to changes in circumstances
- in task-sharing in families
- in learning from others
- thrift and perseverance are important goals
- for students, that success is due to effort and failure to lack of effort.

Short-term Orientation

This orientation is associated with personal steadiness and stability and the belief that the most important events in life occurred in the past or are occurring now. Its values include reciprocating social obligations, respect for tradition and saving 'face'. This manifests as believing:

- there are universal guidelines about what is good and evil
- traditions are sacrosanct
- family life is guided by imperatives
- in one's country (national pride)
- service to others is an important goal
- for students, success and failure is due to luck.

According to Hofstede

- Long-term Orientation is evident in East Asian (China, Japan) followed by Eastern and Central European countries.
- Medium-term Orientation is evident in Southern and Northern European countries and South Asian countries.
- Short-term Orientation is evident in the US, Australia, and Latin America, African and Muslim countries.

In general practice

This dimension is evidenced in the doctor–patient interaction, particularly with respect to views on the causation of illness and motivation to change or to recover from illness (views with respect to the roles played by luck and circumstance, the value of personal effort and perseverance, responsibility to self and family, perceptions of self-worth).

6. Indulgence versus Restraint

This dimension, to some degree, complements the Long-term versus Short-term Orientation dimension. An 'indulgent' society allows relatively free gratification of the desires to enjoy life and have fun. Restraint in a society means that gratification of needs is controlled and regulated by strict social norms.

Indulgent societies

Indulgent societies have a higher percentage of people who say that they are happy and there is a perception of personal life control. In addition:

- high importance is placed on leisure
- more people are actively engaged in sports
- freedom of speech is seen as important
- in countries with educated populations, the birth rate is higher
- in countries with sufficient food, there is a higher percentage of obese people
- in wealthy countries, sexual norms are lenient.

Restrained societies

Restrained societies have fewer people who say that they are happy and there is a perception of lack of life control (ie a sense that what happens is not of the individual's doing). In addition:

- lower importance is placed on leisure
- fewer people actively engage in sports
- in countries with educated populations, the birth rate is lower
- in countries where there is enough food, the percentage of obese people is lower
- in wealthy countries, the sexual norms are stricter.

According to Hofstede

- Indulgence prevails in South and North America, Western Europe and parts of sub-Saharan Africa.
- Restraint prevails in Asia and the Middle East.
- Mediterranean Europe lies somewhere in the middle.

In general practice

This dimension is evidenced in the doctor–patient interaction, particularly with respect to perceptions about life control, what constitutes happiness and the value of leisure.

Appendix B. Exam support guidelines

It is not uncommon for IMGs to struggle with passing exams such as the AMC and FRACGP. There are many reasons for this, but generally they relate to the IMG's:

- particular circumstances (personal, family and social)
- constraints on their practice
- limited exposure to a broad range of presentations (including chronic disease)
- approach to study
- professional isolation and lack of educational support from someone experienced.

The following is a suggested approach when providing support to an IMG who has failed one or more segments of the RACGP exam:

- Identify the reasons behind the IMG's failure.
- Analyse the exam results.
- Formulate an action plan.

What were the reasons behind their failure?

Consider the following when exploring the reasons for failure.

- Study:
  - Allocated time for study – Was it dedicated, regular time or ad hoc?
  - Study methods and resources used – often, a limited number of resources is used. Consequently, the IMG lacks depth and breadth of knowledge.
  - Did anything, such as health issues, personal problems, family or financial concerns, interrupt their study plan?
  - Do they have a study partner or study group? How do they study with their partner or the group? How effective is that study? Sometimes study partners have poor approaches to study, and the required support and guidance is therefore not available.
  - Do they have a supervisor in practice? Are they receiving in-practice teaching? Do they have a more experienced colleague with whom they can discuss clinical cases and ask questions? Having someone experienced who can act as a mentor is of great benefit.
- Exam technique (particularly important with the KFP and OSCE)
- Exam stress and negative attitudes to assessment
- Language (reading and comprehension, typing skills)
- The scope of their clinical practice (and how this compares with the RACGP's 'Competency profile of the Australian general practitioner at the point of Fellowship'):
  - The practice type and location – Is there pressure to conduct shorter consultations? Are they travelling long distances to and from work?

  - Hours of work – Is there pressure to work long hours, thus impacting on study time?
  - The range of clinical presentations that they see – What kinds of presentations are they not seeing?
- To what degree has their study plan been informed by the RACGP's 'Competency profile of the Australian general practitioner at the point of Fellowship' and the Curriculum for Australian General Practice 2016?
- What do they believe are their strengths and weaknesses?

Exam results

Current and previous exam results (particularly if a breakdown of the marks is available) can provide useful information with respect to areas of weakness, as well as informing a learning and study plan.

Consider:

- What is the fail margin? How does it compare with previous fail margins?
- Compare the scores for AKT, KFP and OSCE.
- Are there any patterns or discrepancies with respect to the areas of strength and weakness?
  - What do these discrepancies suggest?
  - Was there difficulty with one particular segment of the exam over another? What does this suggest?

The KFP and the OSCE are the components that generally cause more difficulty: the KFP because of issues with clinical reasoning and the OSCE because of weak clinical skills and communication skills in particular.

There may be difficulty with both of these components because of insufficient clinical experience and exposure to a broad range of presentations.

