

Junior doctors' understanding and enactment of interprofessional learning and practice: A study of international and Australian medical graduates in teaching hospitals

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**Junior doctors' understanding and enactment of
interprofessional learning and practice**

*A study of international and Australian medical
graduates in teaching hospitals*

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Doctor of Philosophy

University of New South Wales

2012

ABSTRACT

This study explored Junior Medical Officers' (JMOs), particularly international medical graduates' (IMGs) understanding of interprofessional practice (IPP) and its links to patient safety. It investigated their willingness to practise interprofessionally and identified factors inhibiting collaborative IPP. The links between IPP and patient safety are established. Evidence supports the benefits of health professionals working collaboratively for enhanced patient outcomes. Hospital environments are complex with proliferating professional and departmental cultures. Patients are managed by a multiplicity of health professionals. We know that to practise interprofessionally challenges the territorial traditions of health professionals. An understanding of IPP and a preparedness to put patient interests before professional self interests are fundamental to realising improved patient safety. There are difficulties associated with transformation to a collaborative approach to patient care. Paradoxically, overcoming cultural boundaries between interdependent health professionals is one prerequisite for practising interprofessionally. This thesis contributes to our knowledge about junior doctors' perceptions of IPP in teaching hospitals and organisational factors challenging their interprofessional functioning. It reveals compromised intraprofessional practice linked to the hierarchical culture of hospital doctors. A triangulated method comprising semi-structured interviews, a survey questionnaire and ethnographic observations was employed for the research. Thirty two international and Australian medical graduates (IMGs and AMGs) from three Australian teaching hospitals participated. Four themes framed the study: culture, communication, collaboration and competency. The findings highlight diversity in the cultures and medical training of JMOs. Participants' experience of shared learning was minimal, limiting their proclivity to IPP in postgraduate training. JMOs' willingness to embrace IPP is overshadowed by the challenges of adapting to different cultures within hospitals, understanding other health professionals' roles, and working with inadequate support and supervision. Mutual respect and communication are lacking, both intraprofessionally and interprofessionally.

Excessive demands, bounded professional cultures and uncompromising hospital organisational cultures impede IPP. The findings can be applied to other comparable settings and individual issues such as supervision, explored in further research.

To my sons Hamish, Julian and Edward

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ABBREVIATIONS

ACAT	Aged Care Assessment Team
AMC	Australian Medical Council
AMG	Australian Medical Graduate
AMO	Admitting Medical Officer
BPT	Basis Physician Trainee
CAT	Computerised axial tomography
CNC	Clinical Nurse Consultant
Consult	Consultation
CPR	Cardiopulmonary resuscitation
CT	Computed tomography
ECG	Electrocardiogram
ECHO	Echocardiogram
ED	Emergency Department
EMU	Emergency Medical Unit
Gastro	Gastroenterology
Geri	Geriatrics
GI	Gastrointestinal
HDU	High Dependency Unit
ICU	Intensive Care Unit

IMG	International Medical Graduate
IPL	Interprofessional Learning
IPP	Interprofessional Practice
ISBAR	Introduction, Situation, Background, Assessment and Recommendation
JMO	Junior Medical Officer
MRI	Magnetic Resonance Imaging
NESB	Non English Speaking Background
NSW	New South Wales
NUM	Nurse Unit Manager
NZ	New Zealand
Ortho	Orthopaedic
OT	Occupational Therapist
PACE	Patient with Acute Condition for Escalation
Physio	Physiotherapist
RMO	Resident Medical Officer
RN	Registered Nurse
SPSS	Statistical Package for the Social Sciences
SRMO	Senior Resident Medical Officer
SSS	Site Specific Supervisor. Ethics approval requires a supervisor at each hospital where research is conducted
UNSW	University of New South Wales

UK	United Kingdom
USA	United States of America
USSR	Union of Soviet Socialist Republics
WHO	World Health Organisation

TERMS

Outlier	A patient in a ward other than the appropriate ward for their condition
Residency	The period of JMO training following graduation
Resident	A JMO in the first two or three years of postgraduate medical training
Rotation	A JMO training term of either 10 or 12 week blocks
Secondment	A period of JMO training conducted away from their primary teaching hospital at smaller or rural hospitals
Term	A rotation to a specific surgical or medical specialty
Vocational Training	Supervised accredited training undertaken by JMOs to fulfil requirements for membership of specialty colleges

Conference presentations arising from the research

Milne, J., Greenfield, D., Braithwaite, J. “Educating junior doctors about interprofessional practice: more barriers than enablers”. *The Continuum of Education in the Healthcare Professions: AMEE An International Association for Medical Education* Centre de Congres, Lyon, France, 25-29 August 2012. Peer reviewed conference abstract and oral presentation (abstract accepted).

Milne, J., Greenfield, D., Braithwaite, J. “Undercurrents affecting the enactment of interprofessional practice for enhanced patient safety in teaching hospitals”. *Inspiring Concepts in Health Management: Australasian College of Health Service Management Congress 2012*, Marriott Surfers Paradise Resort & Spa, Gold Coast, Queensland, 15-17 August 2012. Peer reviewed conference abstract and oral presentation (abstract accepted).

Milne, J., Greenfield, D., Braithwaite, J. “Interprofessional practice, patient safety and Junior Medical Officers: will they ever be united?” *28th Conference of the International Society for Quality and Safety in Health Care*, Hong Kong, 14-17 September 2011. Peer reviewed conference abstract (Poster accepted).

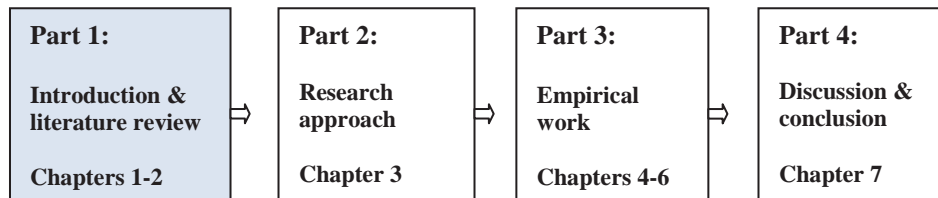
Milne, J., Greenfield, D. Braithwaite, J. “Working towards shared goals through interprofessional practice: are doctors really on the team?” *ACHSM/NZIHM 2011 International Congress* - Rotorua, New Zealand, 24-26 August. 2011. Peer reviewed abstract and oral presentation.

