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International medical graduates and general practice training: How do educational leaders facilitate the transition from new migrant to local family doctor?

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ABSTRACT

Objectives: To document medical educators’ experience and initiatives in training international medical graduates (IMGs) to become general practitioners (GP).
Design: Qualitative social-constructivist emergent design with descriptive and interpretive analyses.
Setting: GP vocational training in Australia, Canada, Ireland, New Zealand, the Netherlands, and UK.
Participants: Twenty-eight leaders of GP training.
Intervention: Data collected from public documents, published literature and 27 semi-structured interviews.
Main outcome measures: Tensions in training and innovations in response to these tensions.
Results: Medical educators identified tension in teaching IMGs as it could be different to teaching domestic graduates in any or all aspects of a training program. They felt an ethical responsibility to support IMGs to provide quality health care in their adopted country but faced multiple challenges to achieve this. They described initiatives to address these throughout GP training.
Conclusions: IMG’s differing educational needs will benefit from flexible individualized adaptation of training programs.

Introduction

Many high-income countries rely on international medical graduates (IMGs) for their health workforce (Aluttis et al. 2014). However, the symbiosis of a health care need, and IMGs’ willingness to migrate does not necessarily lead to an easy transition (Durey, Hill et al. 2008; Chen et al. 2011; Terry et al. 2014). There are tensions and challenges for doctors, their colleagues and patients (Woods et al. 2006; Triscott et al. 2016; Skjeggestad et al. 2017; Davda et al. 2018; Najeeb et al. 2018) especially when IMGs fill vacancies in under-served areas where patients often have higher clinical needs and fewer personal resources [Australian Institute of Health and Welfare (AIHW) 2017].

IMGs are known to have lower pass rates in postgraduate examinations than doctors who complete medical and specialist qualifications in the same country (Andrew 2010; Esmail and Roberts 2013). (Falcone and Middleton 2013; O’Neill et al. 2016) and, those from some countries, are at higher risk of malpractice claims (Dyer 2009; Elkin et al. 2012; Jeyalingam et al. 2018). In Australia, IMGs studying outside the training program have lower exam pass rates than IMGs on the Australian General Practice Training Program (Hoffman 2015).

Educators now recognize the stress and challenge of transitions from student to junior doctor to consultant (Teunissen and Westerman 2011) and are researching how to facilitate these changes (Schumacher et al. 2012). In terms of transitions, IMGs often experience a series of obstacles in a labyrinth to independent practice (House of Representatives Standing Committee on Health and Aging 2012) and arguably could face bigger transitions when moving from one country to another (Harris and Delany 2013).

Doctors who want to become general practitioners (GP trainees) learn by working in general practice under the supervision of experienced GPs (GP supervisors) who are accredited for teaching (Wearne et al. 2012). GP trainees also require experience of GP relevant hospital specialties.
and must pass qualifying examinations. GP training programs oversee GP trainees’ clinical placements and provide an educational program of workshops and learning resources (Michels et al. 2018). Being part of a program is compulsory in some countries whereas in others GP trainees can complete the training requirements independently. IMGs compete with domestic graduates to enter formal training programs. In Australia and Canada, training is offered in exchange for doctors working in under-served, usually rural areas.

When IMGs undertake GP training, they join systems and programs designed for that country’s domestic graduates. IMGs may encounter a range of challenges to successfully engage with these systems and programs. In order to support IMGs undertaking GP training, GP supervisors and training organizations need to understand and create ways to address them. This research explores these challenges of supporting IMG GP trainees. We set out to identify the tensions faced in IMG training and how leaders of GP education innovate to facilitate IMGs’ transition to qualification for independent general practice.

Methods

Overview

This research was part of a larger project examining the current tensions and innovations in GP vocational training in Australia informed by international experience. The research was conducted from the constructivist position that “the reality we perceive is constructed by our social, historical and individual contexts” (Kuper et al. 2008). This study is based on qualitative interview data. We reviewed the Australian and international literature and publicly available documents regarding GP vocational training. This review informed our direction of enquiry, our choice of international countries and interview guides. We chose five countries to expand on our Australian data. Canada, Ireland, the Netherlands, New Zealand, and UK were selected for their similarity to the Australian approach to GP training and for their innovation.