Action plan

Having explored the reasons for failure, all the issues should be listed according to the following headings:

- Clinical knowledge and its application
- Clinical reasoning
- Clinical practice
- Exam technique
- Study
- Other

From this, an action plan for preparing for the next exam may be prepared. It is important:

- to not keep doing 'more of the same'
- that a variety of study resources is used
- to find someone more experienced who can act as a mentor.

Clinical knowledge and its application

Core topics (such as diabetes, hypertension, heart failure) require depth of knowledge. It is not appropriate to rely solely on John Murtagh's *General practice* for study. Other texts and sources of in-depth knowledge must also be used.

Clinical guidelines are available on the RACGP and other websites. Knowing guidelines off by heart does not necessarily equate to being able to apply them in practice. This is where clinical experience, application of knowledge, shared decision making and communication skills are important.

John Murtagh's *General practice* is useful with respect to:

- being familiar with common problems, red flags, masquerades and what should not be missed
- problem solving with respect to the common presentations (refer to Part 3 – Problem solving in general practice).

The RACGP *check* and *gplearning* modules are very useful because information is presented with reference to clinical cases and contexts.

Areas of confidence or strength should be revised so that the knowledge remains fresh.

Clinical reasoning

Many factors impact on clinical reasoning, including knowledge and its application, the ability to problem solve and clinical experience (time in practice as well as breadth of practice).

Other aspects of clinical reasoning, which often aren't highlighted, are the ability to:

- apply the general to the specific
- problem solve in a new context
- present and discuss the decision with the patient (this enhances confidence and is also part of shared decision making).

Clinical reasoning is facilitated when there is structure to the consultation and a process for problem solving. Clinical practice entails the management of patients who come with a particular presentation within a specific context. No two contexts (or patients) are the same. In the consultation, information is gathered (history, examination, investigations) and simultaneously processed as regards its meaning and value and what further information may be required. The importance that is placed on individual pieces of information influences decision making and the relative importance of each piece of information is contextual. KFP questions and OSCE cases test clinical reasoning and must therefore be approached as if managing a real patient in practice rather than as a textbook case.

Case discussion is one way of improving clinical reasoning. The following guidelines will make the case discussion more meaningful:

- Don't just discuss 'interesting cases'. Discuss undifferentiated presentations and cases where more thinking is required in order to problem solve.
- Don't make assumptions and be wary of making invalid interpretations.
- Only use the information at hand.

- Ask: What would happen if …
  - the parameters of a case were changed (eg age, gender, severity of symptoms, comorbid conditions)?
  - test results came back normal/abnormal?
  - the patient's condition worsened?
  - other symptoms developed?
- Information gathering – an appropriate list of differentials should always be generated with every presentation. In order to do this, it is necessary to think about what information is required to rule in or out each differential with respect to:
  - history-taking
  - physical examination
  - ordering of investigations.
- Consider red flags, masquerades and things that shouldn't be missed.
- Investigations – differentiate between:
  - first-line, second-line and routine tests
  - screening and diagnostic tests; tests that assist with diagnosis and tests that assist with management
  - necessary and unnecessary tests (don't order a test if it will not affect decision making).
- Prescribing – Therapeutic Guidelines, *Australian medicines handbook, Australian Prescriber* and NPS MedicineWise are all good resources.
- Management:
  - should be tailored to the individual (ie the person and the context)
  - should include shared decision making
  - should be separated into immediate (what must be done now), short term (in the next few days), medium term (in the next few weeks or perhaps few months) and long term.

The following articles provide guidance for getting the most out of case discussion:

- Linn A, Khaw C, Kildea H, Tonkin A. Clinical reasoning: A guide to improving teaching and practice. Aust Fam Physician;2012;41(1/2):18–20. Available at www.racgp.org.au/afp/2012/januaryfebruary/clinical-reasoning [Accessed 10 February 2020].
- Morgan S, Ingham G. Random case analysis: A new framework for general practice training. Aust Fam Physician 2013;42(1/2):69–73. Available at www.racgp.org.au/afp/2013/januaryfebruary/random-case-analysis [Accessed 10 February 2020].

Clinical practice

This is perhaps the most difficult issue to address, particularly when it is not realistic or not possible to change practice or even to get experience with a broader range of presentations within the same practice. Helpful alternatives include:

- case discussion and role-play of clinical cases with an experienced GP or medical educator – cases taken randomly from a day's consulting are an excellent source of material for discussion (including cases from an experienced GP's day)

- direct observation of consults by an experienced GP or medical educator
- observation of an experienced GP in their consulting.

Exam technique

Exam practice is useful for identifying issues with exam technique. There are many resources available for AKT and OSCE practice; however, resources for KFP practice are limited. The principles of the KFP examination are critical to understand and practise with good quality cases/questions is key. Poorly written cases/questions only serve to confuse and generate negative attitudes.

Study

In formulating a study plan, the following should be considered:

- preferred learning methods
- dedicated, regular study time (no interruptions)
- study partner or study group (face to face or Skype/FaceTime)
- a realistic timeline (What will be done and when? – so that everything is covered, while at the same time allowing for revision)
- prioritisation of study topics.

On the last point:

- Uncommon and rare presentations do not justify detailed and extensive study. However, common problems require a high level of detailed knowledge and understanding. The difficulty is in deciding which topics to prioritise. The article by Georga Cooke et al (Common general practice presentations and publication frequency) is a useful guide in this respect (refer to Resources list).
- Study topics can be grouped into 'short' and 'long' topics according to whether they require less or greater amount of study. When time doesn't allow for an in-depth session on a common problem, it may be more advantageous to cover, for example, three or four uncommon conditions that will each take only a small amount of time.