Milne, J., Braithwaite, J. Greenfield, D. “What do doctors really think about working interprofessionally? Lessons to improve clinical practice.” *School of Public Health and Community Medicine Postgraduate Research Conference, University of New South Wales, October, 2010*. Oral Presentation.

Milne, J. Braithwaite, J. Greenfield, D. “Interprofessional practice: what does it mean to doctors?” *5th Annual Emerging Health Policy Research Conference: Menzies Centre for Health Policy, University of Sydney, Australia, 11 August 2010.* Abstract and oral presentation.

Milne, J., Braithwaite, J., Greenfield, D. “What happens to relationships when many of the doctors are trained elsewhere? Reflections on a many-faceted problem in inter-professional practice.” *All Together Better Health 5 (ATBH5) - International Interprofessional (Education, Practice and Research) Conference: Australasian Interprofessional Practice and Education Network (AIPPEN), Sydney, Australia. 6-10 April, 2010.* Peer reviewed conference abstract and oral presentation.

Part 1: Introduction and literature review



Chapter 1: Introduction

1.1 Introduction

The medical workforce of a country is critical to the health of its population. Much is entrusted to the doctors who constitute that workforce. However, doctors alone cannot fulfil their role without the contribution of other health professionals, particularly nurses and allied health professionals. In most developed countries, the delivery of health care has become increasingly sophisticated, paralleling the rapid development of medical research and opening the way for offering new modes of treating illness and disease. Patients are now more knowledgeable about their illnesses and have high expectations of their health care and the outcomes of treatments. The demands placed on those who deliver their care are heavy.

1.2 The medical workforce in Australia

The medical workforce in Australia is dependent on the services of International Medical Graduates (IMGs), also referred to in the literature as Overseas Medical Graduates (OMGs) and Overseas Trained Doctors (OTDs). In Australia, the United Kingdom (UK), Canada and the United States of America (USA), IMGs constitute 23-28% of the medical workforce (Van Der Weyden and Chen 2004). A long term shortage

in the Australian medical workforce supply is predicted, ensuring an ongoing need to attract the services of IMGs (Bayram, Knox et al. 2007; Joyce, Stoelwinder et al. 2007; Health Workforce Australia: Information Analysis and Planning 2012). The Australian Medical Workforce Advisory Committee (2002) reported that IMGs comprised up to 30% of the medical workforce in public hospitals. IMGs entering the Australian health care system come from a range of cultures and educational backgrounds. Their integration into the health system is not straightforward.

With the ongoing recruitment of IMGs, McGrath (2008) cautions that there must be a duty of care to the public as well as to those IMGs who come to practice in Australia. IMGs typically receive insufficient orientation to the culture and the presenting complexities of the Australian health system.

1.3 The context of the research

In Australia, the setting for this research, the complexity of the health system is matched by the complexity of investigations, procedures, and treatment options for patients' conditions and the array of health professionals involved in their care. Graduating doctors enter the hospital system to commence postgraduate training, armed with great clinical knowledge. Together with doctors more advanced in their training, they move between different hospitals as part of their clinical training experience, ongoing development, and continuing education. However, the working environments they encounter require more than clinical knowledge. What becomes important is how they work interprofessionally with their health professional colleagues and the degree to which they recognise and value the virtue of collective expertise in caring for patients.

The growing complexity of health services, health treatments and the organisation of medical practice has been instrumental to growing concerns about patient safety and health outcomes (Carroll and Quijada 2004; Dyer 2011; Weller, Barrow et al. 2011). These concerns have been at the core of the interest that has developed in interprofessional learning (IPL) and interprofessional practice (IPP) (Braithwaite and Travaglia 2005; Steinert 2005; Gozu, Kern et al. 2009; Piterman, Newton et al. 2010;

Greenfield, Nugus et al. 2011; Interprofessional Education Collaborative Report of an Expert Panel 2011).

IPL, sometimes referred to as interprofessional education (IPE), and IPP, require the involvement of more than one profession working for a common purpose. “Interprofessional education for collaborative patient-centred practice has been identified as a key mechanism to address health care needs and priorities” (Rice, Zwarenstein et al. 2010:60). Joint active learning is fundamental to IPL, the underlying principle being that this leads to health professionals working together for improved patient outcomes, through greater quality of treatment and care (Bray and Howkins 2006). Health professionals include doctors, nurses and allied health professionals, often referred to collectively as allied health. The term allied health, a somewhat ambiguous term, applies to specialised health professionals who complement the work of doctors and nurses (Grant 2007). In Australia, the term embraces a wide range of health professionals: audiology; dietetics and nutrition; occupational therapy; orthoptics; orthotics and prosthetics; hospital pharmacy; physiotherapy; podiatry; psychology; radiography; speech pathology; and social work (Australian Health Workforce Advisory Committee 2006; Grant 2007).

IPP is predicated on the principle that collaborative practice of all health professionals in the planning and delivery of patient treatment and care, offers greater quality and enhanced patient safety. Patient care is optimised because the patient is purposely the focus of their combined skills and care (Braithwaite and Travaglia 2005).

Collaborated learning and collaboration of effort are at the heart of IPL and IPP respectively. The interdependency of health professionals therefore underlies the concept of IPP. An understanding of IPL and IPP is therefore essential to achieving collaborative effort (Garling 2008). Doctors in the medical workforce are integral to the collaborative effort necessary for effective patient centred care and patient safety. The interconnectedness between their role and the role of nurses and other health professionals, particularly allied health professionals, is essentially an interdependency. However, their tendency has been to work in silos reflecting the bounded, inward focus

of their traditional, professional training disciplines (D'Amour, Ferrada-Videla et al. 2005; Thistlethwaite 2008). The health and hospital system within which all health professionals work is complicated and multifactorial in nature, which in turn can vicariously affect patient outcomes. Therefore complex health care systems rely upon collaborative effort for effective functioning and optimal patient outcomes (Reiheld 2006).

