THE UNIVERSITY OF WARWICK

Non UK qualified doctors and Good Medical Practice:

The experience of working within a different professional framework

Report for the General Medical Council

February 2009

Anne Slowther
Gillian Lewando Hundt
Rachel Taylor
Judith Purkis

Warwick Medical School

Health at Warwick

Research Team

University of Warwick
Warwick Medical School:
Dr Anne Slowther – Associate Professor of Clinical Ethics
Rachel Taylor – Research Fellow
Paula Williamson – Research Secretary

Institute of Health:
Gillian Lewando Hundt – Professor of Social Sciences and Health
Dr Judith Purkis – Research Fellow

Barts and the London Queen Mary School of Medicine and Dentistry:
Dr Sheila Cheeroth**,** OBE Clinical Lecturer

Acknowledgements
We would like to extend our thanks to all participants who took part in the interviews and focus groups or completed the questionnaire survey. We would also like to thank Dr Penny Trafford for her help in arranging one of the focus groups.

Contents

1. Executive summary

1.1 Background

The UK has a high number of Non UK qualified doctors working in its health care system. Previous work has suggested that ethical decision making in health care varies across different jurisdictions and cultures. Doctors coming to work in the UK may be faced with different social and cultural practices and an unfamiliar health care system, both of which will shape their experience of ethical practice. Information provided prior to working in the system may not be sufficient to prepare them for what this actually means for them in practice.

(*S 2.1 S3)*

1.2 Study aims

The overall aim of this study was to explore the experience of doctors who have qualified outside the UK in working within the ethical regulatory framework of 'Good Medical Practice' (GMP, GMC 2006), and to make recommendations to the GMC regarding the necessity for developing specific approaches to assist doctors qualified outside the UK in their transition to practising within this framework.

(*S 2.2)*

1.3 Methods

The empirical study used both quantitative and qualitative research methods to understand the knowledge and practice of Non UK qualified doctors. The primary research sample was drawn from the GMC registration database of doctors who had registered between 1st April 2006 and 31st March 2008 and stratified on the basis of country of qualification.

Interviews were conducted with twenty six doctors who had qualified outside the UK and were now working in a range of specialties and at different levels within the NHS.

A questionnaire survey was sent out to 3911 doctors and was completed by 106 Non UK qualified doctors and 30 UK qualified doctors providing data that allowed for some comparison with the experience of UK qualifiers who had also recently commenced work in the NHS.

Interviews with fifteen key informants involved in training and support for Non UK qualified doctors provided a further perspective on the difficulties faced by Non UK qualified doctors in their transition to working in a different regulatory framework.

A web search was conducted for information available to non UK qualified doctors in relation to professional practice in the UK. These included professional organisations, post graduate deaneries, NHS sites and organisations offering training for the Professional and Linguistic Assessment Board (PLAB) test. Resources and support for refugee and asylum seeker doctors were also identified.

1.4 Findings

The main information, training, and support available to Non UK qualified doctors wishing to work in the UK has little emphasis on ethical and professional standards but focuses mainly on practicalities of immigration, registration, availability of posts and, where required, passing the relevant examinations. None of the websites that a doctor seeking to work in the UK might access, including the GMC website, have clear signposting to the ethical standards required of doctors in the UK that would be easily apparent to a Non UK qualified doctor. Therefore it is unlikely that most Non UK qualified doctors will have accessed information on ethical standards and guidance prior to registration with the GMC. The main source of information for these doctors is the copy of 'Good Medical Practice' (GMP) that they receive on registration. However this is not always either read or understood and can be seen as difficult to interpret in the realities of day to day practice.

(*S4, S6)*

Other than provision of literature, there is limited opportunity for training for Non UK qualified doctors prior to registration, or on entering the NHS workplace. Training for PLAB is not compulsory and can be of variable quality. Experience of induction courses for Non UK qualified doctors following registration was generally favourable but the availability of these courses is patchy and appears to be decreasing.

(*S6.1)*

Recognition of the ethical, legal and cultural context of UK health care does not actually happen until doctors are working in practice, even if they have good pre registration training. There is a perceived need for training and/or support alongside clinical practice, either in protected clinical attachments or more generally during initial posts so that links can be made between experience and theoretical guidance.

(*S6.2, S8.3)*

Many Non UK qualified doctors find a distinct difference in the ethical framework in which health care is practised in the UK compared to their country of qualification. The main contrast is in the model of doctor patient relationship. The emphasis on individual autonomy and patients' rights in the UK and the degree to which this is articulated and regulated in formal legal, ethical and institutional policies. The concepts of individual autonomy, duty of confidentiality, and informed consent to treatment are recognised as important by all doctors but the level of importance given to them in the UK was a surprise to many Non UK qualified doctors.

(*S7.2, S8.1)*

The experience of dealing with ethical dilemmas in practice is similar for both UK and Non UK qualifiers. Dealing with poor practice in colleagues is difficult for both groups and is the area where there is least clarity about what is the right approach. Concerns include absence of support outside the clinical team, negative consequences for the doctor reporting poor practice, and frustration that even if poor practice is highlighted nothing is done about it.

(*S7.25)*

Many Non UK qualifiers identify having concerns about communication on entering practice in the UK. These concerns range from difficulties with subtleties of language and dialect to misunderstandings of the nuances of non verbal communication and social and behavioural norms. Training in communication skills was identified as particularly useful in the

induction programmes attended by some Non UK qualifiers.

(*S8.2)*

There is a clear difference in the perception of Non UK qualified doctors on how supported they feel in practice depending on whether or not they are in a formal training post. The lack of an established peer network for Non UK qualified doctors particularly in the initial stages of employment increases the isolation experienced by many in an unsupported clinical environment.

(*S8.3.2)*

Many European doctors have similar difficulties with communication or lack of familiarity with the shared decision making model of health care to their non EEA counterparts.

(*S7.2, S8.1, S8.2)*

1.5 Conclusions and Recommendations

This study identified a number of difficulties experienced by Non UK qualified doctors in their transition to practice within the UK ethical and professional regulatory framework. These include a lack of relevant information about legal ethical and professional standards and guidance prior to registration, variable levels of training and support specifically in the areas of communication and ethical decision making, and isolation in non training posts. The key difference between Non UK qualifiers and UK qualifiers is the emphasis on individual autonomy and shared decision making between doctor and patient which is the current norm in the UK and the contrast with their experience of a more paternalistic model of the patient doctor relationship in their country of qualification. Non UK qualifiers are presented with the guidance and regulatory frameworks but lack tacit knowledge held by UK graduates of the context in which the law and guidance was developed. Provision of specific information and educational resources prior to registration, accompanied by in practice support would help to develop a more effective understanding of GMP and its implications for practice in the UK. A number of recommendations have been made to facilitate this:

1. **Development of a web based portal for ethics information prior to registration for Non UK qualified doctors, hosted by or supported by the GMC.**

2. **Development of specific resources to support Non UK qualified doctors in practice, including information about the cultural context of the UK professional regulatory framework.**

3. **Provision of appropriate, formal induction for Non UK qualified doctors to include specific consideration of the legal, ethical and social context of health care in the UK.**

4. **Further development of mentorship schemes for all Non UK qualified doctors, including those from the EEA, during the first two years of employment, building on current pilot schemes for refugee doctors.**

2. Introduction

2.1. Background

The UK has a long tradition of international medical graduates working in its health care system. Until the expansion of undergraduate medical training in the UK in 2000, Non UK qualified doctors were seen as essential to meet the shortfall in UK qualified doctors for delivering patient care within the NHS. Since February 2008 non EEA (European Economic Area) international medical graduates (IMGs) cannot apply for specialist training programmes but will still be eligible to apply for non training posts (subject to registration and satisfaction of immigration requirements). There are no immigration restrictions on EEA medical graduates applying for posts and working in the UK health system. Table 1 shows the numbers of doctors working in the UK in different grades in 2007. Of those 37% had qualified in a country other than the UK (6% in an EEA country). This figure rises to 56% for non consultant non training grades (staff grade, associate specialist, hospital practitioner, clinical assistant). Thus although the number of IMGs in the UK is likely to decrease in the future there will still be a large number of doctors who have qualified overseas working in the UK, many in non training posts. The range of countries and cultures from which these doctors come to the UK is great. Table 2 shows the number of doctors from different countries who are registered with the GMC.

All doctors who work in the UK are required to be registered with the General Medical Council (GMC) and to comply with the standards of good practice set out in the core GMC guidance 'Good Medical Practice' (GMP). These professional standards are the benchmark against which decisions about a doctor's fitness to practice are taken. A lack of awareness or understanding of these standards on the part of a doctor may have adverse consequences for the doctor (he or she may lose their registration) but it may also mean that patients receive care that is below the standard that they can and should expect.

GMC guidance, and the wider professional regulatory framework that governs all doctors practising in the UK has developed over many years in response to a range of factors including advances in medical technology, changes in legislation and a progressive shift in societal norms towards a greater emphasis on individual autonomy. In its revision of 'Good Medical Practice' (GMP) in 2006 the GMC noted that the main cultural change since its previous publication in 1995 was '*an increased expectation of patients and public involvement in both individual and organisational decisions in health care'* (GMC invitation to tender 2008). The guidance was therefore revised to focus on a doctor's obligation to work in partnership with patients. Professional regulation, and indeed legal regulation, in the UK has not developed in isolation from the influence of other countries' ethical and legal frameworks, and GMC guidance is founded on ethical principles that are recognised by many if not all international health care systems. However because of the contextual framing of professional regulation noted above there are likely to be clear differences, as well as similarities, between the professional standards set out by the GMC and those expected in some other health care systems.

Table 1: Hospital and Community Health Services (HCHS): Medical Staff by Country of Qualification				
	All Countries of Qualification	**United Kingdom**	**Rest of EEA**	**Elsewhere**
All staff	**90,698**	**57,116**	**5,627**	**27,955**
Consultant (including Director of Public Health)	32,911	23,436	2,360	7,115
Associate Specialist	2,907	994	172	1,741
Staff Grade	5,840	1,435	529	3,876
Registrar Group	30,354	18,279	1,662	10,413
Senior House Officer	5,458	2,354	295	2,809
Foundation Year 2	4,818	3,709	256	853
House Officer and Foundation Programme Year 1	5,225	4,528	185	512
Hospital Practitioner/ Clinical Assistant	2,848	2,138	151	559
Other Staff	337	243	17	77

Reproduced from the NHS Information Centre NHS staff 1997-2007 (Medical and Dental) statistics http://www.ic.nhs.uk/statistics-and-data-collections/workforce/nhs-staff-numbers/nhs-staff-1997--2007-medical-and-dental (accessed 4th February 2008)

Table 2: Top five European Economic Area (EEA) and International Jurisdictions from which the GMC has Received (full) Registrations (number of doctors)	
Germany (4,091)	India (27,931)
Poland (2,086)	South Africa (7,992)
Greece (1,797)	Pakistan (7,066)
Italy (1,696)	Nigeria (2,912)
Spain (1,133)	Egypt (2,694)

Information from GMC tender document February 2008

An individual doctor's personal professional standards will be informed by a range of factors including their medical training, the legal and ethical frameworks that govern practice within their country and the cultural norms within the society in which they have previously practised. There is some evidence that ethical decision-making in medical practice varies across different jurisdictions and cultures, particularly in the area of end of life decision-making and consent/information sharing, Studies suggest that cultural norms, for example attitudes to the role of the family in medical decision-making, and social context including the health care structure of the country, influence both the identification and experience of ethical dilemmas faced by clinicians (Ganz 2006, Hurst 2007, Rhunke 2000). Doctors coming to work in the UK will encounter both a different societal culture and an unfamiliar health care system, which will shape their experience of ethical practice. They will also encounter a different professional regulatory framework articulated in GMP and may experience difficulty in identifying, understanding and adapting their behaviour to this guidance.

The GMC, in addition to setting and monitoring professional standards, has a role in educating and supporting doctors to ensure that they understand and incorporate the principles of GMP into their working lives. Such education and support should be based on evidence of the needs of doctors in a wide range of posts and stages in their career development. Doctors who have not qualified in the UK may have specific educational and support needs, particularly in the period of transition to UK medical practice, that are not shared by UK qualified doctors. This report describes a study commissioned by the GMC to provide evidence that will inform the development of its work in encouraging doctors to adopt the principles of GMP in their day to day practice with a focus on the needs of non UK qualified doctors in this transition period.

2.2 Aims and Objectives of the Study

The study had two interconnected aims:

1. To explore the experience of doctors who have qualified outside the UK in working within the ethical regulatory framework of GMP.
2. To make recommendations to the GMC regarding the necessity for developing specific approaches to assist doctors qualified outside the UK in their transition to practising within this framework and to suggest what approaches might be effective.

In order to achieve these aims four specific objectives were identified:

1. To describe the current experience of doctors qualified outside the UK in accessing information and advice on the ethical and legal framework for practising medicine in the UK.
2. To explore the experience of doctors qualified outside the UK in identifying and resolving ethical dilemmas arising in their day to day practice.
3. To explore the approach to ethical decision making and concordance with the principles of GMP in response to hypothetical scenarios by both doctors qualified outside the UK and doctors qualified in the UK.
4. To identify specific training or other needs of doctors qualified outside the UK in relation to their knowledge and understanding of the ethical and legal framework for health care in the UK.

3. Previous Research relevant to this Study

NB for the purposes of the literature review, IMG refers to any doctor working in a country other than where qualification obtained. Therefore the specific IMG UK definition (which excludes EEA doctors) does not apply.

3.1 Integration of International Medical Graduates into a different Culture

A small number of studies, mainly from North America, Australia and New Zealand, have looked at the experiences of international medical graduates (IMGs) integrating into a different culture. These studies include quantitative and qualitative methods but the majority involve interviews or focus groups with international medical graduates. While ethical issues were not explicitly explored many of the common themes identified across studies have relevance for ethical decision making and professional practice of doctors working in a culture different to that in which they qualified. These themes include lack of knowledge of the health care systems and regulatory frameworks in the new country (Curran 2007, Hall 2004, Zulla 2008), difficulties in communication (both verbal and non verbal) (Fiscella 1997, Curran 2007, Pilotto 2007, Hall 2004, Zulla 2008), differences in cultural perspectives on family life (Searight 2006, Kales 2006) and cultural concepts of disease (Kales 2006), different approaches to teaching and learning (Pilotto 2007), and different models of the doctor patient relationship (Searight 2006).

A lack of familiarity with the organisational structures and processes of the health care system in the country of practice will clearly create practical difficulties for the IMG. However if this also includes a lack of knowledge of the professional and legal regulatory frameworks in the system this may have serious implications for professional practice. An interview study of IMGs participating in a Family Medicine training programme in Missouri identified a lack of knowledge about the legal importance of documentation of medical care as a specific difficulty. They also highlighted unfamiliarity with a multi disciplinary team approach leading to difficulties in relationships with other professional colleagues such as nurses and health care assistants (Searight 2006). A Canadian study of IMGs, Directors of IMG training programmes and allied health professionals working with IMGs found that IMGs needed a better understanding of how to work in the Canadian health care system, including an understanding of legal and ethical issues (Hall 2004).

Several studies identified effective communication as a challenge facing IMGs. This included straightforward language barriers but also more complex issues relating to picking up non verbal cues, concerns about different cultural protocols, and the lack of communication skills teaching in their country of qualification. A systematic review of the communication needs of IMGs in training concluded that clinicians involved in training IMGs should '*Explore IMGs' understanding of cultural boundaries; teach the use of open-ended questions; encourage reflective listening skills; and develop IMGs' ability to explore psychosocial issues'* (Pilotto, 2007, p.226). Studies in North America and New Zealand reported IMGs describing real difficulty in offering emotional support to patients because of concerns about infringing gender or social boundaries (Fiscsella 1997, Hawken 2005). In Fiscsella's (1997) study of IMGs and American graduates' narratives of encounters with patients, IMGs described difficulties in communicating emotional support because of limited language resulting in patients thinking that the doctor did not care. Effective communication with patients is an essential requirement for obtaining informed consent, discussing

diagnoses and negotiating treatment options. The shared decision making model of the doctor patient relationship which is a feature of many Western health care systems including the UK, is often unfamiliar to IMGs who have qualified in a health care system that has a more paternalistic model. The IMGs in Searight's (2006) study described clear differences in patients' expectations of the doctor patient relationship between the US and their country of qualification. American patients were seen as '*more inquisitive and active in medical decision making' (p. 167).*

Countries with a more paternalistic model of the doctor patient relationship may also have a different perspective on the relationship between a patient and his or her family. This can lead to differences in behaviour of doctors in relation to truth telling and confidentiality, as discussed below in s3.3. Searight (2006) reported that IMGs found the nature of family life in the US, lack of extended family support networks, and involvement of outsiders in 'family affairs' such as marital dispute and child discipline at odds with their own cultural experience. Different cultural perceptions of disease may also lead to difficulties for IMGs. Kales (2006) compared the response of US trained doctors and IMGs to a simulated patient vignette of an elderly patient with late life depression. The IMGs were significantly less likely to diagnose depression and to recommend a first line antidepressant as treatment. The authors suggested that the reason for the discrepancy may lie in a difficulty of acculturation of IMGs, many of whom came from societies where depression was less likely to be diagnosed and was often stigmatised. There appears to be a risk that IMGs may be seen as clinically incompetent due to differences in cultural attitudes.

