

Article

Views About and from International Medical Graduates' General Practitioner Training in the United Kingdom

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Abstract

International medical graduates (IMGs) make up a significant proportion of general practitioners (GPs) in high-income countries such as the United Kingdom (UK), the United States of America (USA), Australia, and Canada. This paper compares views about IMGs with their own views in relation to the timing of GP placements in GP specialty training programs in the UK. It presents an inductive thematic analysis of focus groups with GP specialty trainers and trainees (149 participants across 32 focus groups), examining opinions about the ideal timing of GP placements. Trainers and home graduates argued that for home graduates, the ideal sequence depends on the trainee's previous experience. They also suggested that IMGs should start in a hospital placement to develop familiarity with the healthcare system. In contrast, most IMGs expressed a preference for starting in a GP placement, so that they can gain an understanding of the requirements of their specialty as early as possible. There is a contrast between what IMGs said about themselves and the views shared by trainers and home graduates. This highlights the need to involve IMGs in the design of support programs targeted towards them. Recommendations include tailoring training to account for individual career paths and providing training about the healthcare system before the start of the first placement. This could improve the efficiency of GP training programs at a time of extreme pressure on healthcare systems and training providers.



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1. Introduction

International medical graduates (IMGs), also called 'overseas doctors' or 'migrant doctors', are doctors 'practicing medicine in a country (...) different from their country of primary medical qualification' [1]. IMGs make up a significant proportion of the workforce internationally as well as in the United Kingdom (UK), where their numbers have risen in recent years from about a third of the workforce [2] to 40% [1,3]. Trends indicate that doctors from low- or middle-income countries relocate to high-income countries such as the UK, United States of America (USA), Australia, or Canada [4]. One of the most impacted specialties is General Practice, where demand is outstripping recruitment [5], which the UK National Health Service (NHS) is trying to mitigate with an active international recruitment program [6,7]. The picture is similar in the USA, where the COVID-19 pandemic has highlighted how much the USA's healthcare system relies on IMGs [8] and how IMGs fill important gaps in the healthcare system, including 41% of positions in primary care and high-need urban and rural areas [9,10].

Although there are discussions about IMGs, few publications focus on their training needs or reflect their voices [11]. The two main areas of focus have been the 'attainment

gap' between IMGs and home graduates [12–14] and the disproportionate complaints made against IMGs [6,15]. These discussions often focus on workplace problems without considering the wider context of the experience of IMGs [1]. Research on the experience of IMGs [1,2] has highlighted that the period immediately following arrival is critical in shaping long-term experiences and that support should be tailored to individual needs, because IMGs have a wide range of factors impacting this initial period (for example, language proficiency, personality and motivation factors, previous cross-cultural experience, training, and separation from family members).

This paper compares views about IMGs in GP (general practitioner) training in the UK with what IMGs said about themselves, thus amplifying the voices of IMGs in discussions about them. The discussions focus on whether IMG GP trainees should be allocated to a hospital or GP placements first when starting GP specialty training, which is a powerful factor in shaping the overall training experience. The findings provide new insight into the particular needs of international GP recruits, which is a group that is crucial in meeting the medical needs of the population at a time when both the healthcare system and universities involved in medical education are in crisis. While this study was carried out in the UK, the discussion is relevant to other countries where IMGs play a significant role in the healthcare system.

2. Methods

The research project evaluated the 1 + 2 GP specialty training model [16], which has now been implemented in Wales and is in the process of being introduced in England. Under this model, GP trainees spend a total of 12 months in hospital settings and 24 months in primary care settings instead of spending 18 months in each.

The evaluation followed a mixed-methods design [16], combining focus groups [17] and surveys [18] with GP specialty trainers and trainees. Ethical approval for this study was granted by the School of Social Sciences Research Ethics Committee at Cardiff University (reference number: 3869). All participants gave informed consent by completing a consent form before the focus group. This paper explores trainee and trainer perspectives on preferred hospital placements and the timing of secondary care experiences within a three-year training scheme, comparing what IMGs said about themselves in the focus groups with what trainers and home graduates said about them.

The results of the main evaluation can be found in [16]. For this paper, the author identified all instances where IMGs were mentioned in the focus groups by reading the transcripts and coded them to indicate whether the speaker was an IMG. Responses from IMGs were compared with home graduate and trainer responses, building on the thematic analysis of the entire data set. IMGs were mentioned in 15 out of 32 focus groups, including trainer focus groups as well as trainee focus groups for each round of data collection. Out of 26 trainees, 11 identified themselves as IMGs, and none of the trainers had been IMGs. Overall, trainers and home graduates talked about IMGs as often as IMGs talked about themselves. All responses that referred to IMGs were analyzed, and quotations were selected to include examples from the broadest possible range of focus groups. All codes that appear in more than one focus group are included in the results section.