1.4 Rationale and scope of the research

This thesis is positioned within the general scope of interprofessional learning (IPL) and interprofessional practice (IPP). Interest in IPL and IPP in the health professions has developed in countries with comparable medical education programs and health care systems such as the UK, the USA, Canada, New Zealand (NZ) and Australia. A commonality between these countries is their reliance on the services of International Medical Graduates (IMGs) to overcome medical workforce shortages. IMGs are medical graduates whose medical education and training has taken place in countries where the medical education programs are not recognised as being comparable to those of western countries. The lack of recognition equates to different standards of medical training and medical practice, along with which are many associated issues that bear upon the whole spectrum of safety and quality in health service delivery (Rothman and Cusimano 2001; Hall, Keely et al. 2004; Kostis and Ahmad 2004; Leonard, Graham et al. 2004; McGrath 2004; Hawken 2005; Van Der Weyden 2005; Braithwaite, Hindle et al. 2006; Spike 2006; Tromp, Rademakers et al. 2007; Smith 2008; Gozu, Kern et al. 2009; Elkin, Spittal et al. 2012).

Within the context of IPL and IPP in the health professions, the work concentrates on one sector of health professionals, medical graduates, at the junior medical officer (JMO) level. The thesis examines the experience of IMGs as JMOs in the IPL and IPP framework, drawing in AMGs by way of comparison to illuminate the characteristics of IMGs

1.5 Study aims and significance of research

In the absence of research specifically involving IMGs within the context outlined, I aimed to explore the field of IPP in an IMG population, looking at AMGs and other health professionals in that process. Further aims were to investigate barriers to the collaborative working relationships of IMGs and to determine the extent to which patient outcomes may be affected by barriers to IPP identified.

The degree to which IMGs are able to adapt and integrate into the hospital system may affect their effort to collaborate with other health professionals and colleagues, if they have no experience or understanding of IPL and IPP. Research specifically focusing on IMGs, IPL and IPP in the delivery of health care has not been conducted, so far as I am aware.

This research also seeks, more broadly, to determine the extent to which JMOs understand the concept and purpose of IPP in enhancing patient safety. Additionally, the study investigates factors associated with their practice, which may inhibit IPP. It explores the interrelationship between health professionals in teaching hospitals and recognises the internationalisation of the medical workforce by including in the study, both IMGs and AMGs.

In the context of this study, IPL and IPP are used interchangeably. In postgraduate medical training, the opportunity for IPL occurs in the practice of JMOs. Use of the term JMOs includes both IMGs and AMGs.

1.6 The research method

The research was conducted using a triangulated method approach. The three tools employed comprised face-to-face semi-structured interviews, a questionnaire survey, and ethnographic observations. All data were collected on-site at participating teaching hospitals.

1.7 The organisation of the thesis

The thesis is structured in four parts and seven chapters overall. From the beginning and progressing through the work, the main parts and associated chapters are diagrammatically represented to indicate where the chapters are positioned within the whole thesis.

The literature review follows this introductory chapter and completes part one. In the second part of the thesis, the research approach is expounded. The third part presents the empirical findings from the research undertaken. Finally, part four draws on and reflects upon, the results of the findings in generating discussion. The ramifications of the findings and their significance are discussed. Opportunities for future research are presented before concluding the thesis.

1.8 Conclusion

This chapter has provided an introduction to the thesis. The background and positioning of the research within the context of the Australian medical workforce has been explained. The focus, rationale and scope of the work have been described and the aims and research method outlined.

Chapter 2: Literature Review

2.1 Introduction

This chapter provides insight to the field of inquiry within which this work sits. It leads in to the theoretical and methodological concepts based on the literature, focusing on IMGs and IPL and IPP. From analysing the literature, it is evident that much research and commentary has taken place in the fields of IPL and IPP (Carpenter 1995; Ovretveit 1997; Parsell and Bligh 1999; Hudson 2002; Irvine, Kerridge et al. 2002; Atwal 2004; McGrath 2004; Anderton 2005; Barker, McKimm et al. 2005; Curran, Deacon et al. 2005; D'Amour, Ferrada-Videla et al. 2005; Hean and Dickinson 2005; Horsburgh, Merry et al. 2005; McNair, Stone et al. 2005; Braithwaite, Hindle et al. 2006; Zwarenstein and Reeves 2006; Barr 2007; Reeves, Zwarenstein et al. 2008; Thistlethwaite 2008; Piterman, Newton et al. 2010; Interprofessional Education Collaborative Interprofessional Education Collaborative Report of an Expert Panel 2011).

A considerable body of literature about IMGs exists, earlier works emerging during the 1970's (Butter and Grenzke 1970; Corbett 1970; Evans 1970; Beaubrun 1971; Kendall 1971; Millis 1971; Beljan 1972; Haug and Stevens 1973; Lockett 1974; Mason 1974; Shapiro and Denholtz 1974; Stevens, Goodman et al. 1974; Bergen and Lenoble 1975; Mamot 1977).

There has been a growing body of work beyond the 1990s (Fiscella and Frankel 2000; Boulet, Van Zanten et al. 2001; Birrell 2004; McGrath 2004; Van Der Weyden and Chen 2004; Hawken 2005; Narasimhan, Ranchord et al. 2006; Spike 2006; Whelan 2006; Bayram, Knox et al. 2007; Mahajan and Stark 2007; Pilotto, Duncan et al. 2007; Rao, Kramer et al. 2007; Thind, Freeman et al. 2007; Tromp, Rademakers et al. 2007; Foster 2008; Musgrave and Cordella 2008; Wong 2008; Kuteyi, McLean et al. 2009; McGrath, Henderson et al. 2011).

From the literature, it is evident that much attention is given to factors associated with four predominant themes and sub-themes, which were identified as: culture, integration and acculturation (Fiscella and Frankel 2000; Horvath, Coluccio et al. 2004; Whelan 2006; Louie, Roberts et al. 2007; Foster 2008; McGrath, Henderson et al. 2011); communication and interaction (Boulet, Van Zanten et al. 2001; Rothman and Cusimano 2001; Hall, Keely et al. 2004; Spike 2006; Schyve 2007; van Zanten, Boulet et al. 2007); collaboration and teams (Rothman and Cusimano 2001; Hall, Keely et al. 2004; McNair 2005; Mahajan and Stark 2007; Wong and Lohfeld 2008; Kuteyi, McLean et al. 2009); and competence in relation to quality, safety and professionalism (Rothman and Cusimano 2001; Kostis and Ahmad 2004; Leonard, Graham et al. 2004; Hawken 2005; Van Der Weyden 2005; Spike 2006; Tromp, Rademakers et al. 2007; Smith 2008; Greenfield, Nugus et al. 2010). The four themes and their sub-themes are at the core of working and learning collaboratively and practising safely and professionally (Figure 2.1). In the study, the four main themes and the sub-themes were used as a framework within the context of IPL and IPP, to explore the role and practice of IMGs in the overall hospital environment of JMOs, nurses and other health professionals. The inclusion of IMGs to determine their orientation to IPP and their functionality in relation to these themes is of critical importance to patient safety.