Two published studies have looked specifically at the ethical difficulties facing doctors working in a different culture from their own. Both studies focussed on the experience of Muslim doctors working in the US (Padela 2008) and the UK (Molloy 1980). Padela (2008) interviewed Muslim physicians trained outside and now practising in the US. Participants identified areas of ethical challenge in their work related to their Muslim faith included catering to populations whose lifestyles were at odds with Islamic teaching, end of life care and maintaining a faith identity within the culture of medicine. Molloy also identified tensions for doctors between trying to stay true to their faith while working in a secular society and a medical code of practice based upon the Christian faith, a dilemma characterised by Molloy as '*a choice between conscience and standard practice'*. (1980:143)

3.2 Undergraduate Training in Medical Ethics in different Countries

The process and content of medical education will shape the practice of doctors following graduation, and this will be further influenced by explicit and implicit learning in the post graduate clinical setting. Since the nineteen eighties there has been an increasing focus in several countries, including the UK, on developing students' values, social awareness and interpersonal skills in addition to scientific knowledge and clinical skills within a medical curriculum. The integration of medical ethics into the core curriculum in UK medical schools followed a recommendation in the 1993 GMC document 'Tomorrow's doctors' which included a specific knowledge objective of '*ethical and legal issues relevant to the practice of Medicine'* (GMC 1993: p14) In the current version of 'Tomorrow's Doctors', published in 2003 and currently under revision, the specific guidance on the curriculum links directly to the GMC guidance for qualified doctors on good medical practice (GMC 2006). Thus while each medical school develops its own curriculum, the regulatory role of the GMC in setting and monitoring standards of medical education means that there is likely to be a strong focus on GMC guidance in UK medical students' undergraduate training. In 2007 the

GMC also published Fitness to Practise guidance for medical students, further emphasising the link between undergraduate and post graduate professional expectations in UK medical practice (GMC 2007).

In a review of ethics curricula in undergraduate medical education Goldie (2000) described the broadening of the ethics curricula to include context as well as principles and an examination of ethical behaviour in day to day practice (Goldie 2000). Much of the literature on teaching ethics and on professionalism emphasises the development of good character as a key aim of the curriculum (Rhodes 2002, Eckles 2005). The consensus statement on the core curriculum for medical ethics in the UK refers to *"the creation of good doctors who will enhance and promote the health and medical welfare of the people they serve in ways which fairly and justly respect their dignity, autonomy and right"'* (consensus statement 1998: 188). Discussions of appropriate teaching methods refer to the importance of practice based learning (Roberts 2004, Roff 2005) role modelling and mentoring (Eckles 2005, Lynoe 2008 Thulesius 2007) in promoting the required attitudes and virtues that make a good doctor. The significance of the hidden curriculum in medical students' learning is also recognised (Hafferty 1994, Stephenson 2006). Thus the experiential learning of medical students, observing and responding to the ethical challenges arising in the specific clinical and social context in which they are working may be as important as the formally taught curriculum in influencing the behaviour of qualified doctors. This could have implications for the preparedness of Non UK qualified doctors working in the UK who may have had a different experience in training.

In 1999 the Assembly of the World Medical Association passed a resolution recommending the inclusion of medical ethics and human rights in the teaching of medical students' world wide. While much of the literature on the aims and methods of medical ethics education focuses on North America and the UK, with both the US and the UK having national consensus statements on the inclusion of ethics in the medical curriculum since the early 1990s, there is evidence that the inclusion of ethics education in medical curricula is not restricted to Western health care. A survey of 206 medical schools in 13 countries in Asia found that 89 of the 100 medical schools that responded had some medical ethics teaching in their curriculum (Miyasaka, 1999). The majority of schools had separate ethics courses which were generally secular in origin. There appeared to be less focus on integration of ethics into the clinical curriculum than is advocated in the Western literature and the authors suggest that this may be because of a perception of ethics as a conceptual rather than practical element of medical education. They note that in Japan medical ethics education has traditionally been taken as a unit of medical humanities, and given a character resembling liberal education. It is important to recognise however that the integration of ethics into clinical teaching within an integrated curriculum is not universal even in countries that have strongly advocated such an approach. Surveys of medical schools in the US (Silverberg 2000), Canada (Lehman 2004), and the UK (Mattick 2006) have all found to differing extents a lack of integration of ethics teaching in the clinical curriculum. However, unlike the Asian medical schools reported in Miyasaka's (1999) study, teaching methods clearly focussed on ethics in practice rather than theoretical concepts. A survey of twenty five medical schools in eighteen European countries found all but one included ethics teaching in the curriculum but the content, method and level of integration into clinical teaching varied widely (Claudot 2007).

The literature highlights the variation in availability, content, structure, and level of integration into clinical practice of ethics teaching in medical undergraduate education

throughout the world. However, despite different training, there is evidence that physicians adjust their practice according to the context in which they work, for example country, organisation, legal framework and available resources (Willems 2000, Richter 2001, Miccinesi 2005). There is also evidence that commonalities across ethical and cultural traditions can be identified and developed in medical training. A study of medical ethics teaching in an Arab country found that students could identify medical ethical issues based on Western ethical constructs and suggested that the ethical principles articulated in a Western framework (the Four Principles approach) may be common to the student's Islamic religious beliefs (Ypinazar 2004). Even if cultural differences influence how doctors perceive ethical difficulties in practice, there is evidence to suggest that the type of support they require to deal with these difficulties is similar across countries (Hurst 2007). This study of primary care physicians in four European countries found that the type of support identified as most useful was practical contextual support, e.g help in weighing outcomes and clarification of the issue whereas access to relevant ethics literature was seen as less helpful. This would support the evidence from undergraduate training on the importance of experiential rather than theoretical learning in ethics.

3.3 The Impact of Cultural Differences on Ethical Decision-Making in Clinical Practice

Most empirical studies of ethical decision-making in different cultural contexts are comparative studies between two or more countries and the majority focus on Europe and North America. We found studies which included the following countries: Sweden 9 papers; Germany, 8; The Netherlands and the UK, 7; Belgium, 6; Switzerland, Denmark, US and Italy, 5; Japan and Austria, 3; France, Spain, Portugal, India; Australia and Israel, 2 ; China, Ireland, Canada, Thailand, Hungary, Estonia, Finland, Turkey Greek Czech republic, Lithuania, and Norway. Overall, the literature reveals that there are differences in ethical approaches across countries and cultures including, differences within Europe (e.g. Bosshard 2005, Miccinesi 2005, Hurst 2007), between Europe and the US (Rodriguez 2007, Feldman 1999) and between the "East and the West" (Ruhnke 2000).

The clinical situations reported in the literature that are most associated with ethical challenges are end of life (EOL) care and end of life decision making (EOLD), neonatal care, confidentiality, consent and disclosure. The majority of the literature is focussed around EOL, probably because it is the clinical situation most often identified with ethical dilemmas. EOL situations encompass issues to do with disclosure, consent, neonatal care, withdrawing and withholding treatment and hastening death. The role of the individual patient, the doctor and the family are also highlighted in EOLD.

The reasons behind the country/culture differences in approach to certain medical situations can be grouped into 3 main areas:

- The patient doctor relationship.
- Influence of physician religious beliefs on ethical decision-making.
- The organisational and legal context of clinical practice.

3.4 The Patient Doctor Relationship (paternalism, autonomy and the role of the family)

Over the past twenty years there has been a clear shift in the model of the patient doctor relationship in UK health care from a predominantly paternalistic model to one of partnership, shared decision making and patient centred care. The ethical principle of respect for individual autonomy has become dominant and the legal and professional framework

supports patients' rights in making their own decisions about medical treatment, and disclosure of information. The GMC guidance on consent, revised in 2006, emphasises the shared decision-making model in its title 'Consent: patients and doctors making decisions together' (GMC 2006). Families are recognised as having an important role, particularly if they are carers of the patient, but their involvement in decision-making or access to information is dependent on the patient's present or previous consent (see for example the Mental Capacity Act (2005). This development of an ethical and legal focus on individual autonomy in health care is also seen in other countries particularly the US and Canada and increasingly in other Western European countries. However this model is not universal and in many countries the patient is identified more closely with the family unit and individual autonomy carries less weight. Studies over the last decade exploring the role of the family in disclosure and consent suggest that in non-Western countries the family still plays a more significant role and is afforded greater respect by physicians (Chaturvedi, 2008, Mobeireek 2006, Jafarey 2005, Ruhnke 2000 and Feldman 1999). These studies explored Indian, Saudi Arabian, Pakistani, Japanese and Chinese perspectives and practices. In these cultures the patient is seen less as an individual and more as part of a family unit within a wider society.

Jafarey (2005) conducted focus groups and individual interviews with a range of physicians at different levels of seniority in a private sector tertiary hospital in Pakistan focussing on the understanding and experience of informed consent. They found that many participants, while acknowledging the importance of providing information to the patient refused to draw a distinction between the patient and the family, *"both are one and the same"* (p.94). However the picture painted was not one of family taking precedence over patient in decision-making, rather more that the family was seen as aiding the process of providing information to the patient. Participants expressed concern that the Western approach of giving all information to the patient might cause distress and not be appreciated by patients. This paternalistic approach to disclosure of information to patients is echoed in papers from Hong Kong (Chan 2004), China (Feldman, 1999) and Singapore (Chan, 2000). A few studies have compared the attitudes of doctors in different countries to information disclosure and family involvement in decision making. These studies have tended to suggest a dichotomy between Eastern family orientation and Western individualism (Rhunke 2000, Feldman 1999). Mobeireek (2006) found that physicians' views towards information disclosure in Saudi Arabia were mid way between those of the USA and Japan using the same questionnaire survey.

Given the lack of restrictions on EEA doctors coming to the UK, of particular relevance to our study is the variation of approaches within Europe. Hurst (2007) found that Italian doctors were much less certain about disclosing a diagnosis to a patient than doctors in UK, Norway and Switzerland and Rodriguez-Arias (2007) in their study of French and American perspectives on advance directives, found that if there was a dispute between the family and the patient wishes, the French physicians would be more likely to comply with family wishes. An end-of-life decision making study compared doctors from Russia, Sweden and Germany (Richter 2001). Russian doctors were more likely than the Swedish and German to resuscitate against the patient's wishes in a hypothetical situation and reported less difficulty in decision making.

However the picture regarding the patient doctor relationship and the role of the family is more complex than may be suggested by these cross country questionnaire surveys. Different cultural norms and practices may exist within as well as between countries, particularly in countries with multicultural and multi faith societies.

3.5 Influence of Physician's Religious Beliefs on Ethical Decision Making

Three large European studies looking at physicians' attitudes and practices in end of life care found an association between physicians' religious beliefs and decisions relating to withdrawing and withholding life sustaining treatment. In a large prospective observational study in intensive care units across 17 European countries, significant differences in type of end of life decision, time to treatment limitation and discussion with patients' family were found to be associated with religious affiliation of physicians (Sprung, 2007**).** Withholding of life sustaining treatment as a form of therapy limitation occurred more often if the physician was Muslim, Jewish or Greek Orthodox while withdrawing of life sustaining treatment was more likely to be initiated if the physician was Catholic, Protestant or had no religious affiliation. In a questionnaire survey of physicians working in a range of specialities where end of life decisions are made across six countries in Western Europe and in Australia researchers found that individual religious affiliation or 'life stance' had some influence on attitudes and practice in decisions involving terminal sedation and life shortening, but the strongest influence was on attitudes to and practice of physician assisted suicide (Cohen 2008). The less striking effect of religious affiliation in this study compared to that of Sprung (2007) may be due to the extremely low incidence (<1%) of any religion other than Catholic or Protestant in the sample. In a questionnaire survey of physicians working in neonatal intensive care units eight European countries religious affiliation was associated with differences in end of life decision making in two distinct ways (Cuttini 2000). Physicians who attached a high importance to their religion were less likely to have withheld intensive care or administered drugs which might shorten life, as were the small number of physicians from Muslim, Jewish or oriental religions. The conclusion drawn from these different studies appears to be that individual religious beliefs play an important role in doctors' attitudes and practices in end of life decision-making across a range of clinical situations but the level of influence is likely to depend on how important a role religion plays in the doctor's life. This is supported by two small studies looking at Muslim doctors working in secular societies (US and UK) which found that doctors experienced tensions between their religious and cultural beliefs and the practice of medicine within a Christian / secular medical framework (Padela 2008, Molloy 1980).

3.6 The Organisational and Legal Context within which Doctors' Practice

Doctors practice medicine within a complex social, legal, organisational and ethical context which is specific to the country in which they are working. A range of different influences and constraints are therefore likely to influence their decision making in clinical care. The broader cultural and individual religious influences have already been noted but the specific legal, organisational and economic context are also important. There is evidence in the literature that the kind of ethical dilemmas that arise in health care and the approach of health professionals to them, is influenced by wider organisational and social factors. Many of the dilemmas associated with advances in medical technology in developed countries are not encountered in developing countries where issues of poverty and lack of local health infrastructure create more pressing ethical concerns (Chaturvedi 2008).

Within Europe both clinical decision making in an intensive care context and rationing decisions in primary care are influenced by the legal and organisational framework of the country and health care system in which clinicians practice (Cuttini 2000, Hurst 2007).

Knowledge of the health care system in a new country of practice may be an important factor in adapting to the ethical and professional practice of health care in that country. In both the EURELD (Miccinesi 2004) and EURONIC (Rebagliato 2000) studies, country was found to be the most important determinant of physicians' attitudes and practices in end of life decision making after correcting for other variables such as religion suggesting that broader social factors play a significant role. A review of the literature on end of life decision making in neonatal intensive care in thirteen countries identified four major factors affecting treatment choices for disabled newborns; '*the availability of resources, societal attitudes toward medical interventions and life with disabilities, the roles of physicians, parents and other decision-makers, and the role of the law'*(Wolder-Levin, 1990:.901).

From this summary of relevant research in the area we can see that the attitudes and practices of doctors in both the identification of and approach to ethical decision making are shaped by a complex range of influences including individual religious affiliation, content and structure of undergraduate training, cultural attitudes to relationships and to concepts of illness, and the legal and organisational framework within which they practice. Moving to practice in a different country requires recognition of and adjustment to shifts in norms and perspectives at a range of levels, many of which may not become apparent until doctors are working in practice. There are few studies that have explored the experience of doctors moving to work in a different culture and none that have specifically considered the impact of this transition on ethical and professional practice. In view of the numbers of non UK qualified doctors coming to work in the UK and the diversity of countries and cultures from which they come there is a need for further research evidence on these key issues.

4. Web Based Information Training, and Support Available for International Medical Graduates Coming to Work in the UK

Doctors who have qualified overseas and who are seeing to work in the UK will seek information from a variety of sources. As part of this study we sought to identify what information and support was available for these doctors, both generally and specifically in relation to ethical and professional practice, and how easily the relevant information could be accessed. A survey of the web looked for information which would be likely to be accessed or useful to overseas doctors working or planning to work in the UK. We searched relevant web sites for information available to non UK qualified doctors in relation to professional practice in the UK. These included professional organisations, post graduate deaneries, NHS sites and organisations offering training for the Professional and Linguistic Assessment Board (PLAB) test which all doctors who qualified outside the UK, European Economic Area or Switzerland must pass prior to registration with the GMC. Resources and support for refugee and asylum seeker doctors were also identified.

In this section we outline and review the sources of information identified.

4.1 Web Based Information

The General Medical Council (GMC)
This is the professional body responsible for maintaining the UK register of doctors so all doctors wishing to work in the UK will go to this site for information. The site has a range of information for doctors and patients. There is a section entitled 'Guidance on good practice' and a separate section for Non UK qualified doctors. There is also a quick link on the home page to 'Good Medical Practice'(GMP), the core guidance for all doctors practising in the UK. The 'Guidance on good practice' pages have links to a list of GMC guidance as well as interactive case studies demonstrating the practical application of GMP. However from the home page it is not easy to recognise how extensive the GMC's role is in providing guidance to doctors working in the UK and the close link between that guidance and the role of the GMC in assessing doctors' fitness to practise. The role of the GMC is set out on a separate page from the home page and includes its four main functions:

- keeping up-to-date registers of qualified doctors
- fostering good medical practice
- promoting high standards of medical education
- Dealing firmly and fairly with doctors whose fitness to practise is in doubt.

It is not clear from this statement that in fostering good medical practice the GMC has developed a range of guidance and support materials for doctors to assist them in maintaining appropriate professional standards, nor is it clear against what standards the GMC assesses a doctor's fitness to practise. Doctors who have trained in the UK will be aware of the range of GMC guidance and could be expected to directly access the relevant web pages when seeking advice or information but international medical graduates may not intuitively seek out the guidance section when initially seeking information about working in the UK. The

section that they will seek out is that pertaining to international medical graduates. This provides comprehensive information about eligibility to register, the registration process and other practical information and links. However it does not have a link to the guidance pages nor does it emphasise the GMC's role in supporting and monitoring good medical practice once a doctor has obtained registration. Better signposting could significantly improve the awareness of and access to an extremely useful and highly relevant source of information on the content and context of professional medical practice in the UK.

British Medical Association (BMA)
As the independent trade union and professional association for doctors and medical students, this is another site that international medical graduates seeking to work in the UK are likely to access. The home page of this site has a clear link to the ethics section which contains a wealth of information including BMA publications on ethical issues, guidelines, discussion papers and links to other web resources. Key practical support for doctors includes toolkits on, for example, confidentiality and consent which provide up-to-date support on dealing with complex situations. In addition, there is information about the BMA Medical Ethics team which provides advice to doctors with ethical concerns or queries. More general support for doctors is provided on the 'Doctors' Health and Well Being' pages which include information about the BMA's counselling and 'Doctors for Doctors' service. Also available are resources for doctors in difficulties including a list of support organisations and website resources for doctors in difficulty. However, while these resources are highly relevant for doctors practising or wishing to practise in the UK it is unlikely that they would be accessed de novo by international medical graduates unless they had a specific interest in ethics. The BMA site also has a section providing useful information for international medical graduates. However this is not directly accessed from the home page so may be missed. The resource once accessed, like the GMC site, provides practical information on immigration, registration and obtaining a post in the NHS but does not refer to or link to information on professional practice or ethics. The BMA also has a range of resources to specifically support refugee doctors including a package of benefits and free counselling service. There is guidance for clinical attachments undertaken by international doctors prior to taking up a substantive post. The guidance specifies the educational objectives of these attachments which include:

- Gain experience in clinical governance and the legal aspects of health care, by attending relevant meetings
- Become aware of the expectations of the British patient, to enhance their clinical communication skills and learn as much as possible about the doctor-patient partnership

These objectives go some way to acknowledging the importance of the cultural organisational and legal framework of UK health care for IMGs. Interestingly knowledge of ethical issues (including GMP) is only listed as '*an additional area that may benefit a clinical attachee'*.