Other

The IMG should be encouraged to address factors such as personal and family concerns that contributed to previous exam failure or that may affect future performance. The aim would be to minimise, as much as practicable, anything that may act as a distraction to study and remaining focused in the lead-up to the exam as well as during the exam.

Exam anxiety is another issue that is best addressed earlier rather than resorting to 'quick fix' measures at the last minute.

Appendix C. Case studies

Language skills

Case 1 – Dr Xiong

Dr Xiong is specialist trained, younger doctor who has adapted well to working in general practice. You have observed his consulting and you find that he has some minor knowledge deficiencies. His clinical skills are of a good standard. The reception staff report to you that patients have been complaining of difficulty understanding him and they are reluctant to see him again. From your interactions with him, you have noticed that he has an accent but by paying close attention you were able to understand what he was saying.

Is there anything else about Dr Xiong's consulting that you would like to know?

It is important to obtain a clearer understanding of the patient complaints. There are many possible explanations for why patients might be reluctant to rebook with Dr Xiong. Is language the problem (eg accent, language skills) or is it communication skills instead? The issue may be his consulting skills; however, are patients putting it down to an issue of 'language' or 'culture'? Has anyone else, besides patients, had difficulty understanding Dr Xiong? Could it be that the reception staff do not relate well to Dr Xiong and/or have difficulty communicating or interacting with him?

What kinds of things contribute to difficulties with communication?

There are several factors that may contribute to communication difficulties:

- ineffective communication skills, including body language and attention to verbal and non-verbal cues
- language (eg vocabulary, sentence structure, idiom)
- pronunciation, accent and intonation
- a doctor-centred approach.

Are there any other issues that should be considered?

Other issues to consider:

- prejudice on the part of staff/patients
- patients who are difficult to understand for the same reasons as the doctor (eg accent, pronunciation, idiom).

What are the obstacles to improving language skills?

Obstacles include:

- not devoting time to practising language skills
- unwillingness or inability to change.

Exam failure

Case 2 – Dr Goran

Dr Goran is an older doctor who passed the written segments of the Fellowship exam (AKT and KFP). He has, however, failed the clinical segment (OSCE) by a significant margin.

How might you explain this?

There are several possible explanations:

- overconfidence – he may believe, or others may have told him, that he has good clinical skills and that he shouldn't have any difficulty passing (and he therefore did not study)
- inadequate preparation for the exam (eg too busy to study, not dedicating sufficient time to study, not prioritising exam preparation time, learning cases off by heart and not actually role-playing them, not role-playing to time, not being critical enough with each other in the study group, inability to connect with a study group)
- professional isolation
- unfamiliarity with exam requirements.

Dr Goran is quite upset by his result. He says that he didn't find the cases difficult. He ran out of time with several cases and consequently was unable to address management adequately. You understand how this might have happened because you have observed him in his consulting and his style is very considered. You believe that he has good clinical skills, however, because of his style, his consultations are invariably long.

How can you assist Dr Goran so that he doesn't have the same problem when he next sits the exam?

- It would be useful to review his consulting skills, even though you may have observed him previously. Certain approaches or habits in the consulting room may not work so well in the exam room where time is limited. There may be something about his consulting skills that you haven't considered, and which is contributing to his slowness.
- Useful strategies as practice for the exam include:
  - Role-play a variety of scenarios with an emphasis on efficiency and time management. Provide him with a framework or some useful tips that he can also practise in the consulting room.
  - Video-record some of the role-playing so that he may gain insight into his strengths and weaknesses.

Case 3 – Dr Alexei

Dr Alexei is an older doctor who passed the written segments of the Fellowship exam (AKT and KFP). He has, however, failed the clinical segment (OSCE) by a significant margin. You have observed him in consultations and you believe that he has good clinical skills. You have noticed that he tends to be nervous when he is being observed and makes simple mistakes (forgetting something that the patient has said, being distracted by the computer, having to stop and think frequently). His nervousness is worse when doing exam practice, to the point that the consultation becomes unstructured and he runs out of time.

How can you know that it is only his nervousness that is responsible for his failure?

The fact that his consulting deteriorates even further during role-play suggests that it is his nervousness. Case discussion would be a simple way of deciding whether there are any clinical skills concerns that also need to be addressed.

How can you assist Dr Alexei with his performance anxiety?

Dr Alexei's performance anxiety is not something that will be managed solely with simple strategies that he can implement during the exam. Similarly, 'quick-fix' measures just before the exam (such as taking a sleeping tablet the night before or an anxiolytic on the day of the exam) will not help. This is a bigger problem that Dr Alexei must address for himself. You can assist him by highlighting the importance of seeking help and seeking it early. He should discuss his problem with his GP and referral to a psychologist would be beneficial.

Case 4 – Dr Uma

Dr Uma failed the AKT and KFP exam on her first attempt, despite being very capable clinically. She admits that she didn't study as much as she might have because she thought that she would pass. She says that she has already put together a study plan and will be working on this diligently.

How can you assist her with her preparations for the next exam?

You remind her of the importance of addressing areas of knowledge deficit, including patient presentations that she is not seeing or that she is not very practised at. She can also reflect on the topic areas in the paper that she found more difficult and put those on her learning plan.