Figure 2.1. Themes and sub-themes adopted to explore the role and practice of IMGs and AMGs in the context of IPL, IPP and patient safety



2.2 The literature search process

The literature search began with identifying terms associated with IPL and IPP and terms related to doctors trained in countries outside Australia. The associated terms for IPL and IPP were based on those used in research previously conducted by Braithwaite and Travaglia (2005). The terms searched for the latter, doctors trained in countries outside Australia, resulted from searching for different interpretations or terminology used to describe doctors working in countries, other than their country of original training. Although the most current term used is IMGs, there are variations on this term. For example, *overseas trained doctors* (OTDs) and *foreign medical graduates* (FMGs). In New South Wales (NSW), the term Australian Medical Council (AMC) graduate is a term used for IMGs who seek to reside and practice medicine in Australia on a permanent basis. In order to obtain full registration, that is, registration without conditions, they are required to successfully complete AMC examinations and a year of

supervised training, during which time they are somewhat loosely described in hospitals as ‘AMCs’.

The search, using a broad, multi-method approach, was conducted over the period April to July 2008. It was not restricted and covered all years within the databases searched. Some additions were made in 2012 to update the original literature review.

2.2.1 Search strategies

Drawing on the database examination model established by Braithwaite and Travaglia (2005), key database search terms for IPL were selected (Table 2.1). Also reflected in Table 2.1 is the fact that as noted by Braithwaite and Travaglia (2005), the term interprofessional and its synonyms is broad and requires searching under a variety of inter-related terms. In searching for key terms relating to IMGs, the same systematic method was used resulting in the terms shown in Table 2.2.

Table 2.1: Search terms for IPL and IPP

1	Interprofessional
2	Interdisciplinary
3	Interoccupational
4	Interinstitutional
5	Interagency
6	Interdepartmental
7	Intersectoral
8	Interorganisational
9	Interprofessional relations
10	Multiprofessional
11	Multiagency
12	Multidisciplinary
13	Multiinstitutional
14	Multisectoral
15	Multiorganisational
16	Team

Table 2.2: Search terms for IMGs

1	AMC doctor or AMC graduate
2	Doctor trained overseas or doctor trained abroad
3	Foreign trained doctor
4	Foreign medical graduate
5	International doctors or internationally trained doctors
6	International medical graduates
7	Migrant doctor
8	Overseas doctor
9	Overseas medical graduate
10	Overseas qualified doctor
11	Overseas trained doctor
12	Overseas trained physician
13	Overseas trained specialist

2.2.2 Search strategy 1: database searches

In locating the published literature relating to IPL, IPP and IMGs, four databases were systematically searched for the two distinct fields; firstly for IPL and IPP and secondly, for IMGs. These databases were: Medline (medicine), Embase (medicine and health services), CINHALL (nursing and allied health), and PSYCHINFO (psychology).

The symbol '\$' denotes truncation of the word in the databases searched in recognition of variations in spelling. For example, the term *interprofessional* may be one word, a hyphenated word (inter-professional) or two separate words (inter professional). Variations in the terms for IMGs were also considered, such as overseas trained and the hyphenated form, overseas-trained. For the same purpose of seeking broad coverage, the prefixes '*inter*' and '*multi*' were used in searching the IPL and IPP literature to capture data relevant to all JMOs. References were downloaded to Endnote version X.02, a

bibliographic software package. Supplementary references to the original literature reviewed were downloaded using Endnote version X.04. The numerical results of the respective database searches for the two fields explored, are presented in Tables 2.3 and Table 2.4.

Table 2.3: Results of database searches for IPL and IPP

	TERM	MEDLINE	EMBASE	CINAHL	PSYCHINFO	COMBINED
1	Inter-profession\$ or interprofession\$	35,793	868	7,414	996	45,071
2	Inter-disciplin\$ or interdisciplin\$	15,352	10,683	5,256	4,755	36,046
3	Inter-occupation\$ or interoccupation\$	5	3	4	13	25
4	Inter-institut\$ or interinstitut\$	7,851	343	4,086	110	12,390
5	Inter-agen\$ or interagen\$	928	742	474	1,002	31,46
6	Inter-department\$ or interdepartment\$	60	49	412	308	829
7	Inter-sector\$ or intersector\$	492	357	176	110	1,135
8	Inter-organisation\$ interorganisation\$	0	0	0	0	0
9	Inter-organization\$ interorganization\$	0	0	0	0	0
10	exp Interprofessional relations\$	39,405	1,336	0	0	40,741
11	Multi-profession\$ or multiprofession\$	725	632	571	335	2,263
12	Multi-agenc\$ or multiagenc\$	278	198	270	350	1,096
13	Multi-disciplin\$ or multidisciplin\$	24,829	21,209	17,575	1,451	65,064
14	Multi-institut\$ or multiinstitut\$	8,806	2,178	1,532	75	12,591
15	Multi-sector\$ or multisector\$	366	257	83	78	784
16	Multi-organisation\$ multiorganisation\$	0	0	0	0	0
17	Multi-organization\$ multiorganization\$	0	0	0	0	0
18	Team\$	403	119	15,660	3,973	20,155
	Totals	13,5293	38,974	53,513	13,556	241,336

A note about the IPL and IPP search on PsychINFO under the term *inter-disciplin** or *interdisciplin**. The search resulted in 24,523 citations. After reviewing 3,000, it was deemed that many of the references were too clinically specialised dealing with diseases and disease management. Results were then narrowed by using the mapped term *interdisciplinary treatment approaches* (4,459) with further mapping to *teams* (296) which when combined, delivered 4,755 results. Similar narrowing was done from searching the term *multi-disciplin\$* or *multidisciplin\$* from an original 10,874 results to 1,451 from mapping to *interdisciplinary team* approach.