Medical defence organisations: Medical Defence Union (MDU) and Medical Projection Society (MPS))
Both the MDU and the MPS provide educational resources and publications on ethico-legal issues that arise for doctors in practice. Based on their experience of providing professional indemnity to doctors their resources are highly relevant to practising clinicians. The MPS has recently launched a magazine for doctors in their first two years of practice which may be helpful to IMGs recently arrived in the UK. Access to information about workshops and

publications that may be helpful to doctors planning to work in the UK is through the education and publications section of the MPS but is not so clearly signposted on the MDU site. Some of the available resources are only available to members, although MPS publications are more likely to be freely available. The educational and support role of these organisations is less well publicised than the legal services that they offer.

Department of Health

The Department of Health website does not have easily accessible information for IMGs wishing to work in the UK. A search of their publications revealed that a guide for international medical graduates working in the UK was published in 2000 (DH http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4010453). It is not clear whether this guide is still relevant in the light of recent changes to the immigration rules for international medical graduates introduced in 2008 (http://www.dh.gov.uk/en/News/Recentstories/DH_082728). The 2000 guide states that arrangements are being made for induction training for all doctors from outside the UK who have been appointed to a post in the NHS. Information from our interviews with IMGs and key informants suggest that these arrangements are patchy and in some areas induction courses have been discontinued due to either lack of resources or lack of interest.

NHS Deaneries

All post graduate deanery sites in the UK were explored for information available to or relevant for overseas doctors. Most sites had some information but this was often difficult to access and not comprehensive. In general resources and information provided was of a practical nature around issues of immigration, IMG induction programmes, clinical attachments, speciality training, and registration. As was the case with many other sites information on standards of professional practice, legal frameworks and the cultural context of the NHS was rarely available. Examples of Deanery sites that have accessible information specifically for Non UK qualified doctors include the South West Peninsular deanery which has a clear home page link to overseas doctors with information on international recruitment, GMC registration and immigration regulations. Another well resourced website was that of Mersey Deanery which in addition to useful information has the contact details of the Deputy Dean responsible for overseas doctors. Information includes an introduction to the NHS, an introduction to primary medical care, secondary care, admissions to hospital and management structure and a link to the GMC. Although these two deanery sites have information for Non UK qualified doctors, they did not provide guidance specifically on UK clinical ethics.

ROSE

This is an NHS supported website for refugees and overseas qualified health professionals who are settled in the UK and would like to return to working in the health care sector. It is therefore not aimed at IMGs who are seeking to enter the UK for work although many of its resources will be relevant to them. These resources are however extremely limited and do not include any information on professional standards or ethics. The website is currently being updated.

Royal Colleges

There is great variation in the availability of information on the Royal Colleges websites. The Royal College of Physicians (RCP) and the Royal College of Surgeons (RCS) have specific pages for IMGs , covering general issues but, as with other professional body websites, there is no specific reference to professional practice or ethics. In contrast, it was very difficult to

find any information on the RCGP website that was relevant to IMGs. College websites also vary in their information on ethical issues. Most have publications that include ethical guidance but these are not linked to their home pages so would only be accessed by someone specifically looking for guidance on an ethical issue and aware of the possibility that the College would have such guidance.

Other organisations
There are a variety of organisations offering support to overseas doctors in the UK. Many of these are for UK trained doctors from minority ethnic groups as well as those who have trained overseas. In our search on the internet, we found the following organisations, and there may be others:

Association of Pakistani Physicians and Surgeons of the UK
British Arab Medical Association
British Association of Physicians of Indian Origin (BAPIO)
British Indian Psychiatric Association
British International Doctors Association of the UK (BIDA)
Medical Association of Nigerian Specialists and General Practitioners in the British Isles
Nepalese Doctors Association

These organisations take on a variety of roles including supporting junior doctors and those new to the UK, supporting health services in the relevant country of origin, and providing information on education and training for members. BAPIO has recently had a strong focus on supporting doctors in difficulty and is working with the London Deanery to develop a programme of mentors for its members who are trainees. Their website includes a discussion forum to support doctors working in the UK as well as providing information to those considering seeking work in the UK. However there are no clear links to the GMC or references to GMP.

4.2 Education and Training Support

International Medical Graduates (IMGs) but not EEA applicants are required to pass the examination of the Professional and Linguistic Assessment Board (PLAB). There are many commercial web sites offering training courses for PLAB. It is difficult to assess the content or quality of the training from information on websites and most provide examination success rates as an indicator of quality. Some sample programmes do include ethics related topics (one organisation contacted said that ethics was a large component of the training and identified confidentiality, consent and communication skills as key course topics).

Support and training for PLAB and integration into the NHS is specifically provided for refugee doctors in many areas, particularly large cities such as London and Manchester.

The London Deanery website has information about current and previous programmes it has run for overseas and refugee doctors to support them in returning to work. The deanery only works with doctors who are post PLAB I and PLAB II. Between 2003-2007 there was a Clinical Experience Scheme which provided unpaid attachments for overseas and refugee doctors. This scheme has now finished due to the changes of Modernising Medical Careers. The Deanery now runs a Foundation Project for Refugee Doctors: National Clinical Apprenticeship Scheme (CAPS) for Refugees doctors The CAPS scheme is endorsed by the

UK Foundation Programme Office and delivered by a partnership between London Deanery and Refugee and Asylum Seekers Centre for Healthcare Professionals Education (REACHE) Northwest. The scheme places refugee doctors on supernumery placements at F2 level and provides alongside this a heavy educational component (http://www.londondeanery.ac.uk/general-practice/international-gp-recruitment, accessed 10.2.09)

Barts and the London Institute of Health Sciences Department website, provides information on their Refugee and Overseas Qualified Doctors' Programme. This is a programme of courses and support for Non UK qualified medical doctors who have refugee or other settled status to help them in getting back to work. There is PLAB I and PLAB II preparation with a strong ethics component. There is also a study club for overseas doctors which has been running for eleven years which can be attended by doctors without settled status. This provides the opportunity for meeting other people in a similar situation, discussions about barriers working the UK, English language improvement etc.
(http://www.ihse.qmul.ac.uk/staff/staff.php?s.a.cheeroth@qmul.ac.uk, accessed 10.02.09)

Building Bridges is a programme aiming to integrate and co-ordinate the services and support in London for refugee healthcare professionals trying to enter work in the UK. Its steering group includes representatives from the BMA, refugee organisations, the London deanery. It published a report in October 2007 - Building Bridges "Improving Training and Guidance for Refugee Health Professionals in London, a Consultation Document," which proposed that there is more co-ordination in London of the training and guidance services for refugee healthcare professionals to avoid duplication and ensure consistency. Building Bridges works and consults with organisations that support refugee healthcare professionals to try to create a clear pathway for the London based refugee healthcare professional returning to work. It is funded by NHS London and hosted by NHS Employers, The programme delivers a range of training and support from English, advice and guidance to PLAB training and clinical attachments.

REACHE (*Refugee and Asylum Seekers Centre for Healthcare Professionals Education)* North West is an organisation based at Salford Royal NHS Foundation Trust, which supports asylum seeker and refugee doctors and healthcare professionals who wish to enter the workforce in the UK. It provides support in preparation for IELTS, PLAB I and II and obtaining clinical attachments. The PLAB preparation includes comprehensive ethics training in a supportive environment where there is room for discussion. Aspects of UK ethics are studied such as consent, doctor – patient relationship, confidentiality, communication. REACHE has excellent links with the local NHS trusts and runs a Clinical Apprenticeship Scheme which supports people who are taking their programme in gaining clinical placements for 3 months. Ongoing support is given during the clinical placement.
(http://reache.wordpress.com/ (accessed 10.2.09)).

5. Empirical Study Methods

The empirical study used quantitative and qualitative research methods to understand both the knowledge and practice of non UK qualified doctors. Qualitative methods in the form of semi-structured interviews and focus group discussions and quantitative methods through a questionnaire survey were used to explore the perceptions and experience of non UK qualified doctors of dealing with ethical dilemmas in practice and of the information and education they received to prepare them for working within the UK professional regulatory framework. The questionnaire which included a qualitative section where respondents were invited to describe an ethical dilemma provided data from a larger sample of doctors and also provided some comparative data from UK qualified doctors. In addition we conducted interviews with key informants involved in training of non UK qualified doctors prior to registration with the GMC and/or support of non UK qualified doctors in practice. Research ethics approval for the study was obtained from Cambridgeshire multicentre research ethics committee.

5.1 Recruitment and Sample

5.1.1 Sampling frame

For the questionnaire survey and interviews with Non UK qualified doctors the sample for recruitment was identified using the GMC registration database. The research brief was to consider doctors who had begun work in the UK in the previous two years so the sample was drawn from all doctors registered in between 1st April 2006 and 31st March 2008. The database was then stratified by country of qualification. The initial sample size was calculated for a postal questionnaire survey. But as we had the opportunity to conduct an electronic mailing through the GMC we were able to increase our sample size and send a combination of postal and electronic invitations. The sampling strategy was as follows:

From each band of Non UK qualifiers we selected 25 doctors who were sent a postal and electronic invitation to take part in the interview study.

From the remaining doctors in all bands (UK and Non UK) we selected a random sample up to 500 or in the case of bands with fewer than 500 doctors we selected all doctors within the band. These were sent the electronic version of the questionnaire survey.

Of these samples we randomly selected up to 180 doctors within each band who had a UK postal address. These doctors were sent the postal version of the questionnaire survey. The numbers in each category that were sent a postal survey depended upon the number which had a UK address. This varied considerably, for example it was estimated by the GMC that only 25% of the German doctors, compared with 86% of the Pakistani doctors would have a UK address. Table 3 summarises the number of doctors in each band and the sampling strategy.

Table 3: Sample Selection				
Country of qualification	Registered with GMC < 2years	Sent electronic questionnaire	Sent postal questionnaire	Sent interview letter only
UK	10,424	500	180	N/A
Egyptian	127	102	71	25
German	647	500	125	25
Greek	476	451	127	25
Indian	1373	500	180	25
Italian	425	400	100	25
Nigeria	344	319	180	25
Pakistani	728	500	180	25
Polish	661	500	180	25
South African	41	31	20	10
Spanish	133	108	30	25
Totals	15379	3911	1373	235

5.1.2 Questionnaire Survey

The questionnaire study was anonymous to maximise the response rate in what was seen as a sensitive study therefore follow up of non responders was not possible. A general reminder was sent electronically to the whole sample after four weeks. Those doctors receiving an electronic version had the option of printing it out and returning it to a Freepost address or emailing it to the study team. If the latter option was chosen the questionnaire attachment was saved in a password protected file and the email deleted to preserve anonymity.

5.1.3 Interview Study

Non UK qualifiers were sent both a postal and electronic version of the invitation to take part in the study. A reminder was sent after 4 weeks. Those doctors responding that they agreed to take part in the interview study were then contacted by one of the researchers (JP or RT). The Non UK qualifiers survey mailing included an invitation to take part in the interview. Questionnaire responders who also expressed an interest in taking part in the interview study were identified by returning an expression of interest form in a separate envelope to the questionnaire in order to maintain anonymity of the questionnaire responses. All doctors who expressed an interest in taking part in the interview study were provided with written information about this part of the study and then contacted by one of the researchers (JP or RT) who answered any further questions and arranged a convenient time for the telephone interview. Written consent was obtained for all interviews and verbal consent was obtained at the beginning of each telephone interview to confirm that the participant was still happy to take part.

5.1.4. Key Informant Interviews

Key informants were identified initially from a search of NHS Deanery and professional organisation websites and from personal contacts of one of the investigators (SC) who works extensively with refugee doctors in pre registration training. Further informants were identified by participants in the initial interviews adopting a snowballing technique. An email and/or telephone call to make contact was followed by emailing an information pack and consent form. Four interviews were done face to face, the remainder by telephone. All interviews were recorded and transcribed, written consent was obtained.

5.1.5 Focus Group Discussions

Two focus groups were held in London with non UK qualified doctors attending training or support programmes. One included doctors attending a study group as part of pre PLAB training and one included refugee doctors who had recently registered with the GMC and were on a training programme linked to clinical attachments. Each focus group was arranged through contact with a key informant. Understandably the people we were trying to access were busy professionals so finding a mutually convenient occasion for a number of them was always going to be something of a challenge. However the additional perspective gained by the data and insights generated from group interaction (Morgan 1997) was believed to be invaluable to the richness of the project. In order that the disruption to individuals and the time asked of them was minimal, the researchers liaised with the key informants to conduct the focus groups immediately after scheduled teaching or seminar times when people would already be gathered together. Information about the study was provided at least one week before and written consent obtained prior to the commencement of the meeting.

5.2 Sample Characteristics

5.2.1 Questionnaire Survey

The response rate to the questionnaire survey was disappointingly low but much better in the postal survey (109/1373 (8 %)) than the electronic survey (28/3911 (0.07%)). Because of time constraints of the study we were unable to follow this up. This is not entirely surprising given the target group (doctors who had only been working in the NHS a maximum of two years and some who were in their first six months of employment), content of the survey (ethical and professional attitudes and behaviour), and the perceived source of the survey (doctors' regulatory body), however the data can still shed some useful light on a previously under researched area. The majority of responses were from non UK qualified doctors (107/136 78%) therefore it was not possible to make comparisons between the two groups. We have presented data from the UK graduates separately to give some feel for the any possible differences or similarities.

The survey respondents varied in terms of age, gender, speciality, country of birth and qualification.

<u>Gender, Age and Year of Qualification</u>

The sample was fairly equally divided in terms of gender for the Non UK qualified doctors (55 male/52 female), whilst of the UK qualified doctors twice as many were female (9 male/21 female). There were differences in age for Non UK qualified doctors ranged from 24-64 and 78% were ≤ 40 years. The UK doctors' age ranged between 24-35, 86% were ≤ 27 years. They were not comparable concerning year of qualification as the Non UK qualified respondents obtained their first medical qualification between 1968 and 2007 with just under half (47%) qualified before 2000. UK qualified respondents qualified between 2006-2008, with 70% qualifying in 2007 or later since only those qualified in the last two years were surveyed.

Country of Medical Qualification

Respondents were asked for their country of first medical qualification.

Table 4: Country of Medical Qualification of Non UK Qualified Doctors		
Country	**Number of Respondents (N=107)**	**%**
Abu-Dhabi	1	0.9
Argentina	1	0.9
Australia	1	0.9
Brazil	1	0.9
Egypt	3	2.8
Germany	11	10.3
Greece	9	8.4
Hungary	1	0.9
India	11	10.3
Italy	12	11.2
Nigeria	19	17.8
Pakistan	12	11.2
Poland	11	10.3
Russia	2	1.9
South Africa	5	4.7
Slovakia	1	0.9
Spain	3	2.8
Ukraine	1	0.9
USA	2	1.9

Length and country of practice outside the UK

Respondents were asked to list up to three countries they had worked in outside the UK. Ninety eight (92%) had worked in one county outside the UK and fifteen had worked in two countries. The length of practice was between 6 months and 39 years and 60% had worked for three years or more outside the UK. None of the UK qualifiers had worked outside the UK. Table 5 summarises the different regions worked in before coming to the UK.

Table 5: Regions Worked in Prior to Arriving in UK (N=107)					
Region/Country	W. Europe	E. Europe	Africa	South Asia	Other
Numbers of respondents who had worked in one region prior to working in the UK	29 (27%)	9 (8%)	21 (20%)	23 (22%)	11 (10%)
Numbers of respondents who had worked in two countries within a region	6 (5.6%)	0 (0%)	3 (2.8%)	2 (1.8%)	4 (3.7%)

Speciality Training

Respondents were asked to list the clinical specialty that appeared on their GMC registration. Some respondents listed more than one, Table 6 summarises the range of specialties identified.

Table 6: Clinical Specialty of Respondents (N=107)		
	No of respondents	%
Family Medicine/General Practice	16	15
General Medicine	29	27.1
General Surgery	11	10.3
Paediatrics	14	13.1
Gerontology	1	.9
Anaesthetics	6	5.6
Intensive Care	5	4.7
Oncology	4	3.7
Obstetrics and Gynaecology	13	12.1
Palliative Medicine	2	1.8
Emergency Medicine	4	3.7
Orthopaedics	3	2.8
Psychiatry	3	2.8
Specialist surgery (cardiothoracic/head and neck/ENT/paediatric surgery)	6	5.6
Specialist Medicine (cardiology/neurology/GUM/gastroenterology/nephrology/dermatology)	7	6.6
Laboratory based specialty (immunology/microbiology/haematology)	3	2.8

5.2.2 Interviews and Focus Groups

A total of 26 interviews were conducted with Non UK qualified doctors, of these fifteen were male and eleven female. A range of countries of qualification were represented from South Asia Africa, Eastern and Western Europe, and on North American (see Table 7). The two focus groups also had representation from a range of countries all, as would be expected from the recruitment strategy, non European (see Table 8). There were fifteen key informants from a range of backgrounds relevant to the support of Non UK qualified doctors and their integration into the UK health care system (see Table 9).

Table 7: Doctor Interviewees' Country of Qualification	
Country of Qualification	**Number**
Poland	1
Egypt	1
South Africa	1
Greece	2
India	3
Nigeria	5
Hungary	1
Pakistan	5
Iran	1
Italy	2
Russia	1
Spain	1
Germany	1
United States	1

Table 8: Focus Groups Participants Country of Qualification	
Country of Qualification	**Number**
Bangladesh	2
Madagascar	1
Romania	1
Nigeria	1
Somalia	1
Beijing	1
Iraq	1
Pakistan	1
Afghanistan	2
Iran	1

Table 9: Key Informants' Background	
Background	**Number**
General Medical Council	2
British Medical Association	1
NHS Deaneries	5
Royal College of Surgeons	1
Organisations supporting health care professionals who are refugees	2
Trainers on Overseas and Refugee Doctor Programmes	2
Overseas Doctors Support Organisation	1
NHS Trust based programme to support International and Refugee Doctors entering work	1

5.3 Data Collection and Analysis

5.3.1 Questionnaire Survey

Responses to the questionnaires were inputted into an SPSS database. Descriptive statistics were used to analyse the quantitative data, each questionnaire was assigned a code for analysis of qualitative data within the questionnaire. Qualitative data in responses to the questions on ethical dilemmas experienced by participants were analysed with the interview transcripts using NVIVO 7 software.

