ORIGINAL ARTICLE

Barriers to education of overseas doctors in paediatrics: a qualitative study in South Yorkshire

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Objective: To explore the factors that may influence the progress of doctors who come from the Indian subcontinent to train in paediatrics in the UK.

Methods: Overseas doctors training in paediatrics in Rotherham, Sheffield and Doncaster participated in the study. Focus groups were used to collect data; two focus groups, each with 4–5 participants, were conducted at 6-week intervals. Semistructured, one-to-one interviews were conducted to add more understanding and depth to issues highlighted in the focus groups. The focus groups and interviews were audiotaped; the tapes were transcribed and data were analysed using the Grounded Theory; open codes were formed and concepts identified using microanalysis, and initial theories were built.

Results: Lack of information about the National Health Service (NHS)/Royal Colleges, inappropriate communication skills, difficulties in team working, difficulties in preparing for Royal College examinations, visa and job hunting, and social and cultural isolation were identified as major barriers. Problems arose not only from difficulties with language but also from use of local and colloquial words, different accents and difficulty in communicating sensitive issues. Lack of understanding of role in teams and difficulties in working in multiprofessional setting all contributed to the problems. Cultural differences inside and outside the workplace, and social isolation were also highlighted. Induction programmes, mentoring, awareness of the issues within the teams, and courses in communication specifically directed at overseas doctors were identified as means to overcome these barriers.

Conclusions: Several intercultural factors were identified that could act as barriers to the progress of overseas doctors training in paediatrics in the UK. Increased awareness of these factors within the teams would be the first step in resolving some of the issues.

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Training in the UK has appeal for many aspiring young doctors from the Indian subcontinent.¹ However, several factors, such as stress of immigration, differences in culture, working environment, examination systems, communication skills and team working, can all act as barriers to their progress.^{2–5} These problems have been presented as personal views, case studies, subjective assessments or media coverage, and useful practical advice has been given from personal experiences.^{6,7} So far in the UK, no studies exploring these barriers have been conducted using research methodology in a specialty-specific manner. One of the researchers, having been an overseas trainee herself, now supervises training of many overseas doctors. Her own insight into some of these issues led her to objectively explore the barriers affecting the progress of overseas doctors in training using research methodology.

The objective of this study was to identify the barriers to the progress of doctors qualified from the Indian subcontinent who come to the UK to obtain postgraduate education and training in paediatrics.

METHODS

Qualitative research methodology was chosen. A pragmatic approach of non-probability convenience sampling⁸ was used.

After approval from the local ethics committees had been received, a list of senior house officers who had obtained their basic medical qualifications in the Indian subcontinent and were undergoing training in paediatrics in South Yorkshire hospitals was obtained from the human resource departments of individual hospitals or respective Royal College tutors. Sixteen potential participants were identified. Each participant was sent a letter of invitation, an information sheet assuring confidentiality and a consent form. Only 12 of these consented

to take part, of whom nine were included in the focus groups and the remaining three for the semistructured interviews. Participants were allocated to focus groups or semistructured interviews by a secretary matching the availability of different participants and the researcher on predetermined dates.

To provide validity, the method of triangulation was used—that is, using focus groups and semistructured interviews as two different methods of collecting data. A research diary was also maintained to ensure transparency and reproducibility.

Focus groups

Two focus groups, each with 4–5 participants, were conducted at 6-week intervals (table 1). One of the authors (JM) moderated the groups and took notes. A conference recorder was used to tape all the discussions. Predefined questions and additional prompts were used to start the focus group discussions. The discussion was taped continuously and a secretary transcribed the tapes within 5–7 days of conducting the focus group. The typed transcripts were read and checked against the tape recordings for completeness and accuracy, and any further comments were added.