From searching the keyword *team\$* in CINAHL, 32,825 results were returned and subsequently narrowed by mapping to *teamwork* (3,445) and *multidisciplinary care teams* (12,215) for a combined total of 15,660. The Medline search under *team\$* returned 40,795 references and this was narrowed by mapping to *patient care teams*, narrowed again by mapping to *education, methods, utilisation* and *history*. This resulted in 403 references.

Table 2.4: Results of database searches for IMGs

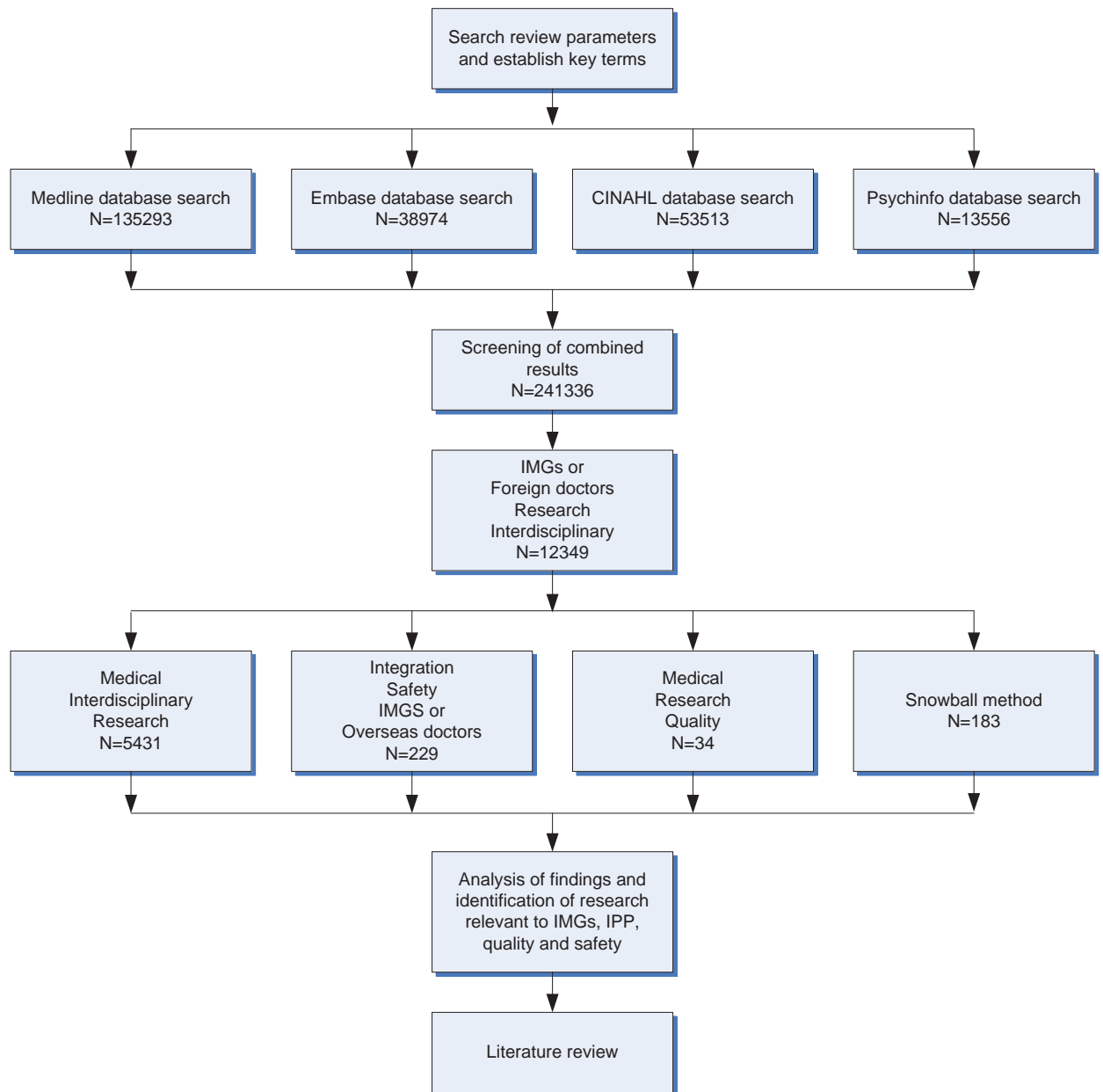
	TERM	MEDLINE	EMBASE	CINAHL	PSYCHINFO	COMBINED
1	AMC doctor* or AMC graduate*	0	0	0	0	0
2	Doctor* trained overseas or doctor* trained abroad	3	1	3	0	7
3	Foreign trained doctor* or foreign-trained doctor*	10	4	2	6	22
4	Foreign medical graduate	2,652	204	276	127	3,259
5	Internation\$ doctors or internation\$ trained doctors	7	2	0	0	9
6	International medical graduates	265	228	45	159	697
7	Migrant doctor*	14	5	3	24	46
8	Overseas doctor*	133	84	29	39	285
9	Overseas medical graduate*	5	0	2	13	20
10	Overseas qualif* doctor* or overseas-qualif* doctor*	3	4	1	0	8

11	Overseas trained doctor* or overseas-trained doctor*	23	17	6	5	51
12	Overseas trained physicians or overseas-trained physicians	0	0	0	0	0
13	Overseas trained specialist* or overseas-trained specialist*	2	1	0	3	6
	Totals	3,117	550	367	376	4,410

2.2.3 Search strategy 2: refinement of results

Duplicates were removed from both data sets. The sets were then combined into one EndNote file, which after further removal of duplicates, numbered 173,142 references. These results were screened using the terms IMGs, foreign doctors, research and interdisciplinary resulting in 12,349 references. From that file, references were searched under the key words of medical, interdisciplinary and research. This resulted in a base file of 5,341 references to examine. The abstracts to these references were examined and those of direct relevance to the study extracted. Other relevant sources of interest were found by combining terms of safety, IMGs or overseas doctors (229 references) and medical, research and quality (34 references). The narrowing process also involved eliminating references that were considered too clinically, or specialty specific. Additional material comprising 183 references was sourced from journal article references using the snowballing method, and from other searches including the grey literature. Figure 2.2 is a schematic representation of the literature search process undertaken and described above. It illustrates the nature of the strategies used in conducting the search and the methods applied to refine the results and analyse the findings.