5.3.2 Interviews and Focus Groups

Interviews and focus groups followed a topic guide (see Appendices 1-3) with the researchers using follow up and probe questions to explore specific issues in more detail. A common problem in research into ethical decision-making is that participants do not always articulate their experience of ethical dilemmas or decision-making in the language of ethics. Therefore in the doctor interviews and focus groups we used questions that invited discussion of situations where doctors experienced a difficult decision or a conflict of views or simply a feeling of discomfort over what was happening in a particular case. We then focussed on situations arising in four specific areas, consent, decisions about end of life care, confidentiality, and dealing with concerns about poor practice. We explored how doctors identified ethical issues, how they resolved dilemmas, and what support mechanisms they used in dealing with these issues. Key informant interviews focussed on the informants experience and views of information training and support available to non UK qualified doctors both pre and post registration, and potential difficulties that these doctors may face in practice. All interviews and focus groups were recorded and transcribed for analysis. Descriptive statistics in SPSS were used to analyse the quantitative data from the questionnaire survey. Qualitative data from the survey and transcripts of the interviews and focus groups were analysed using NVIVO 7 software. Collaborative data analysis was conducted with JP, RT, GH, and AS reading the same interview transcripts independently to identify emergent themes. AS and RT read all the qualitative data from the questionnaire survey. Subsequently a team meeting was arranged at which an agreed set of lower order descriptive categories arising from both the questionnaire and the interview data were established. This agreed process was utilised to increase inter rater reliability (Ford 2000, Bazeley 2007). The interview data was then coded accordingly by JP and RT and the full range of themes utilised but more structure was required in order to be able to clearly ‘tell’ the project (Richards 2005). Through meetings held between AS and GH, then GH and JP a merged set of themes was developed which encompassed all the previous ideas but in a more manageable form. This aided the vital conceptual clarity (Bazeley 2007) required in order to see what results were emerging from the process. These ‘distilled’ themes are those reflected in the sections of this final report.

Findings from the quantitative and qualitative data demonstrated triangulation and synergy from the different methods used and is presented together under key theme headings in the following sections.

6. Preparedness for Practice

6.1 Access to Information about UK Ethical and Professional Practice

Respondents to the questionnaire survey were asked when they had first received information about ethics of medical practice in the UK. Of the UK qualifiers 97% said that they received information in medical school. It is of interest that of the 106 Non UK qualifiers, 11 (10%) also said that they received information on UK ethical practice at medical school. About a third of respondents who qualified overseas said that they received information on arrival in the UK, and 88 (82%) received information when they registered with the GMC. A further 31% of overseas doctors received information on commencing an NHS post and 9% during pre registration training. It appears that most doctors who qualify overseas do not receive specific information about GMP or other ethical guidance until they are registered to work in the UK or are actually in a post. Three respondents said that they had never received such information.

When asked about the form the information took, most doctors (Non UK qualified 78%, UK qualified 90%) said copies of GMC guidance. Nearly all responding doctors had received the GMC information. There was less accessing of information from the Royal Colleges and the British Medical Association by the Non UK qualifiers than those recently qualified in the UK. The majority of UK doctors responded that they have also received ethics training at medical school.

Respondents were asked whether they were aware of guidance from specific organisations, and if so whether they had accessed the guidance, Table 10 summarises the responses. The survey item was: 'With reference to the following organisations please tick as many boxes as apply'.

Table 10: Awareness of and Access to Guidance

	Non- UK N=107		**UK N=30**	
Organisation	**I am aware of the guidance they produce (%)**	**I have accessed the guidance they produce (%)**	**I am aware of the guidance they produce (%)**	**I have accessed the guidance they produce (%)**
Department of Health	45 (42.1)	26 (24.3)	12 (40)	5 (16.7)
General Medical Council	93 (86.9)	69 (64.5)	28 (93.3)	25 (83.3)
British Medical Association	37 (34.6)	21 (19.6)	20 (66.7)	12 (40)
Royal College of Physicians	31 (29)	15 (14)	11 (36.7)	5 (16.7)
Royal College of Paediatrics and Child Health	17 (15.9)	5 (4.7)	9 (30)	3 (10)
Royal College of Surgeons	19 (17.8)	11 (10.3)	9 (30)	1 (3.3)
Royal College of General Practitioners	19 (17.8)	11 (10.3)	9 (30)	2 (6.7)
Royal College of Anaesthetists	13 (12.1)	7 (6.5)	6 (20)	2 (6.7)
Your own NHS Trust	68 (63.6)	54 (50.5)	20 (66.7)	12 (40)

Similarly to the survey findings the interviews with Non UK qualifiers illustrated that the GMC guidance in 'Good Medical Practice' (GMP) was the most commonly accessed source of information that was felt to be more or less useful. However, it was not always clear that

the guidance directly related to professional codes of practice or ethical standards for clinical practice.

"Did you receive any information about sort of the professional regulatory framework or on medical ethics more generally?

Participant: *From the General Medical Council?*

Interviewer: *Yes, when they knew you were interested in registering*

Participant: *I know this is supposed to be relating to Good Medical Practice I suspect that part of that must have been about ethics but I cannot remember the details*

Interviewer: *Yes do you think at the time you found it useful or not especially so?*

Participant: *It was useful even though it was not something I had not heard about before"*

(D8) Africa

Interviewer *"Were you offered any training on some of the professional frameworks or more specifically medical ethics?*

Participant: *I don't actually think so - all that I remember was there was the GMC booklet of Good Medical Practice which was quite helpful I think."*

(D4) Africa

"Well the GMC they referred me to some general not specifically for ethical things, just general aspects of good standards within the GMC and the website and sent me some information."

(D14) Middle East

"Sometimes actually the GMC website can be a bit difficult because a lot of different information …it's difficult to find the information in the time."

(D23) Europe

Some doctors thought that the GMC guidelines were not easy to apply in clinical practice.

"I think the GMC guidelines are more theoretical and for the GMC that's why it is important for this kind of research because the GMC has some standard paragraphs of such and such on the paper but how they apply … I am sorry to say it's a mess"

(D14) Middle East

"I mean a booklet is different from real situations, I am doing clinical practice consulting in my hospital in geriatric medicine and even if you work here a few years some of the issues are not black and white, or clear cut."

(FG1)

6.2 Training Prior to Registration

PLAB and Training Courses

Apart from the GMC information, Non UK qualified doctors are not consistently getting information and discussion about ethics either in training courses, post graduate education seminars or employee induction. Only 20% of Non UK qualified respondents said they received information during training courses for overseas doctors. Post graduate education seminars were a source of information for 37% of UK qualified doctors compared with 13% of Non UK qualifiers. Other sources of information listed included websites (unspecified), discussion with colleagues, PLAB preparation, and self education. All UK and 94% of Non UK qualifiers said that they understood the information received.

In the interviews, some key informants commented that PLAB was not necessarily comprehensive enough in its exploration of ethical understandings, although it incorporates ethical decision making, it was felt that it can be taught and passed without an understanding of the underlying principles. This was felt by those involved in training courses and is expressed here:

"Where the emphasis is very much on getting people through the exam and whatever it takes rather than preparing people to practice which should be the same thing and it is almost the same thing but it isn't quite, so I think there will be less talk about the underlying principles and more about what you need to say to get through the exams."

(K11)

The GMC is aware of the limitations of PLABs and has considered whether changes can be made to the examination so that it better tests ethical understanding.

"We have been discussing with our committee concerned with diversity and equality how the PLAB Part II examination (which is an OSCE clinical examination) should reflect situations that are representative of the sort of diversity of life in the UK. An obvious example is a situation where a partner accompanies a patient and they are a same sex couple."

(K4)

There were ideas of ways to improve the training and examination of ethical understandings of practice.

"That the broader responsibilities of doctors working in the UK… the diversity and the equality agenda, the ethics of practice of medicine, the expectations and the needs of patients in a UK context is a very legitimate issue and more and more of that is being written into the examination."

(K8)

Key informants who worked with overseas and refugee doctors thought that it was important in ethics education to get people from different backgrounds together in a place where they do not feel criticised or defensive barriers go up. Therefore, at least some training should be done outside of the pressurised clinical setting and where a range of perspectives can be explored.

"I think the most conducive thing to learning ethics is actually a non-judgemental atmosphere for discussion"

(K11)

"We have students from lots of different cultures it's not just like one culture and UK culture and have lots of different countries. So we can sit round a table with ten different people and say and what would you do in your country, what would you do in your country? And they can see its different from country to country so then without us having to say that we can say well in the UK this is what we would feel is appropriate… so it doesn't feel like we are saying you're wrong and we are right"

(K1)

Training programmes for refugee doctors run by Deaneries have many discussion opportunities for exploring ethical dilemmas but key informants expressed concerns about commercial PLAB training in this regard.

"*A lot of people who are doing PLAB for instance and preparing to work in the UK are not getting that, (they are) teaching each other and teaching themselves, going on courses run by commercial organisations and using websites developed as either peer support websites or sometimes run by commercial organizations."*

(K11)

"These are commercial courses that are completely beyond our control. We have no control over them and that is many overseas doctors first taste of training in the UK, of how things are in the UK."

(K7)

Non UK qualified doctors were asked if the content of the information that they received differed significantly from what they had expected. The majority (85%) said it did not and 10% responded that it did, mentioning the following issues as difficulties: Confidentiality in relation to family members and treatment of 16 year olds, competent patient refusal of treatment; UK law and social/cultural awareness. One respondent commented on lack of coherence of information with information scattered across leaflets and non functioning links to web based information.

7. Ethical Dilemmas in Practice

7.1 Identifying Ethical Dilemmas in Practice

7.1.1 Frequency of Facing Ethical Dilemmas

Questionnaire respondents were presented with a list of situations where medical decision making can be difficult and asked to rate how frequently they had encountered these dilemmas while working as a doctor in the UK, Table 11 summarises the responses.

It would appear from these answers that Non UK qualified doctors were less likely than UK qualifiers to encounter problems or ethical dilemmas concerning Do Not Resuscitate (DNR) orders, difficulties with individuals with impaired capacity, difficulties concerning disclosure, families of patients thinking differently, requests for assisted suicide and handling poor clinical practice in a colleague. Whilst this may be because they are older and more experienced clinically than the UK cohort, it may also indicate, that their awareness of these areas as ethical dilemmas and their communication skills in exploring them as being less good

.

A small number of doctors (14% of Non UK qualifiers) reported sometimes encountering situations where their preferred course of treatment conflicted with institutional policies, professional codes of ethics or law. This finding is of concern because it could indicate that some doctors are experiencing significant ethical conflict in complying with professional standards in the UK.

7.1.2 Difficulty of Resolving Ethical Dilemmas

Respondents were asked to say which of these suggested dilemmas they found the most difficult to resolve. For the UK qualified doctors two dilemmas stood out as the most difficult; identifying poor clinical practice in a colleague and disagreement among family members. The data from the non UK qualified doctors were more evenly spread although identifying poor practice was one of the items that scored highest, Table 12 summarises the responses to this question. Respondents were given an opportunity to identify other ethical dilemmas they considered difficult to resolve. One UK qualifier respondent gave the example of determining the age at which a child can make his or her own decisions and balancing this against child safety.

Table 11: Frequency of Facing Ethical Dilemmas (%)								
	Never		**Rarely**		**Sometimes**		**Often**	
	Non UK N=107	**UK N=30**	**Non UK N=107**	**UK N=30**	**Non UK N=107**	**UK N=30**	**Non UK N=107**	**UK N=30**
a) You cared for a terminally ill patient and the question of limiting life sustaining treatment or writing a Do Not Resuscitate order came up.	33 (31.8)	0 (0)	18 (16.8)	1 (3.3)	26 (24.3)	11 (36.7)	25 (23.4)	18 (60)
b) You cared for adult patients whose capacity for decision-making with respect to their own health was uncertain or impaired.	26 (24.3)	0 (0)	21 (19.6)	2 (6.7)	33 (30.8)	16 (53.3)	24 (22.4)	12 (40)
c) You were uncertain whether to maintain confidentiality of medical information.	39 (36.4)	6 (20)	38 (35.5)	12 (40)	24 (22.4)	9 (30)	4 (3.8)	2 (6.7)
d) There was significant disagreement among family members or caregivers on the proper course of treatment for the patient.	39 (36.4)	3 (10)	42 (39.3)	14 (46.7)	20 (18.7)	12 (40)	2 (1.9)	1 (3.3)
e) Your preferred course of treatment conflicted with institutional policies, professional codes of ethics or laws.	63 (58.9)	16 (53.3)	26 (24.3)	13 (43.3)	15 (14)	1 (3.3)	0 (0)	0 (0)
f) Scarcity of resources required you to make a difficult choice.	59 (55.1)	9 (30)	27 (25.2)	17 (56.7)	18 (16.6)	4 (13.3)	1 (.9)	0 (0)
g) A patient's cultural or religious views conflicted with your proposed course of treatment.	45 (42.1)	10 (33.3)	42 (39.3)	13 (43.3)	17 (15.9)	7 (23.3)	0 (0)	0 (0)
h) The patient disagreed with your preferred course of treatment for other reasons.	39 (36.4)	3 (10)	45 (42.1)	18 (60)	19 (17.8)	8 (26.7)	1 (.9)	1 (3.3)
i) You were uncertain if a diagnosis should be disclosed to the patient.	52 (48.6)	10 (33.3)	37 (34.6)	16 (53.3)	14 (13.1)	3 (10)	2 (1.9)	1 (3.3)
j) You were asked for assisted suicide or euthanasia.	104 (97.2)	17 (56.7)	0 (0)	11 (36.7)	0 (0)	2 (6.7)	0 (0)	0 (0)
k) You identified poor clinical or ethical practice in a colleague	51 (47.7)	6 (20)	40 (37.4)	14 (46.7)	1 (10.3)	10 (33.3)	2 (1.9)	0 (0)

Table 12: Difficulties of Resolving Ethical Dilemmas (%)		
	Non UK N=107	**UK N=30**
a) You cared for a terminally ill patient and the question of limiting life sustaining treatment or writing a Do Not Resuscitate order came up.	11 (10.3)	1 (3.3)
b) You cared for adult patients whose capacity for decision-making with respect to their own health was uncertain or impaired.	14 (13.1)	1 (3.3)
c) You were uncertain whether to maintain confidentiality of medical information.	8 (7.5)	2 (6.7)
d) There was significant disagreement among family members or caregivers on the proper course of treatment for the patient.	7 (6.5)	9 (30)
e) Your preferred course of treatment conflicted with institutional policies, professional codes of ethics or laws.	7 (6.5)	0 (0)
f) Scarcity of resources required you to make a difficult choice.	4 (3.7)	1 (3.3)
g) A patient's cultural or religious views conflicted with your proposed course of treatment.	10 (9.3)	0 (0)
h) The patient disagreed with your preferred course of treatment for other reasons.	4 (3.7)	1 (3.3)
i) You were uncertain if a diagnosis should be disclosed to the patient.	2 (1.9)	0 (0)
j) You were asked for assisted suicide or euthanasia.	16 (15)	1 (3.3)
k) You identified poor clinical or ethical practice in a colleague	18 (16.8)	14 (46.7)

7.2 Experiencing Ethical Dilemmas in Practice

Respondents were asked to describe a recent ethical dilemma that they had experienced in their work, the decisions that were made and the outcome. They were also asked to rate how satisfied they were with the final outcome on a scale of 1-10 where 1 was not satisfied and 10 was completely satisfied. A range of situations were described and it was clear from many of the descriptions that these cases often caused significant concern or distress for the doctors involved. Many of the dilemmas described fell into categories well documented in the literature including end of life decision making, consent and refusal of treatment, confidentiality, truth telling, the role of the family, and deciding for patients who lack capacity. A major source of ethical concern was disagreement with colleagues, which ranged from differing views regarding medication to concerns about poor clinical or ethical practice. The data presented here includes scenarios described by questionnaire respondents (Q) and examples related in the interviews with Non UK qualified doctors (D).

7.2.1 End of Life Decision-Making

Both UK and Non UK qualifiers described dilemmas around decisions to withhold or withdraw potentially life saving treatment, including the use of DNAR orders. Conflicting views between the clinicians and family were often the cause of the dilemma but even when there was no disagreement doctors identified these decisions as difficult. Most involved patients who lacked capacity to decide for themselves but this was not always the case. A UK

qualifier described a discussion about withholding treatment from a patient who was unable to speak but was able to understand the information.

"It was strange to be discussing the issue with the patient as normally people for end of life are not responsive either via illness or dense CVA etc, interesting but difficult!"

(Q20 UK)

Specific concerns raised centred around decisions being delayed, or made too hastily, or not being reviewed, resulting in actual or potential harm to patients.

"A very difficult decision with the family to what extent this patient should be treated and investigated. Active treatment withdrawn equals death of patient. However it took two weeks before first this decision was made and second when it was made, a long time was taken to find a palliative care placement, and as a result she died in hospital."

(Q19) UK

"A 'Do not attempt resuscitation' order had been placed and I had to discuss with the family (or was invited to discuss with the family by nursing staff). I was placed in an uncomfortable situation of having to re-establish whether the order had been indicated in the first instance."

(Q122) Africa

"…gentleman came in with a LRTI and a DNAR decision was made on admission by a consultant, probably based on the fact that chances of a successful CPR would be low. After a course of antibiotics the patient became brighter and I felt that the DNAR decision was inappropriate."

(Q129) Europe

Another difficult area identified by respondents was that of advance refusal of treatment. Dilemmas often centred on the interpretation of the advance refusal in the specific context of the patient's current condition, and the role of the family in either affirming that the patient would not have wanted treatment or disagreeing with what appears to be a valid advance refusal. This was also a concern for some interviewees.