Sampling

Sixteen expert informants from 14 Australian GP training stakeholder organizations were recruited by purposeful sampling to achieve broad representation. Following consultation with the reference group, we approached the leaders and leading medical educators of the nine Australian regional training organizations (RTOs), the two GP colleges (Australian College of Rural and Remote Medicine (ACRRM) and the Royal Australian College of General Practitioners (RACGP), General Practice Supervisors Australia, General Practice Registrars Australia, and Leaders in Indigenous Medical Education.

From each of the five selected other countries, we recruited one national leader of GP training and at least one regional leader of GP training either by direct contact to the national organization or via personal contacts of the researchers or reference group. The total of 12 international interviewees came from 10 international organizations. Two international interviewees chose to be interviewed together making a total of 27 interviews.

Recruitment

Potential participants were emailed information about the project and invited to nominate times for telephone, videoconference or face-to-face interviews which would be recorded. Interviews were conducted between September 2017 to February 2018, lasted up to 60 min, were recorded and transcribed verbatim. Two experienced qualitative researchers conducted the interviews and anonymous verbatim interview transcripts formed the data set.

Reference group

We established a reference group to guide this research and facilitated six workshops with GP supervisors and medical educators. The reference group included: representatives from two of the Australian RTOs, ACRRM, the RACGP, and the Australian Department of Health. These groups helped direct our approach and gave feedback on our analytic direction and interpretations.

Interview guide

The interview guide was derived from topics identified from the literature review, workshops, and from the reference group. The guide was piloted by the interviewers and refined by them as the interviews progressed. We asked open ended questions with a focus on tensions and innovations in training.

Analysis

The research team iteratively analyzed concurrently with data collection (Charmaz 2014). We used an interpretive lens, drawing on the expertise of the research team (Cresswell 2013) (see Box 1), to identify tensions and areas of effective practice. Interviews were shared between authors and analyzed separately to develop a coding framework and to enhance rigor. Coding was managed with NVivo software (QSR International, Doncaster, Victoria, Australia). Themes were derived from the coding framework following frequent reading of the data and team discussion. Findings and interpretations were discussed with the reference group and meetings of medical educators and GP supervisors to ensure authenticity. The interviews were numbered and labeled A (Australian) or C (Canadian), I (Ireland), N (Netherlands), NZ (New Zealand), and UK (United Kingdom).

Box 1.

SW: GP in Canberra and Alice Springs, academic at Australian National University, working in health policy.

JB: GP supervisor and senior medical educator in rural Victoria.

DS: Professor of Family Practice and Rural Doctors’ UBC Chair in Rural Health, University of British Columbia.

CK: Senior general practice education researcher with postgraduate training in psychology.
**Ethics**

Ethics approval was gained from the Monash University Human Research Ethics Committee project 10033.

**Results**

Participants identified that teaching IMGs was challenging because of the IMGs’ diverse backgrounds and clinical experience. As educators, they felt an ethical obligation to facilitate IMGs transition to providing quality general practice. This required program flexibility to tailor support and education to meet individual IMGs needs.

**Tensions: recognizing difference not deficits**

Participants’ experience was that IMGs brought a wide range of skills across all aspects of the GP training. “Their drivers are different; their issues are different. You know, communication, understanding systems, the nuances of relationships with patients” [A06].

Participants felt strongly that the focus should be on difference not deficit. Labeling IMGs as having learning needs was unfair without also acknowledging their strengths, and the fact that many IMGs brought expertise that local graduates did not have. “Some of our international medical graduates who have come from countries where they were extremely poor, they’ve seen extreme poverty … you know, some of our doctors that come from Pakistan, Afghanistan, Iraq. You know, all of those kind of countries. Particularly, they get this … they get health equity, they get deprivation, poverty, and being a doctor in those environments” [NZ1]. Differences were noted individually and at a system level.

**Individual differences**

Participants first mentioned language, communication, and cultural safety as key fundamentals that they had expected would need focus. Also strongly expressed was the topic of “professionalism”. This umbrella term was used to describe a vital part of practice, but which was itself difficult to define “the things like professionalism, for whatever that means and empathy and those kind of things” [A06]. These were soft skills that were key to effective clinical practice, but hard to teach. There was uncertainty whether a uniform approach was even desirable. “Those areas that are really challenging and we have a large registrar group that come from diverse backgrounds with different ideas. They obviously have different backgrounds and different levels of understanding and what those things mean to them and so it’s a really challenging area. I don’t know whether I want everybody coming out being exactly the same because I think people should be allowed to have their individuality but an understanding of what those things mean within a community” [A09].