We conducted three rounds of focus groups with trainees (between 2020 and 2022) and a single round of focus groups with trainers (in 2020) (for further details, see Table 1). All trainers and trainees in participating schemes were invited to participate. Focus groups were scheduled after training sessions with the help of Training Program Directors. We tracked trainee views as they progressed through their training program and compared them with trainer views about recent changes to the program. The extracts below are

followed by a code indicating trainer or trainee (TR or TEE), year of data collection, and the number of the focus group.

Table 1. Participant overview.

	N Focus Groups	N Participants	N Focus Groups Discussing IMGs	Total Length of Recordings
TR 2020	6	18	5	2 h 40 min
TEE 2020	8	37	3	3 h 20 min
TEE 2021	13	55	5	5 h 6 min
TEE 2022	5	39	2	2 h 17 min
total	32	149	15	13 h 18 min

Participants were recruited through purposive sampling, targeting trainers and trainees across all GP training programs in Wales. All eligible individuals were invited to participate, ensuring a broad range of perspectives. While participation was voluntary, the sample included trainees at different stages of training and trainers with varied levels of experience.

The focus group questions were designed to address the research questions and shaped by the literature review and feedback from the funders. In the second and third rounds, the questions were modified in light of the preliminary findings. Due to the COVID-19 pandemic, all focus groups were conducted online using Microsoft Teams [19,20] with the exception of one focus group in 2022, which was held in person. We ran focus groups in every training program in Wales over the course of the evaluation. The focus groups ranged from 3 to 12 participants (see Table 1). The analysis also includes two individual and two paired interviews [21] from data collection events where only one or two participants joined the session. On these occasions, the same question schedule was used to guide the discussion. All focus groups were audio recorded, transcribed, and anonymized. The transcripts were subject to an inductive thematic analysis [22–24] via NVivo (version 12 Pro) [25]. The first step was developing inductive codes directly from reading the transcripts. These codes were then grouped into broader themes through iterative analysis. To enhance reliability, coding decisions were discussed with a second researcher (Professor Alison Bullock) and the funders, Health Education and Improvement Wales (HEIW). Discrepancies were resolved through consensus.

3. Results

The IMG experience was exclusively discussed in the context of the timing of GP placements. First, I summarize the main arguments made about the timing of GP placements for home graduates. These arguments will be contrasted with what was said about IMGs. All discussions about the timing of GP placements were analyzed through thematic coding. It was assumed that participants were talking about home graduates unless they stated otherwise.

3.1. Views About the Timing of GP Placements for Home Graduates

Overall, trainers were in favor of trainees starting specialty training in GP placements, with a proportion of trainers stressing that flexibility in the starting placement is highly valued. In the first round of focus groups, trainees were split between preferring earlier or later GP placements. In the second and third rounds of focus groups, trainees also demonstrated more support for starting in GP placements. Participants in all three years

noted that there are benefits and drawbacks to either pathway or stressed that the ideal sequence depends on the trainee's previous experience.

I suppose people who might have done GP (The participants sometimes used "GP" as a shortening of "general practice") in foundation years, they maybe could come into it a little later, because I can imagine you would struggle to have every trainee starting in a GP post. (TRFG20 5)

It's been really helpful that there hasn't been a stipulation as to the order of the posts (...) having that flexibility, it's been really, really useful and we use that flexibility. (TRFG20 6)

I think there's pros and cons to both (...) I think it works both ways in a way, and maybe it's personality dependent, or maybe specialty dependent. (TEEFG22 3)

Those arguing for starting, in general, practice placements highlighted that an early GP post helps trainees focus on what they need to gain from subsequent hospital posts. Furthermore, it is important for trainees to find out as soon as possible whether general practice is a good fit, especially if they have no prior experience of working in a general practice setting. On the other hand, it was also acknowledged that hospital experience can give trainees more confidence and that completing two years of general practice placements without interruption is beneficial for skill development.