"…her daughter was saying she had told her that she doesn't want any intensive investigation or any management and just keep her comfortable… and then she recovered and afterwards the patient told us that this was not her formal decision not to be resuscitated."

(D10) South Asia

One Non UK qualifier gave an example of good practice in a situation where interpretation of the advance refusal was unclear.

"A patient …had a pre existing living will in which invasive manoeuvres to prolong life were not to be carried out. The dilemma was how to classify the types of intervention given as invasive or non invasive and not to fail to treat the patient or go against their wishes. Several meetings were organised with the family and a list was made of what they thought the patient would consider as 'invasive' and these were avoided."

(Q163) Africa

7.2.3 Capacity, Consent and Refusal of Treatment

Many examples of dilemmas focussed on patients refusing treatment that the doctor considered to be in the patient's best interests, including refusal of blood transfusion by a Jehovah's witnesses. Both UK and Non UK qualifiers described extensive discussion and negotiation between clinicians, patients and families in these situations and generally expressed satisfaction with the outcome in terms of the ethical process even when the consequence of refusal was the patient's death. A few Non UK qualifiers rated the outcome in these cases as unsatisfactory while accepting the patient's right to make the decision.

"We struggled very hard to convince her but nothing could help us. We had to respect the patients' decision…"

(Q142)South Asia

"A patient had given advanced directives on not to transfuse blood under any circumstances. … and died in CCU due to cardiac failure, his directives were honoured and he paid with his life."

(Q143) South Asia

Another area where patient refusal of treatment created ethical dilemmas for respondents was that of patients in Accident and Emergency departments refusing treatment for overdoses or other forms of self harm. Difficulties in assessing capacity or eligibility to be held under the Mental Health Act were identified. However respondents reported reasonable satisfaction (6-10) on the outcomes of the cases described.

It would appear from the ethical dilemmas described that Non UK qualifiers recognise the importance placed on respecting a patient's right to refuse treatment but feel very uncomfortable with the consequences, particularly in relation to patients with physical conditions. This may be related to their experience of a different model of the patient doctor relationship in their country of qualification. The interviews with Non UK qualifiers would support this suggestion.

"*The whole approach of explaining every aspect of treatment and giving the patient the option to actually make her own decisions, it was something totally new to me because I was used to a system where - okay this is your condition this is your treatment that's it."*

(D11) Europe

The shared decision-making model of the relationship between patient and doctor, and the emphasis on patient autonomy, which is the cornerstone of GMC guidance on consent, was identified by many of the interviewees as a key difference between UK professional practice and practice in their country of qualification. Most appreciated the requirement of providing sufficient information to facilitate informed consent however the depth of detail that they felt they were expected to impart often differed from previous experiences. Many only realised this when they actually came to clinical practice.

"*When I first started I realised that I had to explain every single detail to the patient about the decision about what I am going to do, but I didn't have to do it to such an extent there (country of qualification).*"

(D6) Europe

"*In our country sometimes, you know, we don't have to leave everything to the patient we don't have to get consent for each and every thing*."

(D10) South Asia

This mismatch between previous experience and the UK culture of individual autonomy may also create conflict in the area of confidentiality.

7.2.4 Confidentiality and Disclosure of Information

Case descriptions from the questionnaire survey occasionally identified a dilemma around confidentiality although this appeared to be less of a problem for both UK and Non UK qualifiers than other issues identified. Examples included questions of sharing information with family members or with another health professional. However the interviews with Non UK qualifiers revealed difficulties in adjusting to the importance of confidentiality in UK professional practice and regulation and surprise at just how much emphasis was placed on protecting patients' information.

"*I have come to know that that the important things in the UK which I didn't really take seriously is confidentiality which is different … in our culture, confidentiality is important but in the UK it is very, very important*"

(FG2)

Recognising and adapting to the more obvious implications of the duty of confidentiality such as not deliberately disclosing information about a patient to a third party without consent was less of a problem for these doctors than the more subtle areas relating to data protection and processes of work.

"In the morning we take, print a list of patients to go on the ward round where we consult in a team bedside … so we write down this on the list [whispering] …one just put his in a bag [whispering] … and I realised that I had so many of them you know in my pocket …They did tell us … they did mention about confidentiality, but we were not expecting to such extent that you can't keep a paper in your pocket, these things are different from our system"

(FG2)

A potential problem for doctors faced with unfamiliar codes emphasising the duty of confidentiality is that they apply the code rigidly and have difficulty in judging when sharing of information is permissible or even required. One key informant who is involved in training Non UK qualified doctors described such a difficulty.

"*He was working on the surgical unit, he clerked a patient who was HIV positive. He didn't tell the surgeon the patient was HIV positive as he thought it was a breach of confidentiality*."

(K1)

However it is not only Non UK qualified doctors who struggle with judgements about whether to disclose confidential information. UK qualifiers in the questionnaire survey also described ethical difficulty in making these decisions. How these judgements are made and justified is influenced by a range of factors including GMC guidance, context of the case, established practice within the particular health care organisation and current professional and societal values. Understanding and negotiating these various considerations will be more of a challenge for doctors who are unfamiliar with institutional, professional and societal

values in the UK and who have already identified this as an area of distinct difference to their previous professional experience.

7.2.5 Involvement of Family in Decision-Making

One of the ethical issues that respondents to the questionnaire survey identified as encountering most frequently was a situation where there was significant disagreement among family members or caregivers on the proper course of treatment for the patient. This was confirmed as a key area of ethical difficulty for both UK and Non UK qualifiers in the specific ethical dilemmas they described in the survey. The situations described included, conflict between clinician and family about both decisions to treat and decisions to withhold treatment and conflicts between family members on the most appropriate care for a patient. A few respondents described cases where a relative disagreed with the previously expressed wishes of a patient to refuse treatment or as in one case the currently expressed views of the patient.

All respondents described discussion between the family and clinicians as an important part of resolution of these conflicts and generally expressed satisfaction with the outcome (although this maybe because the outcome was usually consistent with the clinicians' views). Two cases where the family's views prevailed were rated by the respondent as unsatisfactory (3 and 4 on a scale of 1 to 10). Interestingly as many of the cases related to withholding life sustaining treatment only one of the Non UK qualifiers expressed any disagreement with the clinician's decision in these cases. This would suggest that decisions to withhold life sustaining treatment may not create specific difficulties for doctors coming to the UK from different cultures although individual beliefs will influence practice as with doctors who qualify in the UK. In the interviews with Non UK qualifiers one doctor did describe discomfort with decisions to withdraw life sustaining treatment.

"*Yes actually I had a conversation or discussion before with one of the consultants and he said to me 'you have to think of... alright we can keep him alive ... take the reasons to keep him alive. If he is alive what quality of life will he have? Think about this' for me I feel ... it's not our decision is it? God decides that"*

(D2) Middle East

However most of the cases described in the survey were ones in which the respondent was not the doctor ultimately responsible for the decision. Responses to these situations might change when the observer becomes the decision maker.

A different ethical dilemma relating to family involvement involves disclosure of information, including providing information to families and withholding information from patients. As described above the interviews with Non UK qualifiers highlighted the disjunction they experienced between their previous experience and UK professional practice in the area of confidentiality in general. This was perhaps even more keenly felt in relation to families.

"*Clinically whatever I have seen in (country of qualification), I have never come across situations like this. You really have to think twice about telling a person, I mean the close family even about a patient's diagnosis"*

(D7) South Asia

"*Back home there is an entirely different situation my country - if the patient is diagnosed with ovarian cancer we will never go and tell the patient that you have ovarian cancer we would tell the relative, here the practice is entirely different, you would tell the patient."*

(FG2)

These doctors recognised that disclosure to families without the patient's consent is not acceptable in UK practice but however good practice is not always followed by UK practitioners. A UK qualifier in the questionnaire survey described their ethical discomfort when a woman from a minority ethnic group who did not speak English was not told that she had cancer at the request of her children. A mismatch between what the professional codes of conduct state and what is observed in practice can create difficulties for doctors trying to adapt to a different regulatory culture.

7.2.6 Relationship with colleagues

Both UK and Non UK qualifiers who responded to the questionnaire described dilemmas associated with their relationship with colleagues. Some Non UK qualifiers reported difficulties when they disagreed with clinical decisions or institutional policies:

"When analgesia prescription has to follow institutional standards, not clinical judgement of individual patients I had to follow institutional guidance grudgingly."

(Q130) Africa

Others were challenged by the practicalities of working in a multidisciplinary team where other non medical members of the team could make decisions that affected medical care.

"I have been surprised that clinically untrained staff …or with limited clinical knowledge …have got the legal power to challenge a clinical decision."

(Q116) Europe

Data from the interview sheds some light on these reactions to multidisciplinary team work. Many of the Non UK qualifiers described a much more hierarchical system within their country of qualification with doctors being perceived as being unchallengeable.

"*They see the doctor as a god so whatever the doctor says is right, those people they never object to anything, they are happy at everything whatever you say whatever you do*."

(D10) South Asia

However the survey data provided a clear picture of ethical concern by both UK and Non UK qualifiers in relation to observation or experience of poor professional practice by colleagues. Many of the situations described concerned delay in making a decision by a senior colleague with the result that a junior doctor either had to take responsibility themselves or patients were perceived to be harmed by, for example, not having an appropriate end of life care plan in place. Some dilemmas included situations where the junior doctor was placed in a position where they were acting in a way that conflicted with their own view of ethical practice and often they felt helpless to change the situation.

"I was upset as he was the consultant and I had no-one else to report him to. It was not the first time he has asked me to do something so unethical."

(Q23) Europe

"Personally, I ethically disagreed with the decision. I tried to argue that we needed to nominate an IMCA to determine the patients' best interests. However, I was overruled by my SHO, reg and consultant."

(Q01) UK

In most cases respondents expressed feelings of frustration and regret that even if they expressed their concerns about poor practice they were ignored.

"I told my senior registrar, and he stated it was to be noted. No punishment to my knowledge has been dealt. He is still doing it to this day."

(Q09) UK

There were occasional examples of doctors being able if not to confront poor practice directly, to change the situation to one with which they felt ethically comfortable.

"We (the junior doctors) then approached another consultant and the Macmillan team (who were involved since patient was on LCP). Both collectively decided to take patient off the pathway and offer treatment. The patient improved and was discharged home."

(Q144) South Asia

Witnessing of poor practice was an issue that was also raised in the interviews with Non UK qualifiers. Few participants raised the subject spontaneously however when asked, many had in fact already encountered episodes which left them uncomfortable. Some doctors were clear that if they experienced this situation they would discuss it with the person concerned or another colleague. However others expressed concerns about negative repercussions for themselves if they raised these concerns. In a situation where a doctor may already feel marginalised he or she will avoid doing something that might make them more unpopular. They would prefer to leave the decision to others.

"Well I think that if it was something that was life threatening to the patient probably I would have discussed it with somebody but since it wasn't I felt that surely my consultant will pick it up so I left in the hands of someone else'"

(D11) Europe

"*Yes it does happen, it definitely does happen ... you know here I think people feel a bit annoyed if you tell them about their mistake so ... if I am going to tell someone about his mistake he won't like me in future then ... I will refrain from those things*"

(D10) South Asia

It is also perhaps asking a lot of doctors who have recently become part of the system to act when they see others more established in the system ignoring poor practice.

"*The other interesting thing was that everyone in the hospital was discussing him but no-one ever approached him"*

(D10) South Asia

7.3 Applying 'Good Medical Practice'

The core guidance for all doctors working in the UK is 'Good Medical Practice' (GMP, GMC 2006). It is against the standards set out in this guidance that the GMC assesses a doctor's fitness to practise. The GMC has recently developed web based interactive case scenarios as an educational tool for doctors to raise awareness of the guidance and to illustrate how it should be applied in practice. We adapted this model for the questionnaire survey to explore doctors' decision making in four common situations that cause ethical difficulty and to examine to what extent their decision-making was consistent with GMP. Four scenarios were presented (these are reproduced in full in Appendix I). They included:
1. Consent (an elderly woman not wanting to know about the risks of a treatment)
2. Confidentiality (a mother wanting to know about her daughter's visit to her GP)
3. Treatment limitation (for a 40 year old man where family wishes are different from the clinician's advice)
4. Concern over a colleague's clinical practice (colleague smelling of alcohol when arriving for work). This scenario was based on one of the scenarios in the interactive web based resource on the GMC website (http://www.gmc-uk.org/guidance/case_studies/index.asp accessed 4.2.09)

Participants were given a range of options for action in each case and asked to choose which one was the most appropriate response. One of the options was more closely consistent with GMP than the others (see Appendix I)

Both Non UK and UK qualifiers gave a high level of positive responses in the first three scenarios to the course of action most closely consistent with GMP (71-98%). There was less consistency among both Non UK and UK qualifiers in their response to the fourth scenario (dealing with poor practice in a colleague). Some chose the option of speaking to the doctor and asking him to take time off work and others preferred the option of calling the GMC for advice. The highest response was to the option that reflected most closely GMP and the one which is set out on the GMC's 'Good Medical Practice in Action' website which was to ask the doctor to stop seeing patients immediately and that the senior partner would inform the Primary Care Trust (48% non UK and 40% UK). Table 13 shows the responses to the GMC preferred course of action:

Table 13 : Responses to GMP Consistent Course of Action in 4 Ethical Scenarios

	Non UK (N=107)	**UK (N=30)**
Scenario 1	89 (83.2%)	26 (86.7%)
Scenario 2	76 (71%)	27 (90%)
Scenario 3	98 (91.6%)	29 (96.7%)
Scenario 4	51 (47.7%)	12 (40%)

The results suggest that both Non UK and UK qualifiers are aware of GMP and can apply it to theoretical situations particularly around consent and end of life decision making. Dealing with poor practice appears to be much more problematic as already noted from the case descriptions and qualitative interviews. It is not clear from these results whether this is due to unfamiliarity with GMP guidance or reflects much greater discomfort about putting the guidance into practice in a clinical setting. The difference in responses between non UK and UK qualifiers consistent with GMP in the confidentiality case reflects the findings from the interviews and focus groups with Non UK qualifiers who described a clear disjunction

between their previous experience of confidentiality in their country of qualification and the regulatory framework relating to confidentiality in UK health care.

8. Adjusting to Practice Within the UK Regulatory Framework

Coming to practice in the UK inevitably meant some adjustment for every doctor involved in this project. For some the adjustment will be more difficult and complex than for others, for example refugee doctors may be dealing with major psychological and emotional trauma, family displacement and financial hardship in addition to re training and finding work in a competitive environment. Even for doctors who have chosen to move the transition to a different country and culture may be unsettling. General challenges and strategies for adjustment to working in a different health care system have been noted elsewhere (section 3). In this section we focus on the challenges and coping strategies for integration into an unfamiliar legal and professional framework.

8.1 Working in an Unfamiliar World

A common experience expressed by participants in the interview studies and focus groups with Non UK qualifiers was the recognition that they were working in a very different environment in terms of both overall attitudes to patients and the structured framework of rules governing clinical practice. For some this created insecurity and fear that they might inadvertently break the rules.

"*When you come here you definitely see the difference, its different laws, different approach to the patient, different approach to the visitors – the relatives, how to explain things, how do you let them know, what's the disease and the cause, why and here it's a bit different, a lot different and because the law is different and I am not familiar with it, I find this difficult. As my colleagues were saying, it makes you more aware and a bit scared not to do any stupid things as you could endanger your working future*."

(FG1)

Some immediately recognised that they were moving from a form of practice which had afforded them a more elevated status and in these settings where the doctor had more authority, there were fewer ethical dilemmas.

"*The way that medicine is practiced in my country is far different from that in the UK and the way the people are asking questions and how they know their rights is far more different…… In 'my country' the doctor is a kind of king who can do everything that he wants to, so there were no actual dilemmas because I was brought up in a way that whatever was decided was the right thing*"

(D11) Europe

Most key informants recognised the stress that working in an unfamiliar environment can create and the fact that it is more likely to be in the area of ethical and professional practice rather than clinical decision making where mistakes are made.

"*I think some have no idea how big the difference is going to be when they go out there, then they get into their first job they are so stressed and I tell them you are going to be so stressed, that's normal okay, its not you its normal. But they are so stressed and I think its very hard for them at that point to find someone to whom they can go and say 'yes I am out*

of my head here, I am really struggling'…When things go wrong usually for our doctor's(refugee doctors on clinical attachment) its not like they can give the wrong drug or whatever, its usually an approach to a patient or dealing with an ethical issue and they first of all they don't see the warning signals when things are starting to go wrong."

(K1)

Participants expressed surprise at the structured legal and professional framework around certain health care decisions such as consent. The impression gained was that in the UK processes and policies, often perceived as legally based, were much more explicit and prescriptive than in the countries in which the doctors had qualified. This was a source of anxiety in situations where doctors had received little information or training in these legal and professional frameworks prior to working in the UK.

"I think what was maybe difficult for me coming over here was that I did not know a lot about the legal system… I didn't really realise the people, people are more aware of doing things right doing it according to the law and things like that but I don't think there is such a focus on that practising in(country of qualification)."

(D4) Africa

Participant *"Well know the way that the whole NHS is based really on the way that doctors who here document you know events and…*
Interviewer: *Is that quite different to when you have practiced before back in(country of qualification)?*
Participant: *It is actually the record keeping is a bit different*
Interviewer: *In what way?*
Participant: *More detail here"*

(D6) Europe

"*We do consent our patients we have to … but we don't have such huge workload, paperwork in …"*

(D1) Europe

However some participants felt reassured by guidelines which provided a reassuring framework for 'good practice'.

Interviewer "*Yes, how have you felt about the decision making process, does it seem fairly transparent and right to you?"*
Participant: *"Yes it does yes, because yes we have followed the Liverpool Care Pathway which is like for terminally ill patients and that gives us definite guidelines what to consider and other side and things so it is really straight forward really"*

(D7) South Asia

Unfamiliarity with the regulations does not only relate to clinical care. Organisational policies and legislation relating to working practices can also create anxieties for doctors beginning work in the UK. What may be considered responsible behaviour in the workplace in one country may be viewed differently in another. One participant described the discomfort felt when behaving in what they considered a morally commendable way generated opprobrium rather then praise.