**System differences**

System and cultural differences were apparent not just in gender and societal roles, but in how power is used in clinical consultations. “Our American doctors, they struggle… They’re not passing our clinical and written… I think our way we practice General Practice here is much more community. Thiers is much more hierarchical” [NZ1]. The system differences meant that IMGs had different expectations of their role, which in turn created more work for educators as they helped them adjust to a new context.

“I think there are different approaches and I’m trying to think of how to generalize of course but I think if you come from a different health system and if you’ve done your undergraduate training in a different health system, if it differs significantly then or if you’ve just been raised as a person in a different system you have different expectations. So yes, I think there is more work to be done with people from different health systems than from our own” [I2].

**Educational differences**

There were further differences in what and how IMGs had learned during their earlier training “we find that the quality of their training varies a great deal from probably better than ours to really worse” [C1]. Clinical reasoning was a particular issue “Clinical reasoning in general practice is different to other specialties and it’s really getting the IMGs in particular, getting their head around the fact that general practice isn’t easy, it’s really challenging and so you’ve really got to think like a GP” [A16].

**Motivations and rewards in assisting IMGs**

Participants found teaching IMGs different to teaching domestically trained doctors. They puzzled over how best to support IMGs and while they were aware that this was a shared international challenge, with much to learn from each other, this has not yet happened: “many countries are grappling with this and we’re doing as much as we can to try and help them, but I think it would be fair to say that we are aware that it is harder for them to get to the same point at New Zealand trained doctors” [NZ2]. Participants aimed to train high quality GPs to serve the community, who were “…fit for purpose doctors in terms of having the attitudes, the behaviors and the skills to meet the needs of their communities” [A19].

This aim was in tension with regulations in New Zealand and Australia which enable IMGs without formal GP qualifications to work as GPs. “I don’t know of many profession in the world … that you can call yourself a professional, without having achieved an appropriate qualification. Why can you call yourself a general practitioner when you have not achieved the fellowship standards of either College?” [A10]. Educators felt obliged to address this inequity by giving IMGs more support especially as IMGs often worked in isolated rural and remote areas, with limited peer support. “The general public has a right and needs to know that they are receiving safe, quality care from the doctor who is there working as their GP” [A15]. This ethical obligation to train brought intrinsic rewards when IMGs passed their GP exams “a lot of them have come as you know from a system that is so different and then they’re put in relatively isolated areas, the odds are pretty much stacked against them so being able to support them and get them through I think is very satisfying” [A19].
Solutions

Just as IMGs needed specific knowledge, skills, and attitudes to practice effectively in their new country, so educators of IMGs expressed the importance of appropriate knowledge, skills, and attitudes to teach them. Despite the traditional order that attitude comes last on the list, getting this right was first priority.

Battling prejudice

Participants were careful to counter prejudice or racism expressed towards IMGs, arguing that stereotypes of them as unskilled, expressed in reluctance of GP supervisors to work with them, was unjustified. “We’re very aware of trying not to have preconceived ideas about anybody. We battle that. You know, people say, ‘I don’t want an IMG’… what do you mean you don’t want? You know, what are you saying? Cos many are great”[Can 1]. “There are differences in training international medical graduates but one mustn’t be prejudiced in it at all because many of them are absolutely exceptionally good”[11].

Selection and admissions

Participants considered it important to select the right people for training. In Canada and Australia, the aim of offering IMGs’ training in exchange for working in rural areas, is that they will stay in that area once qualified. But the competition for training risks IMGs saying they are keen to work long term in rural, when in fact they are better suited to and more keen on urban practice. “I think the most important thing is just the screening and the admissions process—that they have the right fit for the program that they want to go to. It’s very competitive, and they’ll kind of say yes to anything. But in fact, it’s not true. Some are really well suited for rural practice, and some are not. And right now, they’re made to go, and they leave the minute they can leave, and it really doesn’t help the communities all that much”[C1].