Is there anything else that you can do?

You can observe her in her consulting and appraise her consulting skills.

You have never observed Dr Uma in her consulting. Your basis for believing that she has good clinical skills is from the regular case discussion that you have been conducting with her and also from reviewing her clinical notes. You decide to observe her in her consulting and you confirm that she has good clinical skills; however, you notice that Dr Uma has a habit of frequently consulting online resources for things that you expected she would have committed to memory, such as doses of frequently prescribed medications and common disease guidelines. Dr Uma explains that she doesn't bother with remembering things that she can easily look up.

Does this observation matter when it is impossible for anyone to commit everything to memory?

There is nothing wrong with using online resources in the consultation. Dr Uma does it very efficiently and without undue disruption to the flow of the consultation. For the exam, however, certain facts have to be committed to memory. It is also important to have experience in managing a broad range of clinical presentations because information that is used frequently will be retained and then recalled more readily. Dr Uma has not considered that this might work against her in the exam.

For some GPs, it may have been many years since they have had to plan and engage in substantial study. Life events, financial imperatives and work pressures may also compete for their time more than in previous years. It may therefore take more time and they may require extra support to get into a studying frame, to dedicate time for study and to improve the quality of their study time.

In addition, as GPs become more experienced clinically, they develop efficiencies of practice that become habit. They generally also have well-developed problem-solving skills. Consequently, they may find it difficult to explain why they do what they do. Older, more experienced doctors may also find it difficult to go back to a style of practice that students and trainees are expected to demonstrate in an exam. It is not unusual for them to fail a knowledge test (because their knowledge base is not at the expected level for the exam) or even to fail an OSCE exam (because of not paying attention to exam technique).

Case 5 – Dr Anwar

Dr Anwar passed the AKT quite comfortably but failed the KFP by a very small margin. You know him to be quite capable clinically. He admits that he didn't study as much as he should have. He was very confident about his knowledge base and while he did have a study group, he didn't participate in the group activities very often. He admits also that his home study was interrupted because after coming home from work, he would play with his toddler son.

How can you assist him with his preparations for the next exam?

Dr Anwar may have been overconfident about his abilities and therefore did not pay as much attention to study as he might have. Competing priorities (eg family time and responsibilities, other pressures) can make it very difficult when it comes to allocating study time and also studying effectively. Some of these competing pressures can be readily addressed; however, there are situations, such as illness and difficult family circumstances, that aren't easily addressed. Nevertheless, realistic options for managing the situation at hand and enabling regular, dedicated study time should be considered. Even with the most difficult of situations, simple measures and supports can be of great benefit. Sometimes, the better option may be to defer sitting the exam.

Case 6 – Dr Navid

Dr Navid has failed the AKT and KFP, both for the second time. He is distressed because, in his own words, he was 'very close to passing this time'. His results are as follows (pass mark in brackets).

	AKT	KFP
Previous exam	56.7% (66.3%)	52.7% (60.2%)
This exam	62.1% (70.3%)	53.4% (59.5%)

What do you say to him?

Dr Navid's scores are all well below the pass mark and he needs to recognise this. On face value, his scores indicate significant knowledge deficits and significant difficulty with clinical reasoning. The fact that Dr Navid believes that his second set of results were 'very close to passing' suggests that he lacks insight into what is required to pass the written exams.

Could his poor scores be due to poor exam technique?

While difficulties with exam technique (especially with the KFP) can certainly be contributory, Dr Navid's scores cannot be explained by that alone.

How can you assist him with his preparations for the next exam?

A good question to ask Dr Navid is, 'What exactly do you do when you are studying?' It may be that he is passively reading texts and magazine articles rather than identifying and prioritising deficit areas and actively working on them. He may not be aware of the scope of general practice and consequently unaware of what knowledge and skills he is expected to have. In fact, there are many possible reasons for Dr Navid's failure to pass. All these need to be explored and a study plan drawn up (refer to Appendix B).

Dr Navid says that he will defer the exam for six months so that he can apply himself diligently to the learning plan. Twelve months later, he reports to you, once again very distressed, that he has not passed. He says that he has been studying, much more than with his previous attempts, and he cannot understand why he has failed again. He believes that there has been an error with the marking of his papers and he wants to appeal. His scores are as follows (pass mark in brackets).

AKT	KFP
62.3% (71.6%)	55.3% (61.8%)

How do you respond to him?

Dr Navid has the right to appeal if he wishes; however, his scores are still significantly below the pass scores and it is unlikely that this would be due to an error in marking.

How do you explain the fact that his scores are still significantly below the pass score?

There are several possible reasons:

- not studying enough
- not studying effectively
- not adhering to what was recommended in the study plan
- not having someone more experienced to guide him
- working in a limited scope of practice (ie limited exposure to a variety of patient presentations and therefore limited opportunities to gain experience and apply what is learnt)
- lacking insight.

It may be that Dr Navid does not have the abilities, not just to study and pass the exams, but more particularly, the capabilities required of a GP in order to practise safely and independently.

Case 7 – Dr Yin Chan

Dr Yin Chan passed the written segments of the RACGP exam after three sittings (comfortable pass in the AKT, just over the pass score in the KFP). She is very upset because she failed the OSCE. She believes that she should have passed because, in her own words, 'I got the diagnosis in just about all of the cases'.

How do you respond to her statement?