"One more thing I just remembered, whilst being on days on call I had bad tummy and fever overnight. I decided to go to work in the morning although I was ill as in my country we have the culture that men should tolerate this and my sense of responsibility ordered me to go to work. I heard that this could be considered bad practice. I have no idea what to do now, how it is viewed and whom to talk to?"

(D2) Middle East

8.2 Communication Difficulties

Communication at a number of different levels is a key area of difficulty for some Non UK qualified doctors and may create a sense of isolation. Clearly at a basic level language is extremely important and non EEA doctors are required to pass IELT[1] and PLAB before registration to ensure a minimum standard of English to facilitate appropriate practice. A concern among several key informants was that EEA doctors may also not have an adequate understanding of English but were not required to demonstrate their language skills.

"EEA doctors are treated differently because they don't have to take the PLAB exam but it is a big issue and in some ways a bigger issue than IMG's (International Medical Graduates) because IMG's do take an English language test and the PLAB."

(K4)

This concern was also expressed by one of the European doctors.

"for me we don't understand the English language as well so this is a problem as well and it is a totally different system but when we come here obviously I knew that there would be differences and I had to adapt to these differences because it was my choice to come I wasn't forced to come."

(D16) Europe

However it is often other aspects of communication that create difficulties in relationships with patients and colleagues. This may include failure to recognise or misinterpretation of non verbal clues such as facial expression or body language, or more subtle issues relating to cultural expectations of social behaviour. In the past ten years there has been a major focus on the development of communication skills in UK undergraduate teaching in recognition of the fact that communication is key to the patient doctor relationship and that often it is unsatisfactory. These difficulties will be greater for doctors whose language and cultural model of communication is different from that of the UK. Our interviewees identified a range of difficulties in communication in their experience of relating to both patients and colleagues.

One doctor reflected on the different use of eye contact and hand movement in different cultures which could lead to offence or misunderstanding.

[1] International English Language Testing

"the eye contact is other thing, here, in our country eye contact ... it's a natural response to establish eye contact and talk but otherwise ... I was told by one of our family ... the British… just be careful ... they never look at anybody like this ... so I think I had to change myself … …the other thing is tone ... there is something to do with the tone I think it almost makes it sound like one is arrogant."

(D9) South Asia

This doctor realised that the perception of the other person is extremely important and may be at odds with what the doctor in fact thinks he or she is communicating.

"I think this is very important because how we make the other person feel you generate a response from the other person really, a patient or your colleague or anybody."

(D9)

Both doctors and key informants also raised concerns around communication and misinterpretation of cultural behavioural norms.

"…because certain things will just happen in ignorance because it is accepted as fairly normal in a different part of the world and may not be normal here. For instance I can give you an example; a lot of people in the Middle East lot of the males in the Middle East express themselves by hugging. Now if I was to hug another male in this country I would probably be looked at a bit askance if you know what I mean?"

(D22) South Asia

"*Also its about politeness ... politeness is different in different countries ... I am second generation Indian and in my parents' language people don't use the words for please and thank you but it is very well understood whether you are saying please or thank you by the tone of your voice and the look of your face ... and in many languages this is the case ... So someone's perception of another person being rude may just be a cultural barrier.*"

(K11)

Misunderstanding of messages also occurred in training situations, with potential difficulties for future practice.

"They don't see the warning signals when things are starting to go wrong, then when their supervisor says I am not very happy with the way you have handled that. They have a scale of 1 to 10, where 10 is very happy and not very happy is about 7, where as we would put not very happy about ooh number 2"

(K1)

8.3 Sources of Support in Practice

8.3.1 Who Currently Provides Support?

All doctors develop informal support mechanisms to help them in dealing with difficult clinical and ethical decisions. They may also access more formal support for example by seeking advice from their defence union or professional association. We asked survey respondents what mechanisms of support that they would currently use in their clinical practice. Most doctors (both UK and Non UK qualifiers) identified medical colleagues (84% UK qualifiers and 97% UK qualifiers) and other health care professionals involved in the patient's care (56 % non UK qualifiers and 53% UK qualifiers). Only 21% of non UK qualifiers (13% UK) would contact the GMC and 13% (20% UK) would contact the BMA. Non UK qualified doctors were less likely to talk with a member of their family of a friend (10% cf 20%). It seems likely that doctors who have not trained and worked in the UK system previously would have less well established formal and informal mechanisms of support. Once again as in relation to information, Non UK qualified doctors were less likely to access support from the BMA, but more likely to seek support from a religious advisor or a hospital manager or legal department than UK qualified doctors.

Table 14: Support Currently Accessed (%)		
	Non UK N=107	UK N=30
Medical colleague	90 (84.1)	29 (96.7)
Other health care professional involved in the patient's care	60(56.1)	16 (53.3)
Clinical ethics committee	25 (23.4)	3 (10)
Hospital legal department	20 (18.7)	3 (10)
Hospital manager	11 (10.3)	1 (3.3)
Religious advisor	8 (7.5)	1 (3.3)
Defence organisation	24 (22.4)	7 (23.3)
General Medical Council	21 (19.6)	4 (13.3)
British Medical Association	13 (12.1)	6 (20)
A member of your family or a friend	11 (10.3)	6 (20)

One Non UK qualified doctor expressed a marked sense of isolation.

"I do not know where to get help from, during on call I feel helpless – working alone"
(Q114) South Asia.

In the interviews and focus groups with Non UK qualified doctors most, if not all, recognised that they were under prepared for the realities of clinical practice. This is not to say that they were unable to adapt and some fairly swiftly, some with self help and others identifying colleagues that would help.

"*I am flexible I just followed the others and I read a couple of guidelines ...how we should talk to patients, how we should explain what is going on and give them the option to choose so within some days I guess I changed my attitude.*"

(D11) Europe

"One of my previous work colleagues was quite up on things and when you are unsure about this sort of thin I go and speak to them." *(D5) Africa*

The difficulties for Non UK qualified doctors in accessing support, particularly peer support was acknowledged by the key informants.

"The UK graduates from … will come to this hospital, and they will all go off to lunch together- they will all go to the pub together….And they all moan about the consultant, oh he's not doing my assessment, he's not doing such and such, they're worried about a patient that was rude to them, whereas an overseas doctor or a refugee doctor will just go back to their own room." *(K1)*

"They lack someone they can go to who is not part of the hierarchy. …. the thing that they found most helpful was usually when they find another overseas trained doctor who says 'look in that situation this is what you have to do, it's okay having to ask, just do it and they can relate to them."

(K4)

Some doctors felt confident in approaching senior colleagues for support in resolving ethical dilemmas.

"I rang my registrar then we rang the consultant and he was kind enough to come over and he was involved as well and we discussed everything."

(D10) South Asia

"Well I am working at the NHS trust so I would discuss it with a consultant or somebody that has been working in London or in the hospital for longer than me."

(D17) Europe

However there was a clear difference in participants' experience of support from colleagues depending on whether they were in a training post or not (see section 8.3.3)

8.3.2 What Form of Support would be Useful?

Making ethical decisions can be difficult and there is evidence that clinicians value support in helping them to resolve ethical dilemmas in practice. We therefore asked survey respondents what support they could have used when faced with some of the difficult situations described. The responses suggest that both UK and Non UK qualified doctors would value help in dealing with ethically difficult situations. Overall slightly higher percentages of the UK qualified doctors identified support that would be useful and this may reflect the fact that all UK qualifier respondents were within two years of qualification and therefore likely to be less experienced and more likely to need reassurance. For Non UK qualifiers the form of support least likely to be used was help in talking through the ethical issues with your patients (21%) and the most likely to be used was professional reassurance that their decision was the correct one (49%). The answers to this question are summarised in table 15.

Table 15: Types of Support Doctors Could Have Used if Available (%)						
	Yes		No		Don't Know	
Non UK N=107 UK N=30 (percentages in brackets)	**Non UK N=107**	**UK N=30**	**Non UK N=107**	**UK N=30**	**Non UK N=107**	**UK N=30**
a) Help in making clear the ethical issues for yourself and your colleagues?	41 (38.3)	14 (46.7)	23 (21.5)	10 (33.3)	12 (11.2)	3 (10)
b) Help in talking through the ethical issues with your patient(s)?	23 (21.5)	9 (30)	38 (35.5)	16 (53.3)	14 (13.1)	1 (3.3)
c) Help in obtaining more complete information about the patient's situation than was available to you?	31 (29)	14 (46.7)	38 (35.5)	11 (36.7)	7 (6.5)	2 (6.7)
d) Someone with special skills and experience in ethics?	40 (37.4)	6 (20)	26 (24.3)	18 (60)	9 (8.4)	3 (10)
e) Someone capable of providing specific advice on the best course of action?	41 (38.3)	19 (63.3)	25 (23.4)	6 (20)	8 (7.5)	2 (6.7)
f) Help in mediating conflict among different points of view?	33 (30.8)	17 (56.7)	26 (24.3)	8 (26.7)	16 (15)	2 (6.7)
g) Alternative suggestions for ethically appropriate courses of action?	34 (31.8)	14 (46.7)	24 (22.4)	12 (40)	13 (12.1)	1 (3.3)
h) Someone who knew the law, organisational policy and/or national guidelines?	42 (39.3)	12 (40)	23 (21.5)	11 (36.7)	10 (9.3)	4 (13.3)
i) Provision of ethics literature relevant to the situation?	32 (29.9)	10 (33.3)	29 ((27.1)	13 (43.3)	15 (14)	4 (13.3)
j) Professional reassurance that your decision was the correct one?	51 (47.7)	17 (56.7)	15 (14)	8 (26.7)	8 (7.5)	2 (6.7)
k) Help in reviewing current standards of ethics?	35 (32.7)	11 (36.7)	31 (29)	15 (50)	8 (7.5)	1 (3.3)
l) Help in weighing all possible outcomes?	44 (41.1)	16 (53.3)	23 (21.5)	10 (33.3)	6 (5.6)	1 (3.3)
m) Help in making you more comfortable with the situation?	39 (36.4)	17 (56.7)	24 (22.4)	10 (33.3)	10 (9.3)	0 (0)
n) A discussion in advance to help prevent the difficulty?	41 (38.3)	16 (53.3)	25 (23.4)	9 (30	9 (8.4)	2 (6.7)
o) Other (please specify): …… ……..						

8.3.3 Suggestions for Making the Transition to Practice More Supported

Trainers were clear that both clinical attachments and training posts were ideal for making the transition to clinical practice smoother and more supported. There is a lack of support in non training posts that is as yet on the whole unmet.

"I think there should be additional support for overseas doctors definitely you know I think doctors should have gone through some kind of clinical attachment, I mean with the training posts now refugee doctors could go through an apprenticeship placement for 4 months before they can go into the Foundation posts so that's kind of an obvious way of building…"

(K10)

"Yes one of the things that I strongly encourage overseas doctors to do is to undertake a Foundation training post as their first post in the UK. That's getting harder unfortunately. The Foundation programmes include within them professional development programmes that include discussion of ethical issues."

(K7)

Some key informants were in favour of an increase in mentoring in clinical ethics particularly for those in non training positions during the first years of clinical practice.

"Trusts vary. In the case of staff grades and associate specialists, international graduates are disproportionately represented. Some trusts will be pretty good about having mentors available for everybody and that is everybody not only international graduates so people will go to their mentor in the first instance."

(K8)

"The other thing that we organised in Yorkshire that has been going a little bit longer than the induction programme, was a network of mentors for overseas doctors. This is s a group of senior doctors especially consultants who were interested in overseas doctors and made themselves available as mentors. We went for discussing difficulties, for discussing careers that kind of thing. The take up has been patchy. The fact is some are very busy, some of them hardly see anybody at all."

(K7)

"I don't know whether one should have a mentor, something like that would be very good experience, not necessarily in their field. I can think of advantages why it would be best not to have someone involved in their field."

(K9)

Many doctors interviewed did not feel that they were adequately prepared for working in the UK. Seven focus group participants who were asked whether they felt they had been adequately prepared for dealing with ethical difficulties in UK medical practice all answered "no".

Some doctors and key informants felt that if they came from the EU they should have training to adjust to UK (PLAB substitute)

"I think the UK accepts the fact that the doctors from the EU aren't trained in the same way at least about ethical issues. I don't know if you know we may have to take part in some mini exams or something just to challenge us and to test us."

(D6) Europe

"EEA doctors are treated differently because they don't have to take the PLAB exam but it is a big issue. In some ways it is a bigger issue than IMG's because IMG's do take an English language test and the PLAB test. European doctors …don't have to. European law says we have to recognise their qualifications and actually you know that's increasingly where a lot of the problems are coming. "

(K4)

Whilst those that had attended courses, often felt better prepared once in practice it was individuals who were fortunate enough to hold a training post that seemed the most likely to

feel any degree of security and to be able to translate this into effective clinical practice, workplace learning and communication. Having the security of an identified training post with both managerial and clinical lines of support was invaluable; these examples support the importance of both;

"*I think that the biggest impact was my first manager, well first line manager and I suppose whilst I was doing my training I think she was really the best in following ethical issues so I think she taught me a lot … I would say, the head of the department that was her and her deputy, both were great and they both have extreme attitudes to patients you know they want to do the best and sometimes even more if possible*."

(D1) Europe

"Whenever I have a situation that I couldn't cope and because I am a Senior House Officer I always have support from the Registrars or the Consultants. I will try every time that there was something that was arising to take the opportunity to ask and to see how we would cope with things."

(D16) Europe

Conversely the absence of this kind of supportive framework led to a situation where many of these doctors felt unsupported, marginalised and unappreciated, one even felt specifically victimised and bullied. This also meant that at times they were not sure where to turn for support.

"Just coming into the UK most people don't come into training posts so there is actually no-one looking after you. You know I am not even sure if I really had a line manager or anyone looking after me whilst I was in cardiac surgery… at one stage I considered contacting the Medical Protection Society."

(D4) Africa

" most of the work you do in the first instance is as a locum and if you are working as a locum you are not supervised to the same extent … so it is a bit different."

(D6) Europe

Interviews with key informant revealed that the support available outside of training posts was patchy.

"Trusts vary … some trusts will be pretty good about having mentors available for everybody."

(K8)

One participant, now in a training post and receiving excellent support, referred to prior experiences which had occurred outside of a training position as 'bullying' with a clear appreciation of differential dynamics of power.

"I used that word because I thought somebody was trying to use his or her power to make me feel uncomfortable in my position. This is definitely what some people have been doing. For example if the other doctor is a permanent doctor and if I have come there as a locum ... I know it's not right but soon I ignore it I pretend to not to understand... So this is a sort of

bullying but if I am going to be there for a short while as a locum it doesn't really affect me much."

(D9) South Asia

Unfortunately this was not an isolated experience as at least one other participant identified they too had some bad experiences prior to securing a training post and remained starkly aware of the contrast

"I am in a total different environment now and I am not experiencing anything like that … where I am working at the moment is great … everyone is practicing very ethically and there are no real concerns."

(D4) Africa

Non UK qualified doctors are overrepresented in non-training positions and therefore may be unsupported. Good working communication and constructive workplace relationships were seen as imperative throughout the transition to UK practice. Securing a training post generally seemed to establish these individuals within a network of support which better facilitated their ability to adapt. In the absence of this formal network the importance of these two elements of practice became more apparent. Most participants recognised that consultants in particular were extremely busy and they therefore sought most of their direct clinical support from either their peers or mid grade colleagues. Once again the experiences were patchy both with senior colleagues and peers;

"If I don't know something I can always go to my boss or my other colleagues and there are extremely patient because sometime my questions may be trivial to them but they do remember that I come from a different country and they remember that we may have slightly different approach to ethical issues."

(D11) Europe

"Senior doctors should be more approachable and more helpful to the junior and I am not just talking about the consultant, registrars should be more approachable … because even in my hospital there are a few registrars… you would never like to ask any questions of them because they will embarrass you."

(D10) South Asia

Ideally a safety net of support, communication and guidance should form the context within which these doctors dealt with everyday clinical practice. Currently it is not always in place.

9. Implications of the Study for Policy and Practice

9.1 Discussion

This study aimed to explore the experience of doctors who qualify outside the UK in adapting to practice within the UK professional regulatory framework as set out in 'Good Medical Practice' (GMP), including their access to information and advice in preparation for the transition, their ability to identify and resolve ethical dilemmas in practice and their specific support needs during the transition. A combination of qualitative and quantitative data were collected from doctors who had qualified overseas who were in the first two years post registration with the GMC, and key informants involved in provision of training and support for non UK qualified doctors. Comparative quantitative data was collected from a small number of UK qualified doctors in their first two years post registration. In this section we summarise the key findings in relation to the specific objectives of the study.

9.1.1 How Prepared are Non-UK Qualified Doctors for Entering Practice in the UK with Regard to Ethical and Professional Standards?

The main information, training, and support available to non UK qualified doctors wishing to work in the UK has little emphasis on ethical and professional standards but focuses mainly on practicalities of immigration, registration, availability of posts and, where required, passing the relevant examinations. None of the websites that a doctor seeking to work in the UK might access, including the GMC website, have clear signposting to the ethical standards required of doctors in the UK that would be easily apparent to a Non UK qualified doctor. Therefore it is unlikely that most Non UK qualified doctors will have accessed information on ethical standards and guidance prior to registration with the GMC.

The main source of information for these doctors is the copy of GMP that they receive on registration. However this is not always either read or understood and can be seen as difficult to interpret in the realities of day to day practice. This difficulty in relating GMC guidance to actual practice is not unique to Non UK qualified doctors. A study of UK doctors in 1999 found that although a majority were aware of GMP relatively few had read it carefully (only 4% stated that they had received a copy and knew its contents well (McManus 2001). Although both UK and Non UK qualifiers may share an unfamiliarity with the document the training of UK qualifiers will have been framed both explicitly and implicitly by its underlying principles and hence their practice is more likely to reflect GMP than a doctor who has been trained in a different system.

