Broadening perspectives about incorporating international medical graduates

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1 | INTRODUCTION

In this issue of Medical Education, Al-Haddad, Jamieson and Germeni present the results of a meta-ethnography that enabled them to discuss the experiences and difficulties encountered by International Medical Graduates (IMGs).1 They systematically identified five commonalities among IMGs, providing a holistic conceptual understanding of this important population and its interactions in the clinical environment. This thoughtful article enlightens us about the thinking undertaken by IMGs, offering ways to help reach targets set by the General Medical Council (GMC): ‘elimination of disproportionate [patient] complaints and [IMG] training inequalities’.2 In this commentary, we would like to further that discussion by juxtaposing a variety of stakeholder perspectives with the IMGs’ personal experiences as outlined in the article and the needs of global health workforces, patients and institutions. In doing so, we aim to continue contemplation of how IMGs can best be incorporated into health systems in a manner that enables them and their patients to thrive.

Regardless of where one trains in relation to where one practices, ensuring safe and high-quality patient care has always been the common goal for delivering medical services and medical education. It is noteworthy in this regard that Al-Haddad et al.’s finding of dissonance between IMGs and the host country to which they moved included dimensions of language, culture, education and belonging but did not reflect any indication that IMGs’ goals for high-quality patient care were fundamentally different than those of their host country. If we can presume that commonality, despite whatever differences might exist between IMGs and those trained domestically, the question becomes what roles and activities might various stakeholders play to overcome the disproportionate rate of complaints alluded to above?

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IMG status is often treated as a risk factor for poorer performance based on the rate of patient complaint, and, as Al-Haddad’s findings indicate, there are undoubtedly adjustments that IMGs need to make with respect to learning how to practice in a new context. That said, at least one compelling study from the United States found no evidence of differential patient outcomes between IMGs and Domestic Medical Graduates (DMGs) when more objective national data of Medicare beneficiaries who underwent common surgical procedures were examined.3 To some degree, therefore, we must worry about the extent to which patients have less trust in IMGs’ professional performance and take steps to reduce stereotypes driven by perception. Doctors, in other words, must be evaluated based on their professional performance, not their nationality or any other demographic characteristic. Further, we need to question whether IMGs receive more patient complaints than do DMGs because of differences in communication norms, subtleties in language use, and culturally-driven expectations regarding shared decision-making.3,4 Teaching such things in a context appropriate manner is core business for medical education institutions, suggesting ample opportunity to enhance IMGs’ ability to meet patients’ concerns if earlier medical education processes are incorporated into continuing professional development protocols for IMGs and DMGs alike.5
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In that regard, we would also highlight that intercultural communication is not a challenge for IMGs alone. Rather, it is an essential skill for the global health workforce. The Covid-19 epidemic has only strengthened this observation as it has made us more conscious of the mobility of the world’s population and the importance of global communication and exchange for healthcare to be effective. Regardless of whether practitioners have sojourned to a foreign country themselves, their professional interactions are likely to include both patients and colleagues of diverse cultural backgrounds. IMGs may be more challenged given that they are usually in the minority, but the difficulties they face are also faced by DMGs. Thinking in this way could allow greater collaboration between DMGs and IMGs, encouraging them to work together to provide one another with the necessary learning support and cultural humility.

Such activity can only be enabled, however, if we contemplate the health system as a whole, including various institutions such as medical schools and hospitals, carefully inspecting the contributions they themselves make to systemic bias against IMGs. In the face of a global shortage of well-trained health workers, IMGs make up a large portion of the workforce for a considerable number of countries. With the time and financial investment put into health worker training, the institutions that draw upon IMGs presumably hope for them to stay in the host country and serve their local population. It should be (but is unfortunately not) surprising, therefore, that Al-Haddad et al. reported IMGs often encounter institutional and systematic discrimination. We cannot expect to make progress if we constantly focus only at the level of individuals, defining competencies they must develop and maintain, without specifying actions that yield evolution at the institutional level aimed at constructing an inclusive and integrated environment. Social communities that provide IMGs a better sense of belonging, offering additional language training, and establishing additional educational opportunities are all options that fit with the core issues highlighted by Al-Haddad et al.’s findings.

In summary, IMGs, as part of a global health workforce, are structurally connected to other stakeholders including patients, domestic medical graduates and various institutions. By considering their diverse perspectives and the contribution each makes to pathways that enable IMGs and, in turn, their patients to thrive, we can work towards reductions in disproportionate complaints and training inequalities. While our commentary only scratches the surface in these regard, we have argued that it is necessary for IMGs and DMGs to establish close and harmonious working relationships, to engage in ongoing development of competencies that enable both groups to manage patients’ cultural-driven expectations, and to ensure that IMGs find themselves in clinical environments that are welcoming of multiculturalism if the healthcare system expects to retain their services and their dedication. Al-Haddad et al.’s article thematically identified many commonalities in difficulties and challenges encountered by IMGs, which should be used to guide future research aimed at examining the diversities of IMGs and locations in which they work to make targeted recommendations that can help address their plight.

Yield evolution at the institutional level aimed at constructing an inclusive and integrated environment.

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Damaged, discouraged and defeated? How mindset may offer hope for healing

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‘But how are you really doing?’ The question seems to linger in my mind—how is it that an emphatic question can cause a cascade of emotions, feelings and reactions? When I think about my answer to the question, I often defer to a car gasoline gauge that could float above my head. Is it more towards full or empty? Most days I ashamedly lean towards ‘empty’, and I question whether I have the capacity or potential to do anything about it. Gordon and colleagues, however, confirmed that most healthcare providers and educators are also depleted from the trauma of transition triggered by COVID-19.¹

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In their research, the authors illuminate the impact of COVID-19 on provider well-being and the broad reach of transitional experiences across our personal and professional lives. In the process, they identified three critical factors that contribute to our social and cultural well-being—whether we feel heard, valued and supported.¹ They highlighted the weight imposed on our various support channels, the perceived stigma within our communities about asking for help and the temporary relief provided by our organisations.¹ Most importantly, they expose the challenge of how we move forward, especially as the COVID-19 pandemic continues to fluctuate.

An area of respite may be an emphasis on our mindset. Carol Dweck’s initial work on mindset suggests we have a propensity of being more fixed minded (i.e. we believe our knowledge and abilities are unmovable) or more growth minded (i.e. we believe our knowledge and abilities are malleable with effort); however, our mindset is highly domain specific and readily influenced by numerous factors.² We have the potential to be very growth oriented about our potential as a clinician and caregiver yet may be somewhat fixed about our creative abilities or capacity to manage our wellbeing and health. Mindset research in health professions education is still in early stages, so there is limited information about how our mindset may be related to mediating transitory experiences and the impact on our well-being.³

Fortunately, research in non-healthcare contexts suggests that supporting a growth mindset can be deeply impactful on individual optimism, well-being and resiliency. Studies of children in educational settings has shown those with a growth mindset often have more optimistic thinking and are better able to welcome new challenges, especially after setbacks.⁴,⁵ Those who have more of a growth