Figure 2.2: The literature search process



Keys to terms used in Figure 2.2

Medline = medical database

CINHAL = nursing and allied health database

Embase = medicine and health sciences database

Psychinfo = psychology database

Source: Figure adapted from Braithwaite and Travaglia (2005)

2.3 Terminology used in the literature for IMGs

Terms such as FMGs and OTDs are still commonly used in reference to IMGs (McGrath 2004; Van Der Weyden and Chen 2004; Han 2005; Tromp, Rademakers et al. 2007; Foster 2008), however, the term IMGs has become more widely used, recognised and accepted internationally (Cohen 2006; Spike 2006; Pilotto, Duncan et al. 2007; Rao, Kramer et al. 2007). As a distinct group, IMGs are variously described in the literature, but essentially defined as doctors trained in countries that do not have reciprocal registration arrangements (Fiscella and Frankel 2000) with the countries in which they seek to work (Narasimhan, Ranchord et al. 2006), or "... graduates from medical schools not located in the country in which they currently practice" (Wong and Lohfeld 2008:53). In Australia, IMGs have been described as "graduates of non-western medical schools" (Hawthorne and Birrell 2002:57). To work in a teaching hospital IMGs are required to pass written and clinical examinations equivalent to the final examinations of Australian medical graduates, constituting the minimum standards required to practice. (Australian Medical Council). More simply, in the USA and Canada, The Education Commission for Foreign Medical Graduates (ECFMG) has defined an international medical graduate as "a physician who received his or her basic medical degree or qualification from a medical school located outside the United States and Canada" (Harden 2006:S25).

2.4 Historical perspective and background to medical workforce shortages

"Since antiquity the practice of the healing arts has been characterized by the free flow of physicians from one country to another ... once this flow was characterized by learned physicians travelling to economically disadvantaged countries, however, in the post World War II period the flow has been in the opposite direction." (Dublin 1997: 407)

The flow in the *opposite direction*, identified by Dublin (1974), has continued in Australia and in other Western countries with comparable medical training programs

and doctor shortages such as the UK, the USA, NZ and Canada, a country “facing a doctor shortage of unprecedented magnitude” (Foster 2008:1). More recently, IMGs have moved from European Union countries to practise in the UK under mutual recognition of medical qualifications, a phenomenon not without emerging questions relating to patient safety (Lancashire, Hore et al. 2009).

In Australia, the emergence of medical workforce shortages, leading to an influx of IMGs, has taken place over the last 25 years (AMA Council of Doctors in Training 2008; Smith 2008). The migration of IMGs has directly resulted from an inability to meet increasing demands on public hospitals from the available medical workforce required for the delivery of health care services. The reasons for this include: the misjudgement of future trends in medical workforce needs, through restricting the growth on medical school places in the 1990s (AMA Council of Doctors in Training 2008); increasing demands on services from a more informed population and higher expectations of services available, brought about by advances in medical science and technology. In Australia, and in many other developed countries, the ageing population is also a contributing factor to an increased demand for medical services, putting pressure on existing workforce shortages in hospitals, regional general practice and in some specialty areas such as emergency medicine (Hawthorne and Birrell 2002). However, the introduction of IMGs into the workforce, has brought with it, problems associated with integration and practice within the health care system, problems commonly shared by Australia and other countries with similar, reciprocally recognised, medical training and education programs (McGrath 2004; Rao, Kramer et al. 2007). The fact that 43% of IMGs in 2002-2003 were from countries with comparable medical training programs compared to 70% in the late 1997-1998 is noteworthy (Table 2.5). It highlights the significance of the increase in IMGs from countries such as India, Pakistan, Sri Lanka, Malaysia, the Philippines and Bangladesh for the same period from 9.6% to 37% respectively (Smith 2008).

Table 2.5: IMGs from countries with comparable medical training and IMGs from Asian countries. Change in percentages from 1997-1998 from 2002-2003 (Smith 2008)

Category of IMGs by percentage	Period	
	1997-1998	2002-2003
Percentage of IMGs from countries with comparable medical training	70%	43%
Percentage of IMGs from Asian countries	9.6%	37%

Between 2000 and 2001, 43% of IMGs came from a range of North American, European and Asian sources (Hawthorne and Birrell 2002). During the ten-year period 1994-2004, source countries also included the Middle East and China. By 2007, IMGs accounted for one quarter of the medical workforce in Australia (Pilotto, Duncan et al. 2007) at which time, no data were available to indicate how this group was practising within the Australian health system, in any health setting (Bayram, Knox et al. 2007).

Medical workforce shortages, leading to the reliance on IMGs in Australia, have been attributed to limits on medical school places in 1980s and 1990s (Smith 2008). In more recent times, other contributing factors have been attributed to locally trained doctors' attitudes towards work differing from the past. For example, less willingness to work longer hours; reluctance to do unpaid overtime; desire for the flexibility to move in and out of the medical workforce and to work part-time (especially amongst the female medical workforce); as well as other lifestyle related factors (Birrell 2004; Tolhurst and Stewart 2004; Spike 2006; Brown and Arnold 2008; Greenfield, Nugus et al. 2010).

Changes in the gender balance of the workforce, reflecting more female graduates, have also had an impact on the medical workforce in Australia. "The Australian Medical Workforce is increasingly 'feminised' and exposed to the global market for doctors" (Brown and Arnold 2008:206). Use of the term global and market is a reminder of the economics and therefore the resources and competition associated with the movement of IMGs to western countries, where there are medical workforce shortages. Reference to the feminisation of the medical workforce highlights the change in sex ratio of female

medical graduates who are more likely to enter general practice and “whose working life approximates 60% that of male doctors” (Brown and Arnold 2008:207).

More recently, medical workforce shortages have been addressed with the opening of new clinical schools and therefore more places for doctors in training. This has raised concerns about the adequacy of training available to the increasing number of doctors in training, and of the number of postgraduate vocational training places that will be available for all these graduates. The view that “Australia faces the real prospect of a training emergency” (AMA Council of Doctors in Training 2008:9) reflects that concern. Nevertheless, aside from these JMO training related concerns, the need for IMGs is likely to continue in the foreseeable future (Health Workforce Health Workforce Australia: Information Analysis and Planning 2012).