Non UK qualifiers seeking to work in the UK would benefit from more information about the legal and ethical framework within which health care operates prior to registration.

Other than provision of literature, there is limited opportunity for training for Non UK qualified doctors prior to registration or on entering the NHS workplace. Training for PLAB is not compulsory and can be of variable quality. Curricula include ethical issues such as consent and confidentiality but to what extent the training moves beyond reiteration of codes of practice and into the more subtle realms of identifying and resolving practical ethical dilemmas is uncertain.

The training available for refugee doctors, in line with other support for this group, is more extensive, and programmes include specific focus on exploring ethical cultural and legal norms in the UK. In contrast doctors from EEA countries do not require, and therefore will not obtain, any form of training or induction pre registration. Experience of induction courses for Non UK qualified doctors following registration was generally favourable but the availability of these courses is patchy and appears to be decreasing. Provision of induction for all Non UK qualifiers that included the ethical, legal and cultural context of working in UK health care should be considered.

9.1.2 How Does the Experience of Non UK Qualified Doctors in Identifying and Resolving Ethical Dilemmas in UK Practice Relate to 'Good Medical Practice'?

Many Non UK qualified doctors find a distinct difference in the ethical framework in which health care is practised in the UK compared to their country of qualification. The main contrast is in the model of doctor patient relationship and the emphasis on individual autonomy and patients' rights in the UK and the degree to which this is articulated and regulated in formal legal, ethical and institutional policies. The concepts of individual autonomy, duty of confidentiality, and informed consent to treatment are recognised as important by all doctors but the level of importance given to them in the UK was a surprise to many Non UK qualified doctors.

The formal process of informed consent was generally regarded as of benefit to practice, both in respecting patient involvement in their health care and in enhancing doctors' clinical competence (the need to explain in detail to the patient requires a doctor to maintain and update his or her knowledge regularly). The difficulties raised for Non UK qualified doctors were when the emphasis on patient autonomy conflicted with a medical view of what was in the patient's best interests (as in refusal of treatment) or restricted involvement of the family in the decision making process. The difference in cultural perspectives relating to family affects attitudes to confidentiality and information sharing. This is an area that creates particular difficulty for some Non UK qualifiers.

Dealing with poor practice in colleagues is a difficult area for both UK and non UK qualifiers. The hidden curriculum in medical training has been well documented (Stephenson 2006) and observing unethical or professionally questionable practice, particularly if it goes unchallenged buy other more senior doctors, will influence the behaviour of doctors who are often in junior positions, and who are anxious to become part of the community of medical practice. The provision of mentors who are outside the clinical team in which the doctor is working could provide support for doctors who have ethical concerns that are disregarded by their colleagues.

9.1.3 What Kind of Support and Training do Non UK Qualified Doctors Require in Relation to their Knowledge and Understanding of the Ethical and Legal Framework for Health Care in the UK?

Responses to the questionnaire show that both UK and Non UK qualified doctors have a good understanding of the elements of GMP at a theoretical level but their experience of putting these into practice in the day to day world of medical decision making may be more difficult. A study of UK medical graduates found that there was a need for more 'on the job' clinical training, highlighting the importance of experiential over observational and theoretical learning for clinical practice (Illing 2008). These doctors also identified a lack of knowledge in non clinical areas such as ethics and law on commencing Foundation posts. If

UK qualifiers require in practice training and support in ethical decision making on commencing clinical practice it is likely that Non UK qualifiers will have similar needs.

Whereas these doctors may be experienced clinically their knowledge of the legal, ethical and social context of UK health care is likely to be less than that of recently qualified UK graduates whose training has taken place within this context. Information available prior to practising in the UK is not sufficient and even if it were it is unlikely to adequately prepare doctors for the experience of working in the system.

A key message from the interviews with Non UK qualifiers and key informants involved in pre registration training was that recognition of the ethical, legal and cultural context of UK health care did not actually happen until doctors were working in practice, even if they had had good pre registration training. There is a need for training alongside clinical practice, either in protected clinical attachments or more generally during initial posts so that links can be made between experience and theoretical codes.

Many Non UK qualifiers have difficulties with communication on entering practice in the UK. These difficulties range from a poor understanding of English to much more subtle misunderstandings of the nuances of non verbal communication and social and behavioural norms. The multicultural nature of UK society provides added challenges requiring doctors to adapt and respond to several different communication styles. Great emphasis is now placed on communication skills teaching in UK undergraduate medical training and this has been accompanied by increased public expectation of competence in communication in addition to clinical competence (Chisholm 2005, Wensing 1998). Non UK qualified doctors who are required to pass PLAB prior to registration will have some assessment of their communication skills in a UK health care context but this will be limited and EEA doctors are not required to demonstrate any proficiency in communication prior to registration. Training in communication skills was identified as particularly useful in the induction programmes attended by some Non UK qualifiers.

There is a clear difference in the perception of Non UK qualified doctors on how supported they feel in practice depending on whether or not they are in a formal training post. Several of the participants had experience of both, usually being in non training posts initially prior to securing an established position. Training posts provide an environment of supported learning and senior clinicians are expected to provide advice and mentorship to trainees. Participants who were in training posts were enthusiastic in their praise of senior colleagues who took the time to answer questions and provide advice in ethically difficult situations. In contrast non training posts are often short term with no identified line manager and an expectation that the doctor should be able to cope on his or her own. The lack of an established peer network for Non UK qualified doctors particularly in the initial stages of employment increases the isolation experienced by many in an unsupported clinical environment. In view of the large number of Non UK qualified doctors in non training posts and the reduction in opportunities for training posts for these doctors, the question of support in these posts is a pressing one.

9.1.4 Different Background, Different Perspectives, Different Needs?

It is important to note that Non UK qualified doctors come from a variety of different clinical, cultural and historical backgrounds and therefore their needs for information training and support are likely to be varied. Refugees, in particular, are likely to have additional challenges, such as gaps in employment, lack of preparation for working or living in the UK

and may be dealing with psychological trauma. However, this group is more supported and their range of needs are better recognised by refugee services, some of which offer free training and support towards IELT and PLAB and help in finding clinical attachments. Key informants working with refugee doctors highlighted the importance of in practice training in the form of supernumerary clinical attachments. This is not a feasible option for doctors who have come to the UK specifically to work but the issue of in practice support particularly in the transition period is also relevant for this group of doctors.

There is a fundamental difference in approach to Non UK qualified doctors between EEA doctors and others in that EEA doctors are not required to pass PLAB. However many European doctors will have similar difficulties with communication or lack of familiarity with the shared decision making model of health care as their non EEA counterparts. Information, education and support for EEA doctors are also required.

9.2 Limitations of the Study

The use of mixed methods provided a triangulated data set giving the study strength. The sample for both qualitative and quantitative data collection included representation from a range of countries of qualification, medical specialties and working environments of the participants.

The poor response rate to the questionnaire survey led to a sample size too small to make any statistical comparisons between UK and Non UK qualifiers. However qualitative data from the questionnaires enriched the qualitative analysis of the interview study providing case scenarios from all 137 respondents. Time constraints did not allow for full piloting and validation of the questionnaire survey although several components were drawn from a previously validated survey instrument (Hurst 2006). All UK doctors had less than two years of practice while many of the Non U K qualified doctors had many years of experience prior to coming to the UK. The groups were therefore not matched for experience in medical practice although were matched for experience of working in the UK health care system. This limited the comparison between the two groups.

9.3 Conclusion and Implications for Policy and Practice

This study has identified a number of difficulties experienced by Non UK qualified doctors in their transition to practice within the UK ethical and professional regulatory framework. These include a marked lack of relevant information about legal ethical and professional standards and guidance prior to registration, variable levels of training and support specifically in the areas of communication and ethical decision making, and isolation in non training posts.

Non UK qualifiers share many similarities with recently graduated UK doctors in identifying the importance of experiential training, and unfamiliarity with legal, ethical and institutional policies on commencing work. Their identified limited knowledge of GMP and difficulty in dealing with poorly performing colleagues is shared by many UK qualified doctors as shown in this and other studies.

The key difference between Non UK qualifiers and UK qualifiers is the emphasis on individual autonomy and shared decision making between doctor and patient which is the current norm in the UK and the contrast with their experience of a more paternalistic model of the patient doctor relationship in their country of qualification. UK qualifiers have been trained within this philosophical and social context and the legal and professional guidance that supports it. Non UK qualifiers are presented with the guidance and regulatory framework but lack the tacit knowledge of the context in which the law and guidance was developed. Provision of specific information and educational resources prior to registration, accompanied by in practice support would help to facilitate a more effective understanding of GMP and its implications for practice in the UK.

A further implication of our findings relates to the role of the GMC in registering doctors to practice in the UK. Our study suggests that at least some Non UK qualified doctors enter UK practice with little information and training on the professional regulatory framework embodied in Good Medical Practice, and no experience of applying this in clinical practice. If the standard expected of doctors registered with the GMC is that of GMP there is a question of how doctors applying for registration with the GMC demonstrate that they meet this standard. This will be the case for all doctors registering with the GMC but particularly so for those doctors who have not been trained within this professional regulatory framework.

10. Recommendations

1. Improved Access to Information Pre Registration

Information for Non UK qualified doctors prior to registration should include reference to professional standards and the legal and ethical frameworks that govern medical practice in the UK. The striking lack of this information in an immediately recognisable format on all websites likely to be accessed by these doctors, including the GMC site, is a cause of significant concern. Ideally there should be a single portal for all relevant information for doctors considering coming to work in the UK. This could include a range of information with links to other relevant sites. There should be clear information on professional standards, relevant legislation for health care practice, and ethical guidance. The GMC's own website should give increased prominence and clearer links to professional standards and guidance for Non UK qualified doctors.

We recommend that a web based portal for information prior to registration for Non UK qualified doctors is developed, hosted by or supported by the GMC.

1. GMC Resources for Non UK Qualified Doctors in Practice

Information and guidance on ethical issues will only really become relevant when doctors begin practising. The importance of in practice training and support has been recognised for all doctors but is not always available to Non UK qualifiers. The GMC could provide support materials relevant to Non UK qualified doctors specifically focussing on the application of legal, ethical and professional guidance in practice. An example would be an electronic newsletter with focuses on a specific ethical issue, with links to the relevant guidance and case examples. Collaboration with Non UK qualified doctors who could describe their own experience and provide input into the development of hypothetical cases would make the resource more relevant. Current GMC guidance has been developed in the context of a gradual shift within UK health care and society in general to a greater emphasis on individual autonomy reflected in the focus on shared decision making and patient centred care. This contextual background is unfamiliar to Non UK qualified doctors. The GMC may wish to consider producing a brief introduction to the philosophical, legal and social context within which the professional guidance and standards have been developed in the UK to assist their understanding and interpretation of GMP and other GMC guidance.

We recommend that the GMC considers developing specific resources to support Non UK qualified doctors in practice

2. Induction for Non UK Qualified Doctors Commencing Work in the UK

Most Non UK qualified doctors are unfamiliar with the legal, ethical and institutional framework for health care within the UK. Doctors who have experienced induction programmes have found them helpful. Doctors entering training posts are likely to have appropriate induction but this will not be true of the many doctors who commence in non training posts. Some form of induction should be required for all doctors therefore it may be necessary for specific induction to be developed for doctors entering non training posts. Induction should include consideration of the legal, ethical and social context of health care in the UK.

We recommend that NHS Trusts and Post Graduate Deaneries provide appropriate induction for all Non UK Qualified Doctors, including EEA doctors, to include specific consideration of the legal, ethical and social context of health care in the UK.

3. In Practice Mentoring for Non UK Qualified Doctors

Many Non UK doctors, particularly in non training posts, experience isolation and a lack of support when faced with difficult ethical dilemmas. Mentoring schemes, including mentors who are themselves Non UK qualified doctors, offer an opportunity to provide support for these doctors and facilitate their integration. There are a few schemes already in operation in some areas of the UK.

We recommend that there should be mentorship schemes for all Non UK qualified doctors, including those from the EEA, during the first two years of employment, building on current pilot schemes for refugee doctors

Although this study focussed on Non UK qualified doctors, it is evident that UK qualified doctors also have difficulties in facing ethical dilemmas in their work. The need for support in dealing with these dilemmas, including responding to observation of poor practice in colleagues, is not restricted to Non UK qualifiers. The development of mentors, particularly for doctors in junior positions, should be considered more widely. With regard to facing ethical dilemmas in the practice of medicine Non UK and UK qualifiers have more similarities than differences.

References

Bazeley, P. Qualitative Data Analysis with NVIVO. Australia, SAGE Publications Limited.

Bosshard, G., T. Nilstun, et al. (2005). "Forgoing treatment at the end of life in 6 European countries." *Arch Intern Med* 165(4): 401-7.

Chan, H. M. (2004). "Sharing death and dying: advance directives, autonomy and the family." *Bioethics* 18(2): 87-103.

Chaturvedi, S. K. (2008). "Ethical dilemmas in palliative care in traditional developing societies, with special reference to the Indian setting." *J Med Ethics* 34(8): 611-5.

Chisholm, A., Cairncross, L., Askham, J. (2006). "Setting Standards The views of members of the public and doctors on the standards of care and practice they expect of doctors." Picker Institute: 1-90.

Claudot, F., F. Alla, et al. (2007). "Teaching ethics in Europe." *J Med Ethics* 33(8): 491-5.

Cohen, J., J. van Delden, et al. (2008). "Influence of physicians' life stances on attitudes to end-of-life decisions and actual end-of-life decision-making in six countries." *J Med Ethics* 34(4): 247-53.

Consensus Statement (1998). "Teaching medical ethics and law within medical education: a model for the UK core curriculum." *J Med Ethics* 24(3): 188-92.

Curran, V., A. Hollett, et al. (2008). "A qualitative study of the international medical graduate and the orientation process." *Can J Rural Med* 13(4): 163-9.

Cuttini, M., M. Nadai, et al. (2000). "End-of-life decisions in neonatal intensive care: physicians' self-reported practices in seven European countries. EURONIC Study Group." *Lancet* 355(9221): 2112-8.

Eckles, R. E., E. M. Meslin, et al. (2005). "Medical ethics education: where are we? Where should we be going? A review." *Acad Med* 80(12): 1143-52.

Feldman, M. D., J. Zhang, et al. (1999). "Chinese and U.S. internists adhere to different ethical standards." *J Gen Intern Med* 14(8): 469-73.

Fiscella, K., M. Roman-Diaz, et al. (1997). "'Being a foreigner, I may be punished if I make a small mistake': assessing transcultural experiences in caring for patients." *Fam Pract* 14(2): 112-6.

Ford, K., Oberski, I., Higgins, S. (2000). Computer-Aided Qualitative Analysis of Interview Data: Some Recommendations for Collaborative Working. 4: 1-12.

Ganz FD, Benbenishty J, Hersch M, Fischer A, Gurman D, Sprung CL. The impact of regional culture on intensive care end of life decision making: an Israeli perspective from the ETHICUS study. *J. Med. Ethics* 2006;32;196-199

General Medical Council (2006) Good Medical Practice
http://www.gmc-uk.org/guidance/good_medical_practice/index.asp accessed 20.2.09

General Medical Council. (1993) Tomorrow's Doctors.
http://www.gmc-uk.org/education/documents/Tomorrows_Doctors_1993.pdf accessed 20.2.09

General Medical Council. (2008) Consent: patients and doctors making decisions together.
http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance/index.asp accessed 20.2.09

General Medical Council. (2008) Medical students: Professional behaviour and Fitness to Practise.
http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/professional_behaviour.asp accessed 20.2.09

Goldie, J. (2000). "Review of ethics curricula in undergraduate medical education." *Med Educ* 34(2): 108-19.

Hafferty, F. W. and R. Franks (1994). "The hidden curriculum, ethics teaching, and the structure of medical education." *Acad Med* 69(11): 861-71.

Hall, P., E. Keely, et al. (2004). "Communication skills, cultural challenges and individual support: challenges of international medical graduates in a Canadian healthcare environment." *Med Teach* 26(2): 120-5.

Hawken, S. (2005). "Overseas-trained doctors' evaluation of a New Zealand course in professional development." *N Z Med J* 118(1219): U1584.

Hurst, S. A., A. Perrier, et al. (2007). "Ethical difficulties in clinical practice: experiences of European doctors." *J Med Ethics* 33(1): 51-7.

Hurst, S. A., A. M. Slowther, et al. (2006). "Prevalence and determinants of physician bedside rationing: data from Europe." *J Gen Intern Med* 21(11): 1138-43.

Illing, J., Kergon, C., Morrow, G., Burford, B., Bedi, A. How prepared are medical students to begin practice? A comparison of three diverse UK Medical Schools (2008) GMC.
http://www.gmc-uk.org/about/research/REPORT%20-preparedness%20of%20medical%20grads.pdf accessed 20.2.09

Jafarey, A. M. and A. Farooqui (2005). "Informed consent in the Pakistani milieu: the physician's perspective." *J Med Ethics* 31(2): 93-6.

Kales, H. C., A. R. Di Nardo, et al. (2006). "International medical graduates and the diagnosis and treatment of late-life depression." *Acad Med* 81(2): 171-5.

Lehmann, L. S., W. S. Kasoff, et al. (2004). "A survey of medical ethics education at U.S. and Canadian medical schools." *Acad Med* 79(7): 682-9.

Levin, B. W. (1990). "International perspectives on treatment choice in neonatal intensive care units." *Soc Sci Med* 30(8): 901-12.

Lynoe, N., R. Lofmark, et al. (2008). "Teaching medical ethics: what is the impact of role models? Some experiences from Swedish medical schools." *J Med Ethics* 34(4): 315-6.

Mattick, K. and J. Bligh (2006). "Undergraduate ethics teaching: revisiting the Consensus Statement." *Med Educ* 40(4): 329-32.

Miccinesi, G., S. Fischer, et al. (2005). "Physicians' attitudes towards end-of-life decisions: a comparison between seven countries." *Soc Sci Med* 60(9): 1961-74.

