Overseas-trained doctors’ evaluation of a New Zealand course in professional development

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Abstract

Aims To find out how overseas-trained doctors (OTDs) rated the usefulness of the Professional Development component of the Overseas Doctors Training Programme in preparing them to work in the New Zealand health context.

Methods An anonymous postal questionnaire was sent to all 89 doctors that passed the first three intakes of the Overseas Doctors Training Programme in Auckland.

Results OTDs reported a significant increase in the level of comfort in communicating with patients once they were in a clinical setting (p<0.001), and with communicating effectively and safely with Maori (p<0.001). OTDs also reported that the ethical, legal, and reflective practice sessions prepared them adequately to work in New Zealand. There was a low response rate (30%).

Conclusions Responding OTDs said the Professional Development component was valuable and effective with respect to improving communication skills and patient-centred consultations.

Since the introduction in 1991 of the General Skills Category of Residency Policy, New Zealand has received a large number of highly skilled immigrants, including doctors. By 1996, more than 900 overseas-trained doctors (OTDs) had qualified for permanent residence but were not registered to practice medicine in New Zealand.1

Many of these OTDs experienced frustration and hardship in trying to meet statutory registration.1–3 To assist them, the Ministry of Health and the Clinical Training Agency commissioned a bridging programme called the Overseas Doctors Training Programme, which commenced in March 2001 in Auckland and Wellington.

Eligibility requirements included having been granted permanent residency in New Zealand between 18 November 1991 and 29 October 1995, and having passed an English language test approved by the Medical Council of New Zealand.

More than 1,200 doctors applied for the programme; 100 failed to meet the criteria and approximately 600 did not complete their applications by the due date.4 Funding was provided for 340 doctors to participate in the programme over a 5-year period.4

The Medical Council of New Zealand requires all OTDs to make themselves familiar with New Zealand’s legal, regulatory, and professional ethical conduct requirements.5–(p3) Since most OTDs have been educated in healthcare cultures highly dissimilar to New Zealand’s, there are numerous challenges facing them. Furthermore, there are also significant communication needs as OTDs commonly speak English as a second language.

The re-training programme involved two parts. Part A was an 18-week update in medical knowledge and professional development. Part B was a 6-month supervised
attachment in a public hospital. When both parts had been completed, the doctor could sit the New Zealand Registration Examinations (NZREX).

The aim of the programme was to focus on the most important knowledge and skills needed for a doctor to practice safely and competently in New Zealand. All the main clinical specialties were covered in Part A. In addition, there was a professional development component covering communication skills, ethics, medicolegal obligations, and Maori and Pacific issues.

Teaching methods included didactic teaching, interactive demonstrations, and small-group teaching. The main focus was on the development of consultation skills. This was undertaken in small groups facilitated by a general practitioner and involved the OTD undertaking simulated consultations with actors. Self-reflection was encouraged and the facilitator, actor, and peers offered feedback.

Successful completion of Part A involved passing the clinical knowledge examinations as well as the professional development component, in which assessment procedures included consultation examinations conducted with actors, an ethics essay, and a peer-group assessment.

Although there was helpful information from earlier evaluations, we wanted to know what OTDs thought of the course once they were observing (Part B) or working in the clinical context. In hindsight, how well did they think the professional development component had prepared them for working in New Zealand?

Methods

An anonymous postal questionnaire was sent to all 89 (of 96) doctors that passed the first three intakes of the Auckland-based programme. There were significantly more male (74) than female (22) doctors in these intakes. They came from diverse backgrounds and had a wide age-range. Countries of origin included Bangladesh, India, Sri Lanka, China, Egypt, Iraq, Iran, Singapore, Russia, Philippines, Serbia, Albania, and Croatia.

The questionnaire consisted of three sections:

- Section A dealt with preliminary data (e.g. the number of years the OTD was in clinical practice prior to coming to New Zealand). Gender and country of origin were not asked for in the interests of protecting anonymity.
- In Section B, Likert scales (a measure of the extent to which a person agrees or disagrees with the question) were used to measure the perceived usefulness of the course components as well as participants’ perceptions of their own level of skills.
- In Section C, open-ended questions were used to elicit some qualitative data. For example, participants were asked to describe a situation in which they had used the skills learnt on the course; and a situation in which they needed skills that the course had not covered. They were also invited to make suggestions for course improvements.

Results

Of the 84 questionnaires that were delivered, 25 were completed and returned, thus giving an overall response rate of 30%. The number of years in clinical practice prior to coming to New Zealand ranged from 1 to 20 years (mean 8.9 years; mode 15 years). Four respondents were still on Part B. Seven were looking for hospital work, four were working in a hospital, and ten reported other positions. Of these, seven were studying for NZREX. Twelve reported having passed NZREX.
**Communication skills**—Participants were asked to rate how they perceived the usefulness of the small-group teaching on communication skills at two different times: first, how they had perceived it while they were on the course; and secondly, how they perceived it now that they had been observing/working in the hospital setting. An increase in usefulness was indicated, but did not reach 95% significance (p=0.058).

Participants were also asked how comfortable they were in their ability to communicate effectively with New Zealand patients - before and after the course, and at the time of the study (see Figure 1). A Friedman’s two-way analysis of variance showed a significant increase in the level of comfort with their abilities both after the course, and again, once they were in the clinical setting (p<0.001).

**Figure 1. Comfort level in ability to communicate effectively with New Zealand patients (before the course, after the course, and at the time of the study)**

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**Maori cultural sessions**—Participants reported a significant increase in the level of comfort with their ability to communicate effectively and safely with Maori, both after the course and once they were in the clinical setting (p<0.001); see Figure 2.
Additional findings—A significant majority of participants said that the ethics and medicolegal components of the course had meant they felt well- or very well-prepared for working in New Zealand. A majority of the participants also felt the reflective practice/self-care sessions were of value.