Orientation

The first knowledge to pass on to IMGs was clarity about the health system and the role of general practitioners, which might differ from their previous experience “a lot of them have come as you know from a system that is so different”[A19]. Even those who had previously worked as GPs in their home country might need to make significant changes to their practice and unlearn previous habits and norms. “People also come from backgrounds where they already have a professional identity and how that fits what (GP training organization) sees as what you should look like as a GP”[A09]. They needed a clear target that GP training was not just about learning factual information either online or via books, but was about developing the skills to help people. “If you do these series of online modules… what you end up with is doctors that know stuff, but they don’t know how to do it…”The competent doctor not just knows, but actually knows how to work with people to effectively help them with dealing with their health problems”[A07].

Information was also valuable about the different educational approaches to be used. Doctors who had been taught didactically via lectures needed guidance in how to learn through reflecting on practice “there’s some intercultural differences in this so we as Western people are… we really believe in reflecting on our own experiences and sharing them and there’s sometimes some problems with people with other backgrounds—non-Western backgrounds—that they work from like a ‘we’ society and they’re not so keen on reflecting on their own experience, they don’t find those so important; so there’s some mismatch between our… perspectives on this”[N1].

Assessment at entry to training

Assessment of doctors was advocated to enable training to build on current strengths and identify gaps and areas that needed extra input. One Australian program established an intensive assessment at the start of training using multiple choice questions, written exams, and plans to introduce a clinical exam. The results are provided to GP supervisors who can then target training appropriately. “Multiple choice, we as educators, about 15 of us, we sit there and we mark their written, and then as they pop out of the multiple choice, one by one, we grab them and we give them feedback right there and then on what they’ve done. And then we collate that and we put it on a database and so that information there, strengths and weaknesses summary really, is given to the supervisor before they enter practice, and a consultation skills assessment so it takes a day and a half”[A11].

Direct observation

Following an initial assessment, participants advocated for direct observation of IMGs in practice. In Canada, this is encouraged for all doctors new to general practice as part of the competency-based education program. Again, this style of education required explanation and reassurance that it was being done to highlight how best to help doctors learn, rather than to remove them from the program. “Well we encourage all the preceptors to observe all of them very closely at the beginning. We try not to target IMG’s, because that would be kind of unfair. But we like to know early when there’s gaps. And there’s a tendency for many of them to try and hide these gaps, out of fear of shame or getting kicked out. We have no intention of kicking them out, but we … we can send them to a newborn nursery and get them doing physical exams and after 20 or 30, they’re pretty good … it’s better than a disaster where something important is missed and they’re kind of pretending they know. Some of them are not watched on those sorts of exams”[C1].

Observation in practice was supplemented with observation of learners during workshops and other educational events.

Monitoring and early intervention

Program directors realized the benefit of monitoring IMGs’ progress through their training. In the Netherlands, there were monthly meetings to discuss information from multiple sources. “Every month we discuss the residents who are having problems … for exams, for assessments, evaluations and there’s many people from other cultural backgrounds that are discussed far more than the percent Dutch that we
have" [N1]. The same process is used in some Australian training organizations, in Canada, and in England with the aim of preventing the situation of IMGs repeatedly failing the exam. Identifying doctors who are struggling by exam failure, seemed too late. “You intervene at a more appropriate stage, try and support them to overcome those deficits, hopefully they’ll come back into the program and flourish and move through. If you are leaving it very late in a process and not identifying it early enough, then that becomes a problem and hence that is why we’ve got to start to look at those sort of benchmarks along the way” [A09].

Flexible training
GP trainees in Australia, New Zealand, UK, and Ireland are required to work for set blocks of time in general practice and relevant hospital specialties. This approach presumes that all trainees require equal time to achieve the same educational objectives but was thought to create inefficiencies. “Why are we having to spend more resources on them… and not being able to accelerate people through the processes… [we need to] translate some of those resources to those that are in greater need” [A06]. In contrast, Canada’s competency-based approach aims to match educational input to specific needs and avoid unnecessary repetition if competency has already been reached. “So, we get IMG’s who’ve been obstetricians for 20 years in Egypt. We would adjust their program once we assess their competence, so they would spend relatively little time in obstetrics—just enough to maintain their skills and focus on the paed’s that they may have never done” [C1].