While she may well have been able to make a diagnosis in most cases, marks are not allotted for this alone. In some cases, it may not be possible to confirm a particular diagnosis and instead, the candidate is expected to formulate a short list of appropriate differentials or a working hypothesis. Candidates are also expected to manage the patient holistically, using a range of clinical skills. Marks are allocated according to how well the appropriate skills are used in each case.

What might be the reasons for her failure?

There are many possible reasons, including:

- unfamiliarity with what is expected of candidates in the OSCE exam, hence the belief that it is the diagnosis that matters (refer to: *RACGP Education: Examinations guide* for further information on each exam segment, including format, preparation, development, standard setting and results)
- inadequate preparation (eg not engaging in role-play of cases; how the role-play was conducted, such as not being critical enough with each other in the study group; learning cases off by heart; role-playing to script)
- having a formulaic approach and consequently not thinking about the information, not responding to patient cues, providing information and delivering a management plan that is not tailored to the individual.

How can you assist her with her preparations for the next exam?

- Consider the range of clinical presentations that she is exposed to. What is she lacking in experience?
- Observe her in her consulting – it is important to have a sense of what her consulting skills are like in the real situation. If direct observation is not possible, review of video-recorded consultations is an option. An alternative option would be to role-play two to three clinical scenarios (not as exam cases but as she normally would in her consulting). Weak clinical skills or a poorly considered approach to the patient will certainly translate into poor exam performance.
- Exam practice – role-play a variety of scenarios with an emphasis on process, effectively using the necessary skills, responding to the patient and tailoring management. What she learns from the role-play she can also practise in the consulting room so that it becomes habit. Role-play of presentations that she is not familiar with will also be beneficial.

Health, personal and family issues impacting on clinical skills

Case 8 – Dr Thwe

Dr Thwe completed her first 12 months of general practice training and during that time no serious concerns were raised regarding her clinical skills. She then took time off because of various family commitments and returned to training 18 months later. Not long into her current term, her supervisor raises some serious concerns about her clinical performance. He says that Dr Thwe's skills have regressed and that she is performing at the standard of a medical student (ie she is able to gather information and conduct a basic physical examination but has difficulty formulating a diagnosis and appropriate management plan).

The specific concerns are that Dr Thwe:

- asks questions regarding every patient that she sees – often about things she would be expected to know and frequently the same questions
- will sometimes get an opinion from another doctor in the clinic even after already having been told what to do by her supervisor
- appears unable to assess risk in some consultations and has consequently made some significant errors. One example: an elderly patient saw Dr Thwe because of rectal bleeding. Dr Thwe failed to adequately assess the patient and sent him home. The next day, the patient returned to see another doctor and had to be urgently admitted to hospital.

What is going on here?

There are several possibilities as to why Dr Thwe's skills have regressed. For example, it may be that she has a personal health problem or there may be serious issues at home that are causing her to be stressed or distracted. It may also be that Dr Thwe didn't have very strong skills in the first place. For example, she may have been in more supportive working environments previously, or perhaps she was only seeing straightforward presentations and wasn't having to manage more serious presentations as she is now.

What should happen now?

It is important to communicate the concerns with Dr Thwe and ask for her perspective.

Dr Thwe acknowledges that she is struggling and confides that she has been going through a difficult time. She says that she took time off because she didn't have anyone to look after her child when her mother had to return suddenly to her home country. She has been forced to return to work because her husband is now unemployed. She is finding it difficult to look after her child, manage her home responsibilities, work and study.

What else should happen?

It is important to get a better sense of what Dr Thwe's consulting skills are like and direct observation would be the preferred method.

It sounds like Dr Thwe requires more support at home and she should be encouraged to consider realistic options for addressing the situation. It is also important for Dr Thwe to address self-care (ie the various stresses and her mental state). She should be encouraged to seek help from her own GP and other health providers as appropriate.

Case 9 – Dr Alina

Following direct observation of Dr Alina, you provide her with feedback and inform her that there are some aspects of her consulting that could be improved. You noted that with every consultation:

- there was poor structure to the consultation (ie moving back and forth between history and management very frequently)
- she conducted minimal physical examination
- she was hesitant in the formulation of her management plan (as if she wasn't sure what to do)
- the management plan was delivered in a disorganised fashion and the patient appeared confused about what to do.

Dr Alina acknowledges that she is having difficulty. She says that more often than not she is unsure whether she has made the right diagnosis and consequently she goes back to check information. She also says that her patients interrupt her by asking questions and she loses track of what she is doing because she is compelled to respond to them.

How can you assist Dr Alina to improve?

You tell her that from your observation, she might have more surety as to the diagnosis if she takes a better history and conducts an appropriate physical examination; consequently, the required management will be much clearer. Patient questions can generally be left to the end of the consultation. This will assist with maintaining her focus and the flow, and it will probably be easier to answer questions at the end when she has a better sense of the problems at hand.

In consultation with Dr Alina, you prepare a learning plan that will address the concerns and strengthen her skills.

What should be included in the learning plan?

It is important that all issues are itemised on the plan, including how they will be addressed, what resources will be required and the expected outcomes. It is also important to specify a time frame for the plan and what form of assessment will be conducted, upon its completion, to determine whether the outcomes have been achieved. Other important elements to include in the plan are what her supervisor's role will be (if her supervisor is able and willing to assist), and whether Dr Alina might benefit from the assistance of a medical educator and/or mentor (and what their roles will entail).