As indicated previously, a synthesis of the literature resulted in four main themes and sub-themes which formed the framework for this study. I now move to using these themes and addressing them individually, within the context of the hospital settings in which IMGs practise.

2.5 Culture: integration and acculturation

“It is widely accepted that cultural differences between physicians and patients can shape medical encounters and affect quality of care.” (Fiscella and Frankel 2000:1751)

The necessity to recruit IMGs in order to sustain the Australian health workforce arose largely because public hospital and medical workforce needs outstripped supply. This mark of the internationalisation of the workforce has brought with it, culture related concerns, and problems associated with integration into the national workforce. These concerns and problems are commonly shared in comparable countries such as the USA, Canada, the UK and NZ (McGrath 2004).

Problems of integration relate to the diversity of countries from which IMGs emanate, defying any assumptions that they belong to one group. Coupled with this, more often than not, is the problem of communication, which is discussed in a later section of this chapter. Two aspects of integration are noteworthy: firstly, the integration of IMGs into the complexity of the Australian health system and all that is inter-related with the system in the provision of health services to patients; secondly, integration within the more general culture of the country in which they have chosen to practice (McGrath 2004). Concomitant with these two aspects are problems linked to IMGs' diversity; their ethnic and medical training backgrounds, their level of experience, and their clinical knowledge and skills. The problem is therefore multiplied, firstly, by having shortages in the medical workforce and secondly, by the inflow of IMGs, giving rise to ongoing challenges associated with their integration into the Australian medical workforce.

The term *acculturation* has been used in discussion concerning the integration of IMGs and the amalgamation of different cultures. Assisting IMGs to enculturate (Louie, Roberts et al. 2007) and adapt to working in another culture contributes to the extent to which they function effectively. Acculturation of IMGs to their adopted country is crucial if they are to work with other health professionals within a climate of quality, patient centred care (Whelan 2006). A climate of care is fundamental to the notion of IPP and patient safety. This aspect of IPP is therefore of critical importance for IMGs to understand.

Interculturality is another term that has been used in conjunction with IMGs and integration. Rather than describing a situation where "the intercultural problem is one of creating a space in which different worldviews can be accommodated and validated ... it is viewed as ... one in which the *other* enters with the desire and indeed the obligation to minimise their *otherness*" (Musgrave and Cordella 2008:1). Thus on the one hand, desire countered by obligation, and on the other, a difficult tension but crucial to manage in the acculturation process, if IMGs are to integrate and work

interprofessionally as well as intraprofessionally with their JMO peers and senior clinicians (Whelan 2006).

The pitfalls and institutional barriers to IMGs entering the medical workforce culture in Canada have been discussed. Culture is perceived as involving power, producing “asymmetries in the abilities of individuals and social groups to define and realize their needs” (Foster 2008:4). In relation to IMGs in Australia, the effect of this perception would appear to resonate in the unfamiliar cultures of the hospitals they enter, and the effort required to engage with workplaces, social institutions, and a complex health system (Plsek and Greenhalgh 2001) The real challenge for IMGs not initiated in any way to IPP is apparent.

AMGs benefit from: shared education and training experiences; a common base of medical knowledge; a unique (to Australia) population and health profile; the developed skills of working in, and learning about, a complex health system; and the benefits of being inculcated to the teaching hospital environment as medical students and graduates. This is likely to create an environment of relative comfort and familiarity within the medical profession for AMGs. This is one major barrier to IPP practice and is supported by a 2008 Canadian study of IMGs views and experiences, which revealed among other issues: professional uncertainty about expected behaviour; confusion about roles and responsibilities; interprofessional and doctor-patient relationships; and a lack of knowledge about the health system (Wong and Lohfeld 2008).

Along this same theme, is reference to the term therapeutic relationships, viewed as being the “central, interpersonal milieu in which patients are diagnosed, given treatment recommendations, and referred for appropriate tests, procedures or care by consultants in the health care system” (Cooper and Spencer-Dawe 2006:521). The moral value of relationship-centred care is one aspect of this approach, others being related to expressions of emotion, the context of reciprocity of relationships, and the “*personhood*” of relationship participants. Further to this view on the clinician-patient relationship, is the acknowledgment that race and ethnicity also influence these relationships and may have a bearing on quality of health care (Cooper and Spencer-

Dawe 2006). The same authors explore clinical aspects of racial and ethnic disparities which may occur because of the interpersonal behaviour of clinicians, manifested through their beliefs, and negative aspects such as less empathy and information giving, as well as allowing fewer opportunities for questions (Woodward-Kron, Stevens et al. 2011). This notion of interpersonal style is therefore directly relevant to IMGs in their interactions with others. IMGs may not have had the opportunity to develop the professional cultural characteristics of this style, a style which may develop in an environment of IPL and lead on to effective IPP.

The integration of IMGs into the Australian workforce is therefore difficult enough, before addressing issues relating to communication and interaction with other health professionals and with patients, in the provision of health care, within the health system. Orientation to the system; training and support to improve knowledge, communication, and working with health care providers, are identified as areas which would assist IMGs to integrate into the health care system. An awareness and understanding of IPP may do much to smooth the process of transition and integration of IMGs entering the workforce (McGrath 2004).

One of the most important dynamics to consider in dialogue about IMGs and IPP is at the heart of some of the more human aspects associated with the practice of medicine. Human aspects identified in the literature include: the ability to converse; to respect and empathise in the exchange information; to value the work of others; and to collaborate, through sharing and working in partnership. All these elements are critical for effective IPP (Braithwaite and Travaglia 2005; Schyve 2007; Rice, Zwarenstein et al. 2010; Hamilton 2011; Raduma-Tomàs, Flin et al. 2011).

2.6 Communication and interaction

“Communication problems are the most frequent root cause of serious adverse events.” (Schyve 2007:361)

There is overwhelming concurrence of thought about the critical importance of communication between doctor and patient and between doctor and professional colleagues. Not surprisingly, the importance of communication is a recurring theme in the literature (Fiscella and Frankel 2000; Hall and Weaver 2001; Horvath, Coluccio et al. 2004; Kostis and Ahmad 2004; McGrath 2004; Han and Humphreys 2005; Gastel 2006; Narasimhan, Ranchord et al. 2006; Tromp, Rademakers et al. 2007; Foster 2008; Garling 2008; Grattan-Smith 2011). Communication skills are a core element of the interface between doctor and patient in achieving effective interaction (Harden 2006).