I did all of my hospital placements in one go and then started my GP placements. So for me, and I'd never done GP in foundation training either, so I really didn't have any idea of what primary care was like, other than a bit of medical school time, until halfway through my GP training. I don't think that's a very good way of going about it personally. (...) Doing a GP placement earlier on in GP training, in my view, would be better. (TEEFG20 3)

You should start your [specialty training year 1] with GP training because I think you need to know what makes a good GP, and how to practice independently, so that you can learn from the hospital job that you're doing and make them applicable for a GP job. (TEEFG21 11)

The benefit of doing GP all in a run rather than having GP and then hospital is that you can kind of build up momentum. I wonder whether if it's a bit more fragmented, it's harder to build those skills. (TEEFG22 02)

Therefore, discussions about the ideal timing of GP placements for home graduates highlighted flexibility and variety in training paths. As the next section demonstrates, IMGs made similar arguments about themselves, whereas home graduates and trainers tended to view them differently.

3.2. Talk About IMGs

Five participants argued that IMGs should start with hospital placements so that they can become familiar with the NHS, the referral systems, and the IT systems. They suggested that starting, in general, practice would be more difficult because trainees would need to simultaneously learn about the hospital and GP system. One trainee said that these systems are logical to home graduates 'because they've grown up with it'.

[IMGs] need to start hospital posts first because they need to know about NHS systems, referrals and all sorts of things. So probably general practice to start with would not be the best option. Probably they need to start in A&E [accident and emergency] or any medical ward to be able to know about the referrals, hospital systems. How to take referrals. How to send a referral. And also dealing with patients and all sorts of IT systems and everything. So probably it's better to start with a hospital post, rather than going into the GP post straightaway. (TEEFG21 5)

I really think [IMGs] need at least the six months to get used to the NHS system prior to joining the training program. (TEEFG22 2)

You know, if they're an international medical graduate or they're used to a different system [the benefit of hospital posts is] just working out how things work which seems logical to us, but that's because we've grown up with it. (TRFG20 4)

One trainee stressed that the GP training program should be structured in such a way that there was enough support for trainees, including IMGs, to start in a GP placement without the need for additional time in a hospital post.

The GP training program should be structured as such that the right amount of support is already in place (...) if [an IMG] started straight with GP that would be well supported enough to be okay, and that he would be able to get everything he needed from there. It shouldn't be that you have to grind it out for six months in a hospital job first. (TEEFG21 11)

One trainee and one trainer advocated for IMGs to start GP training in a GP placement. The trainee noted that IMGs need to experience a GP placement as soon as possible so that they can switch programs if they find that they are not suited to the GP environment. The trainer talked about a specific IMG and how valuable it was for her to start in a GP placement.

I just thought it might be helpful, particularly if you've not done GP before just so you kind of know what you're signing up to. Especially when people have come to from other countries, they've gone into GP training, they've still got time to change their minds about giving too much time to the training program. (TEEFG22 2)

Currently I have a ST1 who has never worked in the UK or in the NHS (...). I don't think she would have survived in hospital. Forget the current pandemic. I think it was such a cultural change for her that in this instance putting an ST1 straightaway in practice I think has been absolutely valuable. (TRFG20 3)

One trainer noted that IMGs in particular benefit greatly from spending more time in a primary care setting during training.

I think particularly for non-UK graduates who have to adapt to the culture of the UK as well as medicine (...) I think having a longer period in general practice definitely benefits them in adapting. (TRFG20 2)

In summary, those talking about IMGs tended to argue in favor of this cohort starting in hospital placement, with a minority supporting starting in GP placements.

3.3. What IMGs Said About Themselves

Six IMGs were in favor of starting in GP posts, with three having started in a hospital and three having started in a GP post. They highlighted that, when working in a hospital without any general practice experience, it is difficult to know what you need to learn from a GP perspective; they demonstrated that 'you definitely learn medicine from it', but without a grounding in general practice, learning is limited. This is especially important for doctors coming from systems where there is no direct equivalent to general practice.

I think having no experience in GP in the UK before, having my first post in GP is helping me with my future practice as a GP, but also getting to know the system. Getting to know how things work in the GP practice. All those things are helping me progress. (TEEFG21 2)

I studied in Nigeria and I did my foundation year as well in Nigeria. I wouldn't say there's an identical equivalent to GP practice in Nigeria. So I didn't have this UK GP

experience at all. And coming to the UK my first job was a hospital job. So one and a half years was in hospital. So I think [specialty training year 2] was kind of an eye-opener for me. That was the first time I actually did a UK GP job. So it was quite a shock. (TEEFG21 4)

I had my first GP placement as the first placement in [specialty training year 1] and then I went over to A&E and I thought it was really helpful (...) I'm an overseas doctor, so I didn't even know what GPs do before I worked as a GP. So it gave me a lot of knowledge about what struggles as a GP you have, and how are they seen in the hospital, and then when you go to the hospital as well you see it the other way around (...) I'd rather have the GP placement before a hospital placement. (TEEFG21 10)

One IMG trainee argued that the ideal sequence of training posts depends on previous experience.