Learning plans should be realistic and any constraints should be taken into consideration (refer to the RACGP *Practice Experience Program (PEP): Remediator guide*, which provides information with respect to remedial assistance that is available to GPs enrolled in the PEP).

Dr Alina should also spend some time sitting in on her supervisor's or other GPs' consultations so she may gain a better understanding of what competent experienced general practice is and what she should be aiming for.

As agreed, you return to conduct direct observation of her consulting and to determine what progress has been made. You are pleased to see that her consulting has improved considerably and is now of an acceptable standard. You encourage her accordingly.

You return six months later to conduct direct observation of her consulting. You observe a significant deterioration in her skills. In fact, all the original concerns have reappeared.

What might account for this?

Dr Alina's skills may have regressed because of one or a combination of the following:

- a heavy workload resulting in shorter consultation times (and the learnt skills are not maintained because they haven't become habit)
- not seeing any value in adhering to the learnt skills ('it takes too long')
- something may be happening in her personal life that has caused her to be distracted from doing her job properly (eg personal illness, family issues, financial problems).

How might you address this situation?

You inform Dr Alina that her consulting skills have regressed significantly and that they are now much as they were the very first time that you conducted direct observation. You ask her what the reasons for this might be.

Dr Alina says that she has had some health issues over the last few months. She has been diagnosed with diabetes and she has been feeling very tired because she has been finding it very difficult to manage her blood sugar levels. In addition, she has had one cold after another and, consequently, has had to take frequent days off work. She says that even though she may not be 'doing it by the book' as you want her to, she doesn't think that there is anything wrong with her consulting because her patients are happy with her.

How do you respond to her?

You say to Dr Alina that even though her patients might say they are or appear to be happy with her, she has certain obligations towards them, as set out in the Medical Board document, *Good medical practice: A code of conduct for doctors in Australia.* This document sets out the principles that characterise good medical practice and it explicitly states the standards of care and professional conduct that are expected of doctors by their professional peers and the community. Failure to adhere to these principles (ie failure to do the right thing by her patients) may well result in an adverse event and/or a complaint about her to AHPRA. In order to be more explicit, you say to Dr Alina that her haphazard style of clinical work will result in poor outcomes for her patients because she is exposing herself to excessive risk by missing information, failing to identify serious conditions and failing to safety net or follow up her patients.

You also remind her that it is every doctor's responsibility to attend to self-care and to ensure their safety to practise. This means that her personal health issues, family and other responsibilities have to be managed so that, as best as possible, they are not impacting negatively on her clinical capability and consequently compromising patient care. If there is potential for patient safety to be compromised, then time off to address those issues should be seriously considered.

As you are leaving, the practice manager takes you aside and says that Dr Alina has been taking a lot of time off and that this has been very disruptive to the running of the practice. She wonders whether Dr Alina has actually been ill because she has never produced a sickness certificate. She confides to you that she thinks that Dr Alina is lazy and asks you what the best thing to do with her is.

How do you respond to the practice manager?

It is not for you to comment on whether Dr Alina is or isn't lazy and it is paramount that all parties maintain confidentiality in such situations. As for her taking frequent time off work and the matter of sickness certificates, that is an employment issue for the practice manager and the practice principle to address.

Case 10 – Dr Seyed

Dr Seyed sustained significant neck injuries in a motor vehicle accident. He was hospitalised for a short period and he took time off in order to recover. He returned to work and after a few weeks he reduced his working hours because he found that at the end of a full working day he was experiencing significant neck and shoulder pain. Two weeks later he decided to take time off because his pain had worsened and he wasn't coping.

He returned to working after three months. The reception staff soon noticed that he often appeared vague or drowsy. Patients also complained that he wasn't his usual self, he was overly focused on the computer and that he frequently asked them to repeat what they had said.

What might account for this?

There are several possibilities that might account for Dr Seyed's behaviour. He may be:

- taking medication that is affecting his cognition
- under the influence of alcohol or illicit drugs
- significantly sleep deprived
- having difficulty managing his chronic pain
- under significant personal stresses that he is not coping with.

What should be done?

These observations cannot be ignored because they raise concerns about his safety as well as patient safety. It is important therefore to speak to Dr Seyed, as a matter of urgency, to inform him of what has been observed, to give him the opportunity to talk about what is going on and to offer him support. He should also be told that if the concerns are not addressed, he may be reported to the AHPRA under the mandatory reporting regulations.

Medico-legal issues – Drugs of dependence

Case 11 – Dr Yasmina

Dr Yasmina comes to you to discuss a patient who is causing her distress. The patient, a middle-aged nurse, has chronic pain as a result of a motor vehicle accident several years ago. Her condition is now stable and the patient generally attends for repeat prescriptions for her narcotic analgesia. She never books appointments ahead of time, but rings and demands to be squeezed in when her medication is about to run out. When she arrives for her appointment, she is always rude to the reception staff, complaining loudly at having to wait. In the consultation she is condescending to Dr Yasmina and questions her medical knowledge. Dr Yasmina tries to behave professionally towards the patient. She is also concerned that the patient is taking an unnecessarily high dose of narcotic but every time she tries to address this, the patient badgers her and somehow convinces her to increase rather than decrease the dose.

Dr Yasmina says that in the clinic where she works, there are many patients, who are not her regular patients, who are also taking narcotic analgesia. She says that she feels pressured to re-prescribe that analgesia.

What are the issues here?