Language skills and communication skills
Excellent language and communications skills were viewed as essential, and some respondents felt the current standards set by regulators were too low for effective medical practice. One organization was working with a language expert. “We’ve brought in an English as Second Language teacher, and she’s just developing exactly what she can do… many of them aren’t skilled at doing clinical language. They’re good at language, but in the context of a consultation… Well I don’t know how they quite get into the system in Australia or even into our programs sometimes, but people who genuinely have significant deficits in the area of culture, language, understanding, expression that are major barriers to good practice no matter how good your knowledge is. And so we’re working at that; we put a lot of effort into the people who fail the exams” [A16].

Modular learning
GP trainees attendance at educational events and personal study provided an opportunity for tailoring education to learner’s needs, but that flexibility could come at increased cost compared to running a standardized program. “With organizations like xx and yy, we don’t want to buy the whole pack. We just want to be able to access, on an individual identified learner’s needs, a module” [A06].

Developing a new professional identity
Helping IMGs develop identities as GPs in their adopted country was arguably the biggest challenge for educators. They relied on setting up situations in which IMGs could learn by observation and discussion with peers and educators in person, rather than didactic sessions. “I think that the face-to-face stuff is important for lots of reasons. I think that as human beings we like that contact so I think it’s really important that that’s there and that collegiability and that discussion amongst the trainees themselves. They see how other people behave or not just within the group, certainly within the group but also outside of the group how they behave or their understanding of what they should or shouldn’t be doing within practices and then the medical education team” [A09]. This close interpersonal interaction with feedback was seen as the best way of helping doctors learn professionalism.

Supporting supervisors
Most GP trainees time and learning occurs while working in supervised practice. This creates a vital role for GP supervisors and educators considered supporting them to perform this role was similarly important.

Providing educational support across the whole curriculum was a significant challenge, exacerbated by IMGs recruited to work in isolated areas with limited numbers of GP supervisors. “There is a massive group out there that have even greater needs and less fundamental skills or abilities—and that’s not necessarily their individual fault, it’s a collective issue—who are being put into general practice environments in all geographic circumstances, and not supported or trained to do so.” [A06].

Extra time
Another key finding was that educators considered many IMGs needed longer in GP training. “I’d say 30 percent of our IMGs require two-and-a-half to three years of the same content.” [C1]. Similarly in UK, once IMGs were orientated to the country they then progressed and gained the necessary skills. “My premise is that some of those people were on a trajectory, it was just too low a trajectory… I’ll slightly stereotype. Some join and they’re doing okay. They’re gaining knowledge throughout the three years but the trajectory is just a little bit too slow and we hope that the extra extensions will enable them to pass. Some, they join but they’ve actually never worked in the NHS or in the UK and in effect at least a year is a sort of cultural induction in the UK and the NHS. And then, so they go along flat lining for a year and then they have a trajectory that is the same trajectory as others had from ST1 however it’s too late for them to cross the line within the three years” [E2]. Expecting IMGs to complete in the same time frame as domestic graduates seems unrealistic.

Targeted training program
The UK is planning a targeted training program for those who had been removed from the training program. Doctors will be invited to apply if they have “passed the workplace based assessment and one of the two exam parts. The reason being that all our feedback is that people that fail all three parts, or even two of the three, there’s no hope” [E2]. This initiative recognizes that additional training and time may assist some who were unable to complete within
the standard time-frame and program, to gain GP qualifications.

**Clearer exit points**

Educators were reluctant to remove doctors from training programs, preferring to offer remediation and hope for improvement over time. There was a realization that this approach was done to be fair to IMGs. However, some had begun to take a different approach to fairness in establishing clearer exit points. “We’re not good enough yet at removing people, early enough for the sake of themselves, their practices and their patients but we’re definitely getting better at it” [A17].

**Discussion**

Our research has documented the experience of leaders in GP training in teaching IMGs, in Australia and five comparable countries. Educators have a clear purpose to train high quality GPs. They are aware that IMGs’ pre-training experiences can include differences in language, undergraduate training, hospital practice, and how their country of training defined professionalism and expected general practitioners to work. These differences resulted in learning needs that educators could find hard to define. Few of these issues were explicitly discussed with IMGs who may need educational input across the breadth and depth of the GP curriculum. The Canadian competency-based approach enables educators to modify some aspects of the program to IMGs’ needs, but in other countries IMGs are expected to train to become GPs in the same way and in the same time as domestic graduates.