Semistructured interviews

Three participants were interviewed on three separate days (table 1) using a set of prompts. Notes of non-verbal and paralinguistic clues were made and interviews were audiotaped. A secretary transcribed all tapes within 5–7 days of the interviews. The transcripts were read and checked in the

Abbreviations: IMG, international medical graduate; NHS, National Health Service

Table 1 Details of the participants

Participant number	Sex	COO	Length of stay in the UK (years)	Postgraduate qualification in COO
Focus group 1				
1	M	India	3	Yes
2	F	Pakistan	2.5	No
3	F	India	2	Yes
4	M	Pakistan	2	No
5	M	Sri Lanka	1.5	Yes
Focus group 2				
1	F	India	2	No
2	M	Pakistan	2	No
3	M	India	2.5	Yes
4	F	Sri Lanka	1.5	Yes
Interviews				
1	F	Sri Lanka	1	Yes
2	F	India	1.5	No
3	M	India	2.5	No

COO, country of origin; F, female; M, male.

same way as those from the focus groups, and comments from the handwritten notes were then added.

Before the start of focus groups or semistructured interviews, a brief outline of the research project was presented to the participants and they were assured of confidentiality and the anonymity of the data. At the end they were offered professional counselling if required; this offer was not taken up by any of the participants.

Data analysis

The data from the two focus groups were analysed together. The data from the three interviews were analysed separately. Only one of the researchers, who also moderated the focus groups and interviews, analysed the data. Analysis was based on the method described by Strauss and Corbin⁹ using the Grounded Theory approach.

Each transcript was read in detail and open codes were formed by identifying concepts, their properties and dimensions in the data. These were identified by using the microanalysis technique—that is, by detailed line-to-line analysis of the transcripts. This method of microanalysis was used as a free-flowing process going backwards and forwards to the data collected.

The emerging concepts were classified into groups according to similarities and differences. From these concepts, categories were formed, which were developed in terms of their properties, dimensions and relationships. This development led to initial theory building, which was then refined. Refining was done by reviewing the data for internal consistency and gaps in logic and by filling in poorly developed categories and trimming excess ones.

RESULTS

Table 1 shows the details of the participants.

Using microanalysis, the categories that emerged from the focus group discussions were information relating to the National Health Service (NHS) and Royal Colleges, communication, work culture, examinations, visa and job hunting, social and cultural issues, and overcoming barriers. The categories identified by focus groups were also shared by all the participants of interviews. In addition, transcripts from two interview participants identified some undertones of discrimination as another issue. The female participants of both focus groups and interviews indicated certain sociocultural issues specific to women.

From these categories, the following barriers were identified:

1. Lack of information about the NHS/Royal Colleges
2. Inappropriate communication skills
3. Difficulties in team working
4. Difficulties in preparing for Royal College examinations
5. Visa and job hunting
6. Social and cultural isolation
7. Overcoming barriers

Table 2 shows some of the participants' quotes as related to each of these categories.

Information

Lack of information about what to expect on coming to the UK was identified as a barrier. The participants were unaware that the "shortage of doctors" in the UK was not necessarily at the senior house officer level and that there was an average wait of 6–9 months before they would be getting their first job (table 2).

Communication

Despite having good knowledge of written and spoken English, participants had difficulty understanding local words, colloquial terms and different accents; this made communicating with patients and families difficult, especially in the paediatric population. Owing to different sociocultural background, they had difficulty in judging the social and educational background of the families, and in asking parents and patients about their family structure, paternity and sexual history.

The participants said that they had difficulty in articulating their thoughts and felt nervous about volunteering in group discussions. This made them appear to be lacking in knowledge. In Royal College examinations, the participants reported that they did not perform very well in subject communication skills.

The concept of social issues being part of holistic care of a patient was also novel to the participants, and they had difficulty with the issues related to consent, child protection and patient choice.

Work culture

Participants found working in teams and multiprofessional learning to be a challenge. Lack of understanding of roles and responsibilities in a team and not knowing "what is expected of you" was identified as a barrier to "on-the-job" learning and made them appear to be poor team players. Senior house officers in both focus groups and interviews identified pride as a barrier to learning. They said that "fear of losing face" made them inclined to hide mistakes or not accept their mistakes, making it difficult to learn from them. Working relationships with colleagues were difficult, especially early in the job. They thought that nurses lacked trust in them, they felt that they were constantly being watched and had to constantly prove their capability.