There are four issues:

1. The patient's condescending manner towards Dr Yasmina is unacceptable and needs to be addressed.
2. The patient is, more than likely, drug dependent and is blocking Dr Yasmina's attempt to address that problem.
3. Dr Yasmina lacks confidence or is not assertive enough to manage the patient's behaviour.
4. Whether Dr Yasmina is supported by the practice and its policies with respect to managing such patients.

How can you assist Dr Yasmina?

Dr Yasmina needs to be more assertive with the patient; however, she needs someone to teach her how to do this appropriately (what to say and how to say it). Role-playing would be very helpful to practise assertiveness. Once she gains this confidence, she will be better able to manage the patient's behaviour. She should be encouraged to have a discussion with the practice manager and principals about the difficulties she is having in managing demanding and abusive patients. The practice may need to consider an alert system or perhaps exclusion of certain patients from the clinic.

Dr Yasmina says that she has managed to convince some patients to reduce their narcotic dose or to prescribe what she believes is more appropriate. In such situations her colleagues have told her that she has no right to interfere with their treatment.

What can Dr Yasmina do?

Dr Yasmina has the right not to prescribe narcotics if she doesn't feel comfortable about it. She can certainly advise patients about what she believes is more appropriate, but she should not be interfering with her colleagues' management. She should refer the patients to their usual treating GP. She should also speak to her colleagues and tell them that she is not comfortable re-prescribing narcotics for their patients.

How can you assist her?

Once again, Dr Yasmina can be empowered to be more confident in stating her position.

This is also a matter that could be raised at the next clinical meeting.

Medico-legal issues – Documentation

Case 12 – Dr Ali

Dr Ali is a colleague of yours working in the same clinic. It has come to your attention that Dr Ali's note-keeping is very poor. Even when his notes are a little more substantial, his expression is often clumsy. You find this frustrating because it is difficult to know what has occurred in the consultation and what Dr Ali's intentions were. You consequently have to resort to taking a history all over again, which the patients find annoying. While Dr Ali's oral expression is sometimes 'awkward', you have not had any difficulties understanding him.

What are the issues here?

There are three possible issues:

1. Poor note-taking. Dr Ali may believe that it is not necessary to document much or he may not know what precisely should be documented.
2. Language difficulties. Dr Ali's poor note-taking may reflect his English language skills. Difficulties with verbal communication (such as vocabulary and syntax) are often excused by the listener, especially when the speaker is able to convey their meaning. With the written word, the same difficulties cannot be compensated for as easily.
3. IT issues (eg poor computer skills, unfamiliarity with medical software, poor typing skills).

How to address the matter with Dr Ali

Good note-taking facilitates patient care. From reading the progress notes, it should be possible to know what transpired in the consultation and also the doctor's reasoning (what the doctor did and why they did it) (refer to item 8.4 'Medical records', in *Good medical practice: A code of conduct for doctors in Australia*).

Should you speak to Dr Ali about your concerns?

Most certainly. There is often reluctance to voice concerns, but if nothing is said, the situation will remain the same. You will continue to be frustrated by Dr Ali's notes; Dr Ali will remain unaware that his notes are inadequate; and should a time come when Dr Ali might have to defend certain actions or decisions, his notes will not be supportive. Good notes are a doctor's defence and the axiom to work by is: if it isn't written down then it didn't happen.

Why might some people not speak up?

There are several reasons:

- reluctance (eg it's not my problem; they won't listen; they won't change)
- minimising the problem (eg we are all busy; it's hard to keep good notes; he is not the only one who writes poor notes)
- fear of hurting the other person's feelings
- fear of getting a negative response (eg anger or 'the working relationship will suffer').

You decide that you will speak to him. At the same time you are concerned that you might offend him.

What would be your approach and what would you say to Dr Ali?

Such conversations can be difficult because some people do not respond well to feedback. An honest, direct approach, done sensitively, is preferable. It is important to point out to Dr Ali that you are speaking to him because you are concerned for him and you don't want something untoward to happen. You tell him that poor note-taking is a liability and you explain why it is important to have good progress notes. You also take the opportunity to tell him that his referral letters are scant on information; a specialist will read the letter, and it won't reflect well on Dr Ali as a professional. You say to Dr Ali that you would like to assist him.

How can you help Dr Ali?

Educate him about why good note-taking is important and what constitutes good note-taking. Provide examples of good note-taking. Review his notes periodically and provide him with feedback. Create a template that will make it easier for him to write referral letters. Recommend that he use the spelling tool to correct errors.

If language is part of the problem, make specific recommendations. For example:

- language classes
- English-speaking practice
  - if there are children at home, converse with them in English (children pick up language, including its nuances, very quickly; they are also very quick to correct mistakes)
  - speak in front of the mirror while listening to how words are pronounced and watching the movements of the mouth and how words are enunciated
  - record speech (providing information or explanations) and then critically listen to it or have someone else critique it
- making more use of various opportunities to listen to spoken English to learn pronunciation and diction: the news on radio or TV, Australian TV series like *Home and away* or medical programs, audiobooks
- practising reading English to learn vocabulary and language structure: newspapers, simple story books
- reading aloud, pronouncing the words fully and clearly
- training in computer skills and use of clinical software
- writing practice: keyboard skills but also to practise syntax and phrasing.