Miyasaka, M., A. Akabayashi, et al. (1999). "An international survey of medical ethics curricula in Asia." *J Med Ethics* 25(6): 514-21.

Mobeireek, A. F., F. Al-Kassimi, et al. (2008). "Information disclosure and decision-making: the Middle East versus the Far East and the West." *J Med Ethics* 34(4): 225-9.

Molloy, A. (1980). "Attitudes to medical ethics among British Muslim medical practitioners." *J Med Ethics* 6(3): 139-44.

Padela, A. I., H. Shanawani, et al. (2008). "The perceived role of Islam in immigrant Muslim medical practice within the USA: an exploratory qualitative study." *J Med Ethics* 34(5): 365-9.

Peters, J., I. C. McManus, et al. (2001). "Good Medical Practice: comparing the views of doctors and the general population." *Med Educ* 35 Suppl 1: 52-9.

Pilotto, L. S., G. F. Duncan, et al. (2007). "Issues for clinicians training international medical graduates: a systematic review." *Med J Aust* 187(4): 225-8.

Rebagliato, M., M. Cuttini, et al. (2000). "Neonatal end-of-life decision making: Physicians' attitudes and relationship with self-reported practices in 10 European countries." *JAMA* 284(19): 2451-9.

Rhodes, R. (2002). "Two concepts of medical ethics and their implications for medical ethics education." *J Med Philos* 27(4): 493-508.

Richards, L. Handling Qualitative Data A practical Guide. Melbourne, Australia, SAGE Publications Limited.

Richter, J., M. Eisemann, et al. (2001). "Doctors' authoritarianism in end-of-life treatment decisions. A comparison between Russia, Sweden and Germany." *J Med Ethics* 27(3): 186-91.

Roberts, L. W., T. D. Warner, et al. (2005). "Becoming a good doctor: perceived need for ethics training focused on practical and professional development topics." *Acad Psychiatry* 29(3): 301-9.

Rodriguez-Arias, D. M., G. Aulliso, M.P. Salfati, A. Coffin, J.C. Rodriguez-Arias, J.L. Calvo, L. Herve, C. (2007). "Advance directives and the family: French and American perspectives." *Clinical Ethics*: 139-145.

Roff, S. and P. Preece (2004). "Helping medical students to find their moral compasses: ethics teaching for second and third year undergraduates." *J Med Ethics* 30(5): 487-9.

Ruhnke, G. W., S. R. Wilson, et al. (2000). "Ethical decision making and patient autonomy: a comparison of physicians and patients in Japan and the United States." *Chest* 118(4): 1172-82.

Searight, H. R. and J. Gafford (2006). "Behavioral science education and the international medical graduate." *Acad Med* 81(2): 164-70.

Silverberg, L. I. (2000). "Survey of medical ethics in US medical schools: a descriptive study." *J Am Osteopath Assoc* 100(6): 373-8.

Sprung, C. L., P. Maia, et al. (2007). "The importance of religious affiliation and culture on end-of-life decisions in European intensive care units." *Intensive Care Med* 33(10): 1732-9.

Stephenson, A. E., L. E. Adshead, et al. (2006). "The teaching of professional attitudes within UK medical schools: Reported difficulties and good practice." *Med Educ* 40(11): 1072-80.

Thulesius, H. O., K. Sallin, et al. (2007). "Proximity morality in medical school--medical students forming physician morality "on the job": grounded theory analysis of a student survey." *BMC Med Educ* 7: 27.

U. K. Parliament (2005). Mental Capacity Act 2005: 1-88.

Willems, D. L., E. R. Daniels, et al. (2000). "Attitudes and practices concerning the end of life: a comparison between physicians from the United States and from The Netherlands." *Arch Intern Med* 160(1): 63-8.

Ypinazar, V. A. and S. A. Margolis (2004). "Western medical ethics taught to junior medical students can cross cultural and linguistic boundaries." *BMC Med Ethics* 5: E4.

Zulla, R., M. O. Baerlocher, et al. (2008). "International medical graduates (IMGs) needs assessment study: comparison between current IMG trainees and program directors." *BMC Med Educ* 8: 42.

Appendices

Appendix I: Questionnaire

Questionnaire version 1 21.7.08

Exploring doctor's experience of ethical decision-making in medical practice within the UK health care system: a questionnaire survey

MREC number

Thank you for completing this questionnaire. We value your views. Many of the questions require only tick box answers so are quick to complete. Some will take slightly longer. The whole questionnaire should take approximately 30 minutes to complete.

Background information

1) Date commenced work as a doctor in the UK day/month/year _ _/_ _/_ _ _ _

2) Gender: □ Male □ Female

3) Age: _ _

4) What specialty training do you have? (tick all that apply)

Family medicine/general practice	
General Medicine	
General Surgery	
Paediatrics	
Gerontology	
Anaesthetics	
Intensive Care	
Oncology	
Obstetrics and Gynaecology	
Palliative medicine	
Other (please specify)	
None	

5) In what country were you born? ……..

6) a) In what country did you obtain your medical qualification?.....

b) In what year did you qualify……dd/mm/yyyy……..……

7) Since graduating how many years have you worked as a doctor outside the UK?

Country worked in Number of years

1……

2……

3……

Access to information about GMC guidance

8) When did you receive information on the ethics of medical practice in the UK? (you may tick more than one box)

When you were at Medical School	☐
When you arrived in the UK (overseas qualified doctors)	☐
When you registered with the GMC	☐
When you started your NHS post	☐
During any pre registration training (overseas qualified doctors)	☐
Never	☐

9) What form did this information take? (You may tick more than one box)

Copies of GMC guidance	☐
Teaching sessions/seminars at Medical School	☐
Teaching sessions/seminars on training course for overseas doctors	☐
Post graduate education seminars	☐
Employer induction	☐
Information on registration with the GMC	☐
Other (please specify)	☐

10) Did you understand the information that you were given? Yes ☐ No ☐

11) If no were you aware of sources available to help you understand it?
Yes ☐ No ☐

Please specify……

12) **Overseas qualified doctors only**. Did the content of the information/guidance differ significantly from what you had expected? Yes ☐ No ☐

If yes, in what way?
……
……
……

Ethical dilemmas in practice
Below is a list of situations where medical decision-making can be difficult. Please tell us how often you have faced each kind of situation in your work since you began working as a doctor in the UK.

13) Since you began working as a doctor in the UK, how often have you been in the following situations?

	Never	**Rarely**	**Sometimes**	**Often**
a) You cared for a terminally ill patient and the question of limiting life sustaining treatment or writing a Do Not Resuscitate order came up.				
b) You cared for adult patients whose capacity for decision-making with respect to their own health was uncertain or impaired.				
c) You were uncertain whether to maintain confidentiality of medical information.				
d) There was significant disagreement among family members or caregivers on the proper course of treatment for the patient.				
e) Your preferred course of treatment conflicted with institutional policies, professional codes of ethics or laws.				
f) Scarcity of resources required you to make a difficult choice.				
g) A patient's cultural or religious views conflicted with your proposed course of treatment.				
h) The patient disagreed with your preferred course of treatment for other reasons.				
i) You were uncertain if a diagnosis should be disclosed to the patient.				
j) You were asked for assisted suicide or euthanasia.				
k) You identified poor clinical or ethical practice in a colleague				

14) Which of these types of ethical dilemmas or problems in your work would you say is **the most difficult** to resolve? (Tick only one)

□ a □ b □ c □ d □ e □ f □ g □ h □ i □ j □ k

□ Other (please specify): ……..

15) Can you describe a recent ethical dilemma you experienced in your work? The example can come from any aspect of patient care or organizational process. It would be best if you picked a situation that has completely run its course. If you do not have enough room, please continue on the back of the questionnaire.

16) What do you consider to be the **primary (main)** ethical issue or dilemma raised by the situation? (Mark only one. The letters refer to question 13)

□ a □ b □ c □ d □ e □ f □ g □ h □ i □ j □ k

□ other (please specify):……
……
……
……..

17) Please briefly describe the decisions that were made and what happened as a result.

18) Please score on a scale of 1 to 10 how satisfied you were with the decisions that got made in this situation? (1 is not satisfied and ten is extremely satisfied)

Not satisfied **extremely satisfied**

1 2 3 4 5 6 7 8 9 10

19) In thinking back on the case, could you have used:

	Yes	**No**	**I don't know**
a) Help in making clear the ethical issues for yourself and your colleagues?			
b) Help in talking through the ethical issues with your patient(s)?			
c) Help in obtaining more complete information about the patient's situation than was available to you?			
d) Someone with special skills and experience in ethics?			
e) Someone capable of providing specific advice on the best course of action?			
f) Help in mediating conflict among different points of view?			
g) Alternative suggestions for ethically appropriate courses of action?			
h) Someone who knew the law, organisational policy and/or national guidelines?			
i) Provision of ethics literature relevant to the situation?			
j) Professional reassurance that your decision was the correct one?			
k) Help in reviewing current standards of ethics?			
l) Help in weighing all possible outcomes?			
m) Help in making you more comfortable with the situation?			
n) A discussion in advance to help prevent the difficulty?			
o) Other (please specify): ……..			

20) Who would you **usually** speak to if you needed advice about an ethical dilemma in your clinical work? You may tick more than one box.

Medical colleague	
Other health care professional involved in the patient's care	
Clinical ethics committee	
Hospital legal department	
Hospital manager	
Religious advisor	
Defence Organisation	
General Medical Council	
British Medical Association	
A member of your family or a friend	
Other (please specify)	

21) With reference to the following organisations please tick as many boxes as apply.

Organisation	I am aware of guidance they produce		I have accessed guidance they produce	
Department of Health	Yes ☐	No ☐	Yes ☐	No ☐
General Medical Council	Yes ☐	No ☐	Yes ☐	No ☐
British Medical Association	Yes ☐	No ☐	Yes ☐	No ☐
Royal College of Physicians	Yes ☐	No ☐	Yes ☐	No ☐
Royal College of Paediatrics and Child Health	Yes ☐	No ☐	Yes ☐	No ☐
Royal College of Surgeons	Yes ☐	No ☐	Yes ☐	No ☐
Royal College of General Practitioners	Yes ☐	No ☐	Yes ☐	No ☐
Royal College of Anesthetists	Yes ☐	No ☐	Yes ☐	No ☐
Your own NHS Trust	Yes ☐	No ☐	Yes ☐	No ☐

22) Please read the following case scenarios and then answer the questions that follow them

Scenario one
A 70 year old woman who has carcinoma of the descending colon has an appointment with her consultant surgeon. The surgeon proposes to perform a hemicolectomy, hoping to re connect the bowel but with the possibility of needing to fashion a colostomy. He begins to discuss this with the patient when she says 'Please doctor, I don't want to know any details, it will just worry me just do what you think is best'.

Please select which of the options below you think is the most appropriate response for the surgeon (choose only one option):

a) Accept the patients wish not to have information and proceed with the surgery without discussing the procedure any further.

☐

b) Explain that it is necessary for her to know what the procedure will involve, what they are hoping to achieve with the procedure and any serious risks but respect her wish not to have a detailed explanation of all possible risks and benefits.

☐

c) Insist that she must be fully informed of all risks and refuse to perform the surgery until she has agreed to this.

☐

Scenario two
A 15 year old girl attends her GP surgery requesting the contraceptive pill. The GP assesses that she is competent to make a decision about contraceptive treatment and prescribes a combined oral contraceptive preparation. Two weeks later the girl's mother sees one of the GP's partners because of a sore throat. During the consultation she says that she is worried about her daughter. She thinks she may be having unprotected sex and is running the risk of becoming pregnant. She asks if her daughter has been in to the practice to discuss this.

Please select which of the options below you think is the most appropriate response for the GP (choose only one option):

a) Say that her daughter has seen your colleague but you cannot discuss her medical record without her permission. ☐

b) Reassure the mother that her daughter has been in to surgery to seek appropriate advice. ☐

c) Explain that all patient records are confidential and you cannot give information to anyone about a patient without the patient's consent. ☐

Scenario three
A 40year old man has suffered severe brain damage following an episode of meningitis. He is currently in intensive care and requires ventilatory support. He has multi-organ failure and despite intensive supportive measures his condition is not improving. The clinical team considers that further treatment will not be of benefit and will simply postpone the inevitable outcome of death. They wish to withdraw active treatment including ventilation. The man's family insists that all treatment should continue. They think there is a chance that he might recover and in any case they say that it is not up to the doctors to decide when a life should end.

Please select which of the options below you think is the most appropriate response for the clinical team (choose only one option):

a) Accede to the family's wishes and continue to treat the patient with full intensive care treatment. ☐

b) Discuss with the family the different options and try to reach a consensus about the best course of action, taking into account the patient's previous wishes and values if known. Seek a second opinion about the benefits and burdens of treatment and if consensus is still not possible seek legal advice. ☐

c) Inform the family that the decision about treatment is the responsibility of the doctor who is leading the team and is based on the doctor's assessment of what is in the patient's best interests. If the clinical team considers that treatment is not in the patient's interests then it should be withdrawn. ☐

Scenario four
A GP (Dr Jackson) whose wife has recently died has returned to work in a busy general practice which has had a recent increase in patients and therefore an increasing workload. The GP has a history of depression for which he had time off sick five years ago. The other partners have noticed minor mistakes or oversights in his management of patients since his return to work. One morning the practice manager speaks to the senior partner and says that she can smell alcohol on Dr Jackson's breath and that he looks terrible.

Please select which of the options below you think is the most appropriate response for the senior partner (choose only one option):

a) Speak to Dr Jackson after surgery and try and persuade him to take time off and seek medical help. ☐

b) Refer Dr Jackson to the General Medical Council. ☐

c) Call the GMC and seek advice without giving Dr Jackson's name. ☐

d) Ask Dr Jackson to stop seeing patients immediately and tell him that the senior partner will be informing the Primary Care Trust. Offer support and advise him to see his GP. ☐

Thank you for completing this questionnaire. Please either email it to ethics.questionnaire@warwick.ac.uk or post it to Freepost RRYU-HJZR-SJCB, Warwick Ethics, Gibbet Hill Road,, Coventry, CV4 7AL.

Appendix II: Topic Guides

Institute for Clinical Education
Medical Teaching Centre
The University of Warwick
Coventry CV4 7AL
Telephone: 024 7615 0881

Topic guide interview study v1 21.7.08

Exploring doctor's experience of ethical decision-making in medical practice within the UK health care system:

MREC number

This is a telephone/face to face semi structured interview

Introductory questions

1. Can you tell me the year of your first medical degree?
2. What country did you qualify in?
3. What is your nationality?
4. Was medical ethics a part of your undergraduate training? If yes in what way?
5. What would you say has the greatest influence on the way you work and your relationship with patients, your medical training; professional codes of practice, the law, your personal moral code, your religion, any other influence?

Experience of information and training in ethics for working in the UK

1. Prior to registration with the General Medical Council did you receive any information or training on the professional regulatory framework in the UK or on medical ethics more generally? If so:
    a. What did this involve?
    b. Where did the information come from?
    c. How useful did you find it?
    d. How easy was it to access information?
2. Do you think information/training on these issues is important/necessary for doctors coming to work in the UK?

Experience of working in the UK

1. What specialty do you work in in the UK?
2. Thinking about your work in the UK
    a. What sort of areas in your clinical practice are likely to involve difficult decisions?
    b. Are there any issues/decisions/ways of doing things that arise in your clinical practice that you feel uncomfortable with?
    c. Are there any issues/decisions/ways of doing things that cause differences of opinion between you and your patients/clinical colleagues?
3. Can you describe a case or issue that you have come across in the last four weeks that you think raised ethical or moral issues?
    a. What was the main ethical issue as you saw it?
    b. How did you resolve the difficulty (or how was it resolved)?
    c. Did you seek advice or further information to help you resolve it? If so elaborate

d. Who would you usually discuss these kind of concerns/dilemmas with?
e. Do you feel supported in this area of your work?
    i. If yes explain in what way.
    ii. If no what support would you like?

4. Specific prompts on issues of consent, confidentiality, end of life decision-making and dealing with concerns about poor practice in colleagues will be made if these issue shave not already come up in the interview.

Institute for Clinical Education
Medical Teaching Centre
The University of Warwick
Coventry CV4 7AL
Telephone: 024 7615 0881

Topic guide focus group v1 21.7.08

Exploring doctor's experience of ethical decision-making in medical practice within the UK health care system:

MREC number

1. Thinking of the training that you have been receiving in this programme what opportunities have there been to discuss the professional regulatory framework for doctors in the UK?
2. What kind of ethical or professional issues do you think that you might come across when you begin practising on the UK?
3. Do you think they will be different from the kind of issues that arise in the country in which you qualified?
4. To what extent does your medical training and/or your cultural background influence how you behave as a health professional, and in what way? Can you give examples?
5. Where can you access information about ethical guidance for doctors in the UK? Have you done so? What do you think of it?
6. What support would you like to see available for doctors on ethical issues when they begin practising in the UK?
7. Cases presented to stimulate discussion of the ethical issue, how it should be resolved and relevant guidance
    a. Withdrawal of life sustaining treatment
    b. Termination of pregnancy
    c. Involving family in decision-making

Institute for Clinical Education
Medical Teaching Centre
The University of Warwick
Coventry CV4 7AL
Telephone: 024 7615 0881

Topic guide key informant interview v1 21.7.08

Exploring doctor's experience of ethical decision-making in medical practice within the UK health care system:

MREC number

This is a telephone/face to face semi structured interview

Areas to cover

1. Informants role (e.g. educator/provider of information to doctors/regulatory body/professional organisation/peer support group)
2. Personal experience or organisation's experience of providing information and education for overseas qualified doctors who wish to register to practise in the UK.
3. Views on the type of information and training available, accessibility, uptake, and relevance.
4. Views regarding the possible challenges for doctors who have qualified overseas practising within the professional regulatory framework in the UK.
5. Views on the support that should be available to these doctors and whether it should differ from that provided for UK qualified doctors.