Educators try to build on IMGs strengths and to help them learn, while at the same time trying to avoid singling out IMGs for fear this is viewed as racism. Educators described initiatives to help IMGs but mostly these occur discretely rather than as a comprehensive package for IMGs across the whole training program. The overarching need was for educators to have authority to adapt training programs to individual’s needs and to allow IMGs more training time. The initial part of training is often an orientation to a country, its health system, medical culture and the role of general practitioners. An orientation phase is likely to be most effective in supportive practices with experienced, well-resourced and funded supervisors, rather than in under-resourced areas as currently occurs in some countries. Investing in an extra orientation year might reduce the number of doctors who fail exams before the end of their allotted training time, and who feel so overwhelmed that they leave under-served areas as soon as they can.

Teaching professionalism is challenging; medical practice is culturally bound and ethical practice is often determined by different contexts. Educators advocated for opportunities for role modeling, direct observation and workshops as necessary for interpersonal learning. Expecting IMGs to learn professionalism via books or online was considered unrealistic.

**Comparison with published literature**

The need for extra training time is supported by the literature. The American Board of Family Medicine compared the pass rates in their exam of Canadian and US graduates training in Canada and USA, and IMGs training in Canada and USA. IMGs who trained as GPs in Canada, usually 2 years training, performed less well in the American exam than USA or Canadian graduates (Falcone and Middleton 2013). IMGs trained as GPs in the US, performed as well as American trained graduates after 3 years training (O’Neill et al. 2016). Participants rated an alternative option, of clinical attachments in general practice prior to training, as valuable in understanding the health system and the role of GPs (Horman and Wright 2012; Warwick 2014).

Our finding that educators should have flexibility in how they train and support IMGs, was also the conclusion from studies conducted to assess the differential attainment of IMGs in UK general practice exams (Esmail and Roberts 2013). One study articulated that “Doctors who are not equivalent at entry to GP specialty training are likely to struggle with the MRCGP unless they receive training that addresses their specific needs” (Rendel et al. 2015).

Several authors concur with the view that IMGs benefit from language skills beyond the minimum requirements, especially as English language proficiency correlates with exam success (Grierson et al. 2017; Davda et al. 2018; Patterson et al. 2018). The need to teach culturally appropriate, interpersonal competence was considered vital rather than focusing on increased clinical knowledge (Patterson et al. 2018). This ties in with reports that IMGs who were successful in their exams at the first attempts took proactive approaches, refined consultation skills, learnt with UK graduates, valued feedback and supportive relationships (Ragg et al. 2015).

**Strengths and weaknesses of the study**

A strength of this article is that we consulted with highly experienced educators and merged the perspectives of those across Australia with those from comparable international countries. We have opened the discussion to share expertise in an area that creates tension but can be avoided for fear of appearing prejudiced. A limitation is that our perspective is from educators on formal training programs. Different views about the tensions and solutions may have been expressed by IMGs, patients, practitioners, or independent educators or organizations.

**Implications**

Training systems that assume all learners need the same input creates inefficiencies. Instead our participants argue that different inputs are needed to reach the same output. The benefit of more flexible training could create a more efficient system whereby those who learn quickly can progress quickly and others can take more time. Indeed, this is our impression of the benefits of the competency-based approach to training used in Canada. This change could benefit domestic graduates as well as IMGs.

A shift in thinking and practice is needed from notion of equity and fairness meaning a standard training
program. Instead equity could focus on educational need and educational outcomes. This is an argument for learner-orientated training. Rather than presuming all trainees are the same, educators need to judge how best to help individual doctors to become GPs. While countries rely on IMGs to work in difficult areas to staff, it is appropriate to support and train them. If adopted, this approach will need careful evaluation.

Conclusions

IMGs bring different skills and may need longer and more flexible training. Standardized programs are unlikely to be successful and individual approaches are needed, particularly at the beginning of training, to prevent unnecessary repetition or educational gaps.

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S.W. asserts that the views expressed here are her own and not necessarily those of her employer the Commonwealth Department of Health.

Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

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