Medico-legal issues – Boundaries

Case 13 – Dr Omar

Dr Omar is a young doctor who goes out of his way to assist his fellow countrymen, many of whom are refugees and do not speak English very well. Not uncommonly, he gives his mobile number to his patients so that they can contact him 'in an emergency'. A friend of Dr Omar's, who is also a GP, has told him that he should not give his mobile number to his patients because they will pester him. Dr Omar responds that while he has had some nuisance calls, his patients have generally contacted him only when there has been genuine need. Furthermore, he says that he knows of many specialists who give their mobile number to patients, for emergency contact, so he doesn't see that there is an issue.

Is it appropriate for Dr Omar to have given his mobile number to his patients?

The answer is not a simple yes or no. It is important to look at the context. In some circumstances it may be entirely appropriate, especially when access to healthcare, and particularly emergency care, is limited. Doctors also have a right to privacy and need time out for themselves and their family. Moreover, it can become burdensome for the doctor when patients call frequently about trivial matters. The other consideration is that of boundaries and with certain patients it may not be wise for the doctor to give them their private number.

Maryam is approximately the same age as Dr Omar. She has seen him infrequently in the past for minor presentations. She attends today for a tetanus injection, having been scratched by her cat the day before. At the end of the consultation, Maryam asks Dr Omar out for coffee. He accepts. They meet and chat about different things. The next night they meet for drinks after work and the week after that they have dinner together. Dr Omar finds himself drawn towards Maryam. She is very attractive and he enjoys her company.

He is not sure whether he is doing the right thing because he has heard that doctors in Australia are not permitted to enter into a relationship with a patient. He asks his friend for advice. His friend tells him that there isn't a problem because Maryam has been consulting him for relatively minor problems only and that all he has to do is stop seeing her as a patient.

Dr Omar thinks about what his friend has said and decides that he is right.

Is the advice that Dr Omar has been given correct?
Has Dr Omar made the right decision?

No, his friend has not given him the correct advice. From the Medical Board's perspective, it is inappropriate for a doctor to enter into a relationship with a patient, even a former patient.

Dr Omar informs Maryam that if they are to keep seeing each other, he cannot see her as a patient any longer. Maryam understands completely and says that, from now on, she will consult a GP at a different clinic. Even though Maryam does this, she continues to ask Dr Omar for his medical opinion about her medical complaints whenever they meet.

Is it appropriate for Maryam to continue asking Dr Omar for his medical opinion?

No. By doing this, the doctor–patient relationship continues to be maintained.

Six months later, Dr Omar makes an appointment with his solicitor. He is very distressed about a letter he has received from Maryam and mortified about what has transpired. In the letter, Maryam states that she is pregnant, that the child is his and that he must marry her otherwise it will bring shame to her and her family and Dr Omar's name in the community will be blackened. Dr Omar says that he is compelled to do the honourable thing and marry Maryam, even though he knows that the baby is not his because they never had sex.

Is marriage and the paternity issue Dr Omar's only problem? Should Dr Omar report himself to the Medical Board?

Dr Omar should not be hasty in making any decisions regarding marriage because he may well regret it later. He should consult his medical defence organisation on the matter. They may advise him to report himself to the Medical Board rather than wait and see whether Maryam makes a complaint.

Medico-legal issues – Consent and confidentiality

Case 14 – Dr Priyanthi

Mrs Swaminathan confides in Dr Priyanthi, who is also a family friend, that she is worried about her 16-year-old daughter, Usha. She says they are constantly arguing because Usha seems to have lost interest in her studies and wants to go out with her friends all the time. She is also worried that Usha might have a boyfriend and is having sex. She and her husband are beside themselves because their daughter's behaviour is totally at odds with their family values. She fears what her husband might do if their daughter were to become pregnant. Mrs Swaminathan tells Dr Priyanthi that her fears are not totally unfounded because she found a pregnancy test kit in the rubbish bin last week.

Dr Priyanthi commiserates with Mrs Swaminathan, saying to her that, as a mother, she fully understands her concerns and her fear that there may be dire consequences. She also informs Mrs Swaminathan that Usha attended the clinic last week and that she will look at Usha's file right now to find out what transpired.

Has Dr Priyanthi acted appropriately?

No. Dr Priyanthi doesn't have Usha's consent to tell her mother that she attended the clinic, let alone to look into her file. By divulging information in Usha's file to Mrs Swaminathan, she will also be breaching Usha's confidentiality.

How should Dr Priyanthi have acted?

Dr Priyanthi may certainly commiserate with Mrs Swaminathan but looking into Usha's file doesn't solve the problem. If anything, it would inflame the situation if Usha were to find out. Dr Priyanthi can certainly say this to Mrs Swaminathan, but more importantly she should also tell her that she cannot look into Usha's file without consent and that she is bound by strict rules of confidentiality and privacy. Mrs Swaminathan and Usha need to talk and Dr Priyanthi's role could be to bring the two of them together and facilitate that dialogue.

Dr Priyanthi needs to be constantly aware of her dual role as friend and doctor. Interactions of a clinical nature with Mrs Swaminathan should be conducted entirely professionally (with clinical notes) and with continued vigilance as regards impartiality.

Resources

Medical Board of Australia. Good medical practice: A code of conduct for doctors in Australia

RACGP

- Curriculum for Australian General Practice 2016
- Competency profile of the Australian general practitioner at the point of Fellowship
- Practice Experience Program resources
- *RACGP Education: Examinations guide*
- *RACGP Education: Fellowship exams candidate handbook*

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