Participants had mixed views on the value of the peer-group exercises, as well as on the prospects of their later joining a peer group. However 14 participants said they had joined a peer group, and three reported their intention to join one once in practice. Of those who favoured peer groups, five made positive comments about the experience e.g. ‘generally helpful with a good cooperation [sic]’ and ‘a useful way to exchange information’.

Responses to open-ended questions—The majority of participants reported that the most useful part of the course, now that they were in the clinical context, was the consultation/communication skills component. Particular themes were empathy, reflective listening, dealing with difficult situations, open questions, and rapport building.

One OTD, in response to the question about an interaction with a patient in which they had used some of the skills learnt on the course, wrote:

One day during the interview with the patient, I learnt that she was ‘brutally’ told by her doctor that the best option for her (based on her current condition) was to go to rest home ASAP. The patient was still in total disbelief. I knew that was the only viable option for her, yet I did not offer my opinion, just reflected on her feelings. At the end, the patient thanked me for being there for her and said she would consider the rest home option. I felt I just learnt something towards being a better doctor.
This description shows how the skill of reflective listening was being utilised in a clinical interaction. As the participant found, this experience had positive benefits for both the patient and the doctor.

Suggestions for course improvements were sought, as well as any further general comments. Participants offered a range of suggestions for improvement including: more time and practice, more role-plays with the actors, and more time in the peer group.

Another OTD wrote:

PD (professional development) has been the most essential component of the course. Medical knowledge can be easily learned/studied but to master communication skills, lots of practice and usage is needed for most of us. It's not only with patients but also among colleagues & friends. Understanding cultural differences and ethical views helps us to be more holistic.

And another reported:

I realised how good Professional Development was, only when I started Part B. Unfortunately many doctors working at hospital don't apply strategies we were taught on the course (↑ work load, I supposed) [sic]. I consider myself very lucky for getting the opportunity to attend [sic] Bridging Programme.

Discussion

Skill in communication is generally considered a core element of effective doctor-patient interaction. The fact that more than three-quarters of the respondents said that the teaching in communication skills was the most useful course component is in accordance with these views.

The trend towards OTDs gaining more recognition of the value of communication skills once they were in clinical practice, is also consistent with other studies. Whether this increased perceptiveness transfers into actual competence in practice, however, may be more related to motivation. It has been shown that even when knowledge changes it may not result in a more patient-centred style of consultation. It may also take time for new behaviours to be integrated.

OTDs reported they would have liked even more teaching on some specific aspects of communication (e.g. delivering bad news, suicidal/psychotic patients, problems of adolescence, husband abuse, demanding/uncooperative patients, patients that refuse to be interviewed, and establishing rapport with children). The majority of these topics involve emotional responses in both doctor and patient.

Although aspects of how to cope with (both patients’ and doctors’) emotions were frequently raised in small-group teaching, there may have been a lack of emphasis on how to deal with the doctor’s emotional responses. Of course, these skills are important in practice but even experienced clinicians find responding to the patient’s social and emotional problems difficult. Some doctors feel it will increase the patient’s distress, take up too much time and threaten their own emotional survival.

Even if doctors have the skills, they may not use them as they are worried that colleagues will not give sufficient practical and emotional support if needed. Doctors have been shown to be reluctant to discuss patients’ psychosocial problems because they feel that they should do something about the problem. It has also been noted that OTDs have difficulty offering emotional support for fear of violating
gender and/or cultural boundaries.\textsuperscript{16} Such skills may best be taught in the clinical context.

It was reassuring that OTDs found the sessions on ethics/medicolegal obligations helpful. New Zealand has a strong history of truth-telling, informed consent, and confidentiality, but these concepts can be dealt with quite differently in some other cultures. For example, telling the truth to the patient in some cultures is considered disrespectful and sometimes even thought to shorten the patient’s lifespan.\textsuperscript{17}

The low response rate (30\%) invited further exploration. A higher response rate came from Intake 3, perhaps due to the immediacy of the course or possibly more up-to-date contact addresses. There was also a higher response rate from those who had passed NZREX.

From Auckland intakes 1-3, 56 doctors had passed NZREX (unofficial figures) at the time of this study and would therefore have been eligible to find work. Yet only five participant doctors were currently working. One explanation for the low response rate might be that OTDs were feeling despondent about their chances of getting work, and thus less likely to respond to a study evaluating a programme that was meant to help them become practicing doctors.

Other possible reasons are the difficulty of persuading OTDs to give up time as they prepared for registration exams, suspicion about how the research would be used,\textsuperscript{18} financial struggles, and other cultural factors.

In conclusion, evaluative feedback from OTDs on the professional development component of the Overseas Doctors Training Programme was both helpful and thought-provoking. The course content was largely ratified. The most critical aspects of the evaluation referred to a need for even more practice and training, as well as further suggestions for particular topics. It is possible that further integration between the professional development component of Part A and the clinical attachment in Part B would improve both the confidence and the skill of OTDs entering the workforce in New Zealand.

Such integration would provide the opportunity for challenging interactions to be addressed within the clinical environment. It would also facilitate ongoing education and maintenance of the patient-centred approach.

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\textbf{References:}

1. Tyler V. Residency but no registration for nearly 1000 foreign doctors. GP Weekly. 1996;25 September;Sect.1–2.

3. Wenley S. Pumping petrol instead of practising medicine. GP Weekly. 1997;2 April; Sect. 1–2.