Participants also identified a need to develop prioritisation and time management skills, and felt ill equipped to incorporate them in day-to-day practice.

On a positive note, most participants found that they got enough study leave and that the flexibility of examinations helped them to manage their time better. They acknowledged the system of educational supervision and appraisal, but also believed that many supervisors did not have a real understanding of their specific problems. Structured support from national organisations such as the British International Doctors Association was also thought to be lacking.

Table 2 Participants' quotes related to each category of the barriers

Categories	Quotes
Information	It is being advertised in our countries that there is a shortage of doctors in the UK. I did not expect that it would be so difficult to get a job (focus group 2)
Communication	I did not know how to ask a child if she had opened her bowels and felt very foolish asking a nurse what to ask. I did not know it was called 'poo'. (focus group 2) [During Royal College Exam] I had difficulty in gathering, processing and then conveying information in a limited space of time, I knew I had failed. (interview 1) They [patients and colleagues] expect you to understand them and made little effort to make themselves clear. (focus group 1) Colleagues and seniors lack patience and do not give us a chance to express ourselves completely. (focus group 1)
Work culture	There [in country of origin], we worked on our own. There was no concept of team working; you just did everything. Here [in the UK], I did not know how much and what was expected of me. I did not understand shared responsibility. (focus group 2) When I started as SHO [senior house officer] here, I had difficulty in accepting a non-doctor as a teacher. Now after two years, I am more comfortable and value their contribution to my learning. (focus group 1) We are on probation longer than our locally trained counterparts. (interview 2)
Royal College exams	I had never seen a patient with cystic fibrosis in Pakistan. I learnt about cystic fibrosis from the books but it was only when I was asked in the exam I realised that I had to know a lot more about the impact of this illness on the family, child's education, leisure activities, etc. (focus group 2) The emphasis in these exams is different, it is not on factual knowledge alone but more on a structured and holistic approach to a patient. I feel this is 'the right way' of clinical practice but it takes time to understand how to develop this kind of approach to patients. (interview 3)
Job hunting and visa	For my first job I put in 250 applications before I was short-listed and given a job. I had hardly settled down that I had to start the process all over again. (interview 3) We have to take leave from work to queue up to get a visa. We are not treated any differently to asylum seekers and have to justify our existence. Doctors are supposed to be respected by this society, I don't know why we are treated so badly at the consulate. (focus group 1) Job uncertainty, visa difficulties, financial insecurity and the quest for stability force us into taking non-training, SAS posts and then we are labelled as stuck doctors or non-progressing doctors. (focus group 2)
Social and cultural	I feel like a schizophrenic, I lead one life at work and a completely different life at home, I do not know who I am any more. (interview 2)
Overcoming barriers	What would be really useful is updated information from the authorities on the current job market. (focus group 1) I would have definitely benefited if I had some early training in how to communicate with kids, parents and nurses. (focus group 2) I would have done better in the exam if someone had trained me in breaking bad news. (interview 2) I feel that being forewarned is being forearmed. (focus group 1) It would nice to be able to pick up the phone and speak to someone even if it is late in the night.

Royal College examinations

At least one of the two parts of the Royal College examinations had been taken by all participants of both focus groups and interviews. They all thought that the system of examination was fair and unbiased, and that the pass rate was acceptable.

Exam courses run by various private bodies were found to be useful but expensive. The difficulties faced during preparation for exams were identified as follows:

- Time constraints due to shift working and moving jobs every 6 months
- Difficulty in studying alone and not knowing what was relevant and what was not. A lack of a "learning circle" was identified as a demotivating factor.
- Different disease patterns and profiles in the UK, and emphasis on social, behavioural and economic aspects of clinical conditions were not fully appreciated by these participants.