I want to get stuck back into the way things worked in the UK because I was in India, and kind of get back to just my basic patient skills and get back in this country, but because I'd already had an idea, I think it does depend very much on your previous experience, I think, as to what you may find beneficial. (TEEFG21 10)

Two IMGs were in favor of starting at a hospital post, one being strongly in favor, and another indirectly suggesting that delaying the GP placement can be beneficial to allow more time for language learning.

I am an IMG doctor. So I graduated from outside the UK. I feel uncomfortable, very uncomfortable to start from GP, my first rota, because I'm not used to the culture and the medical system. (...) if we start from GP then go to the hospital then we would know what we're looking for (...) but I think that starting from hospital would be better than GP. (TEEFG21 11)

I think one of the things about GP is responding to patient queries which is a bit difficult if you don't really know the culture and know what they're saying, and understand every single word they say. Which would be difficult to start, like I was an IMG (...) having spent three years in the UK now, sometimes I don't understand what is said. (TEEFG21 11)

IMGs, therefore, were predominantly in favor of starting in GP placements, with a minority preferring flexibility or starting in a hospital placement.

4. Discussion

This study highlights a significant mismatch between the views held about IMGs and the views IMGs expressed about their own training needs. Most of our IMG participants preferred starting in a GP placement over a hospital placement, which aligns with previous research on this topic [11]. The arguments for starting in a GP placement are the same for home graduates and IMGs: it allows them to learn about their target profession and provides crucial grounding and context for hospital experience. Arguably, it is more important for IMGs to have early GP experience as they are less likely to have experienced GP placements during their training than their home graduate counterparts and may come from countries that do not view general practice as a distinct specialty. The quotes from IMGs demonstrate that there is great variation among their experiences, for example, due to the length of time spent in the UK before starting GP training, familiarity with British English, and experience of working in primary care.

This study has some limitations. As the primary aims of the larger evaluation project did not focus on the IMG experience, we did not capture a detailed picture of the participants' training backgrounds. Secondly, the study focuses on IMG experiences in the

UK through the National Health Service. Although the trainees reflected on the impact of COVID-19 on their training, none of the discussions considered the impact of COVID-19 on IMGs specifically. Nonetheless, until more research is carried out considering the needs of IMGs worldwide, this paper contributes an overlooked and underrepresented perspective.

The implications of this study are much broader than just the ordering of placements in GP specialty training. There is evidence that the period after arrival in the host country is critical in shaping IMGs' well-being, and consequently their ability to perform well [1]. Furthermore, the first weeks of GP training are pivotal for all trainees, and the 'steep learning curve' [26] of this placement is compounded with additional difficulties for IMGs who need to go through an acculturation process [1]. Thus, it is important to consider what happens during this first placement.

Successful interventions need to consider cultural adjustment and organizational support [2,4], not just the type of placement. Previous research found that the well-being and indirect performance of IMGs could be improved by greater geographical autonomy, stronger social support networks, and better work–life balance [14]. It has also been suggested that a supportive learning environment can encourage GP retention [27]. It would be helpful to provide structured training about the host country's healthcare system, regardless of where IMGs are first placed. This would also benefit home graduates who return after time spent training or working overseas and those who take a career break soon after qualifying [28].

The findings of this study suggest the need for greater inclusion of IMG perspectives in the development of national training frameworks. The consensus was that IMGs benefit from a hospital-based orientation, but this may reduce the relevance of early training experiences. Program directors should consider flexible training pathways that allow for earlier GP placements where needed. Involving IMGs in policy consultations could help ensure that training structures are responsive to their diverse needs and backgrounds.

The details of the debate about the sequencing of placements may not be relevant to countries with different training pathways, but the implications of this study are applicable to all countries relying on IMGs to meet primary care demands. The contrast between what was said *about* IMGs and what *IMGs said about themselves* further highlights the need to include IMG views in decisions about changes to the training program [2,6]. The discussions about the ideal first placement for IMGs in GP training were not as nuanced as the discussions about home graduates. Just like home graduates, IMGs have varied career paths and needs and treating them as a homogeneous group who all benefit from the same training path is just as misguided as in the case of 'home' graduates. Therefore, there is a need for more focus on tailored support for newly arrived IMGs and involvement of IMGs in the design of support programs to mitigate the pressure on training programs and the healthcare system.

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