All participants thought that taking the clinical examination too soon after starting work in the NHS contributed to examination failure, but the pressure of limited registration (4 years of permit-free training in the UK) forced people into taking examinations at the earliest opportunity, even though they did not feel prepared for it. Women felt that they had to constantly juggle their time between family, work and examination preparation. The husband's career often took

priority over theirs. Lack of support networks for childcare was seen as a barrier by women.

Job hunting and visa

The constant anxiety of finding the next job prevented these participants from concentrating on their learning. Applying for posts repeatedly and not being short-listed or being unsuccessful at interviews was demoralising and led to low self-esteem. Applying for a visa every 6–12 months was perceived as a humiliating, expensive and time-consuming experience.

Social and cultural

Most overseas doctors live in hospital houses alongside people from their own country. Although it helped them to settle down, it prevented them from getting integrated into the social system of the country.

Not knowing what to wear at work and on different social occasions was perceived as a barrier in social integration. The issues became more important when going for interviews and examinations.

Overcoming barriers

Many participants suggested specialty-specific workshops on communication skills early in the job. Participants suggested that there should be induction programmes that focus on various issues mentioned as barriers, so that they are better prepared to deal with them. Most participants identified

longer-term appointments and long-term mentoring as additional measures to overcome barriers.

DISCUSSION

This qualitative study identified several factors that act as barriers to education and training of a group of overseas doctors in their early years of training in paediatrics in the UK. We have also shown that these factors are inter-related, and that their in-depth understanding would be the first step in overcoming these barriers. This study was designed to explore actual experiences, behaviours, emotions and feelings of doctors, thus qualitative research methods were considered to be best suited to answer the research question posed for this study.¹⁰

Most participants identified lack of information as a major barrier. This has also been highlighted recently in the media. The Department of Health has recommended development of a one-stop web facility on the Professional and Assessment Linguistic Board and for recruitment of overseas doctors.^{11–13} Our participants endorsed this initiative. In addition, they suggested that this facility should include information on working in the NHS, Royal College examinations and access to career guidance.

Large numbers of complaints received by the NHS hospitals are directly or indirectly because of ineffective communication.^{14–15} Local accents, colloquial language and different expectations all led to bafflement and confusion in the study participants in this study. A similar lack of communication skills has been emphasised in the literature not only from the UK^{7–16} but also from North America and Australia.^{17–18} Pre-employment educational programmes focusing on communication have been developed in Australia.¹⁹ Many deaneries in the UK provide training in communication skills as part of their induction programmes, but these training programmes remain generic, not specialty-specific, and not always available. Our participants strongly recommended that specialty-specific workshops in communication and interpersonal skills should be provided.

In this study, the participants had difficulty with team working. One of the biggest causes of stress at work is not knowing where you fit in a team and what your roles and responsibilities are.^{20–21} There is little published evidence with which the findings of this study can be compared. The induction programmes held by the trusts do not consider problems specific to overseas trained doctors. Specialty-specific, tailor-made induction programmes providing insights into team working and clarification of roles and responsibilities may be more suitable for this group of doctors. Team leaders and healthcare professionals in the UK also need to understand the specific problems that these individuals face.

Considerable variability in medical knowledge and clinical skills of overseas-trained doctors has been identified as a key issue by the Australian Medical Council.¹⁷ The participants in our study also highlighted different disease patterns as one of the reasons for lack of success with The Royal College of Paediatrics and Child Health examinations, although the examinations were perceived as being unbiased and fair. In addition, social isolation, lack of a learning circle, communication difficulties, shift pattern of working, and frequent job hopping acted as barriers to learning.

Problems related to visa and job hunting, as identified by our participants, have been highlighted in the literature.^{5–11} Since completion of this study, new visa regulations for international medical graduates (IMGs) have come into force. Under these, instead of permit-free training for 4 years, IMGs will now require work permits for all jobs.²² This regulation is aimed to provide a better framework for training of IMGs in the future. However, in the short term, this ruling may put further

What is already known on this topic

- Several factors can act as barriers to the progress of overseas doctors.
- These factors include the stress of immigration and differences in culture, working environment, examination systems, communication skills, and team working.

What this study adds

- This is the first study that uses qualitative research methodology to gain in-depth understanding of the barriers to overseas doctors training in paediatrics in the UK, and seeks ways of overcoming these barriers.
- It provides important information for the healthcare community in the UK, particularly in paediatrics, who wish to develop training programmes for overseas doctors.

obstacles in the way of those already in training, and may not allow IMGs to complete their training.²²

In our study, the understanding of social issues was perceived to be important for learning in a multiprofessional environment. Although some advice has been given regarding dress code and presentation at examinations,^{7–23} our study shows that issues are deeper than the external appearance.

To overcome the barriers identified in our study, the participants suggested a one-stop information website, induction programmes with specialty-specific focus tailored for overseas doctors, specialty-specific workshops on communication skills, accessible long-term mentorship, and improved understanding of their problems by the UK healthcare community. It is encouraging to note that recent recommendations of the task forces in Australia and Canada also take some of these measures into consideration.^{18–19}

One of the potential limitations of our study is that the participants were all from the Indian subcontinent. Despite the relevance of these findings being limited to doctors from the Indian subcontinent working in paediatrics in South Yorkshire, UK, the results of our study may represent emerging concepts.^{24–25}

The relationship between the researcher and the participants has been recognised as a source of potential bias.²⁶ This relationship was recognised in our study. These influences are unavoidable to a large extent; however, we have tried to minimise them by having a heightened level of awareness, adhering to basic rules of interviewer's behaviour,²⁷ and having more than one method of collecting data. Another potential source of bias may be allocation of participants to focus groups or semistructured interviews on the basis of availability of dates. Convenience sampling has been used in qualitative research; this method of sampling on a non-probability basis was considered to be the only option open to us.⁸

In conclusion, our study has identified several barriers that are encountered by overseas doctors in their early years of training in paediatrics. Ways of overcoming these barriers have also been sought. The implications of our study are important for overseas doctors who come to the UK and would also help the healthcare community in the UK that wishes to develop training programmes for this group of doctors.

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IMAGES IN PAEDIATRICS

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An unusual case of anaemia and dyspnoea

A 10-year-old boy presented to hospital with a 4-week history of lethargy and dyspnoea. There was no definite history of gastrointestinal bleeding. On examination, the patient was pale and breathless, with a soft abdomen and no palpable masses. Laboratory results showed microcytic anaemia, with a haemoglobin concentration of 4.7 g/dl and a mean corpuscular volume of 81.9. All other blood tests were normal, including B₁₂, folate, tumour markers and coeliac screen. An upper gastrointestinal endoscopy was carried out (fig 1), which showed a smooth mass at the antrum of the stomach at the level of the incisura. A biopsy of the lesion was performed at endoscopy.

Histological examination showed a mixed epithelioid and spindle cell tumour, with a varied mitotic index but no mucosal invasion, confined to the gastric wall. These pathological findings were consistent with a gastrointestinal stromal tumour (GIST) with malignant potential. Immunohistochemistry was positive for vimentin, CD34 and CD117.

The GIST group comprises tumours arising from the mesenchyma of the gastrointestinal tract; they occupy an independent group of digestive tract tumours based on their immunohistochemical properties.¹ There is an almost universal (>95%) expression of the CD117 antigen (part of the transmembrane tyrosine kinase receptor involved in cell growth and interaction).

Although predominantly a tumour presenting in the sixth and seventh decades, they rarely present in children. Symptoms include gastrointestinal bleeding, anaemia, abdominal pain and discomfort with or without a palpable mass. Although most GISTs display a benign pattern of behaviour, predicting their clinical course is difficult.²

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Figure 1 Upper gastrointestinal endoscopy showed a smooth mass at the antrum of the stomach.

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