The centrality of communication and interpersonal skills to clinical expertise and improved health care outcomes (Rider and Keefer 2006; van Zanten, Boulet et al. 2007), is of direct significance to IMGs and to IPP. Barriers to effective communication include aspects related to language and cultural differences as well as inadequate health literacy (Schyve 2007). Dialogue is pivotal in facilitating decision-making about approaches to patient care, based on a shared understanding of team values and philosophies (Britten 1995). Good clinical practice as well as good teaching, is based around “good communication with trainees, patients and colleagues. The two are largely inseparable” (Prideaux and Alexander 2000:822). The fact that frequently, IMGs have had no formal training in communication skills, is a significant barrier to exercising the skills essential for establishing a trusted patient relationship, from diagnosis to ongoing treatment and care (Tromp, Rademakers et al. 2007; Woodward-Kron, Stevens et al. 2011).

Westbrook, Ampt et al. (2008) found in their observational study in a Sydney teaching hospital, that JMOs consisting of interns, residents and registrars spent one third of their time in “*professional communication*” such as meetings, requests for consultations and

patient care planning. Importantly, this was aside from patient communication, adding weight to the importance of interprofessional communication skills. A further factor to consider is that IMGs usually enter the hospital system at the level of a JMO, where there are expectations and assumptions about their professional communication capabilities (Arnold 2002; Hall, Keely et al. 2004; Brown and Arnold 2008).

In NZ, where an estimated 34% of the medical workforce has been trained overseas, Narasimhan, Ranchord, Weatherall (2006) reported on findings from a pilot study to seek the perceptions of doctors and nurses, working daily with IMGs, about the possible training needs of IMGs. Indications from the study, conducted in a teaching hospital, pointed to deficiencies in IMGs' knowledge of the health care system, some aspects of patient management, and communication with patients, patient's families and health professionals. Written communication, in the form of documentation, was reported as an area of training required by IMGs.

In the context of doctors communicating with patients, there have been more recent changes in doctor-patient relationships whereby, "Doctors are encouraged to discuss diagnosis and treatments with patients, and to empower the patient to take part in the decision-making process" (Hastie and Paice 2003:227). IMGs need the competence to interact with patients, to understand their concerns and respond to their questions meaningfully. IPP may assist in facilitating this deeply personal and often sensitive interrelationship between clinician and patient.

Cultural differences present barriers to effective communication in other ways as well (Schryve 2007). Certain words or phrases are open to different interpretation, particularly in situations where body or non-verbal communication occurs (Hawken 2005; Fiscella and Frankel 2000). IMGs need to interact in their day-to-day work with nurses and other health professionals in the dynamics of decision-making and the multiple factors related to the planning and treatment of patients. This includes liaising with a range of health professionals involved in processes such as discharge planning. Finally, poor communication skills can lead to confusion about differences in role

identity and misjudgements about authority figures, aspects which may be often, rightly or wrongly, linked to attitude (Reeves and Lewin 2004; Mahajan and Stark 2007).

If IMGs are to work in a collaborative manner, with collective understanding, it is important for them to develop a degree of collegiality, through communication, with their working colleagues, so that barriers related to reservations about working collaboratively are more likely to be overcome (McCallin 2001). Familiarity may develop through a shared focus on patients, providing opportunities for appreciating what and how someone is actually contributing as a health professional to the welfare of the patient, rather than viewing and possibly judging that person as an individual provider of care.

Associated with communication, is the matter of conflict, which may be much greater if there are misunderstandings involving IMGs. Conflict resulting from professional boundaries is one example, one that the concept of IPL is designed to overcome, or at best reduce (Ferlie, Fitzgerald et al. 2005). IPL offers preparation for IPP to pre-empt the negative effects of bounded individuals holding on to vested power and authority, with little consideration for the patient, the presence of whom, creates their very being as health care providers. Conflict also may arise from misunderstandings based on the misuse of language. For IMGs, this has the likelihood of occurring where skills in English language proficiency are lacking.

2.6.1 English language proficiency

One of the more human aspects associated with the practice of medicine is the doctor-patient relationship, integral to which is the ability to communicate through interaction, conversation and the exchange of information, as discussed above. (Harden 2006). Equally important is the ability to collaborate through working in partnership, cooperating and sharing, which is further discussed in the next section. These human aspects are all fundamental to the strength of IPP in advancing improvements in patient outcomes. (Kohn, Corrigan et al. 1999)

A command of the language is the basis for reliably communicating and working, with patients, families and professional colleagues. For IMGs, spoken English is particularly important (Hall, Keely et al. 2004) and frequently challenging, even though all IMGs must pass mandatory English language tests. To be effective, communication requires comprehensible dialogue (Schein 1992). IMGs unable, or struggling to achieve this through a lack of English language proficiency are at risk of making errors, compromising safety and delivering health care of diminished quality (Schyve 2007). It is vital for the safety of patients and the quality of their care, for communication of JMOs to be comprehensible and unambiguous. Eliciting critical information for accurate diagnosis is fundamental to effective treatment and care. In conjunction with this, are the essential aspects of explaining and instructing patients, of educating them and where necessary, counselling them and offering emotional support. The latter may be particularly difficult for IMGs, taking into account, cultural, role and gender boundaries. (Hawken 2005; Schyve 2007). The nuances of the English language and the idioms commonly used, pose further problems for IMGs, both interprofessionally and in the course of interviewing patients (Hall, Keely et al. 2004).

Important legal, social and linguistic aspects of the Australian health system are often difficult for IMGs to understand if their level of English language proficiency is inadequate. For example, the risk of a mismatch of understanding can increase the possibility for legal action at a future time (Schyve 2007; Grattan-Smith 2011). It is feasible to suggest that some of this information can be obtained or transferred and absorbed, through the direct and indirect cross-communication and teaching, which comes from IPP.

Interaction is inherently linked to communication and dialogue as evidenced in the literature (Schein 1992; McGrath 2004; Narasimhan, Ranchord et al. 2006; Reiheld 2006; Whelan 2006; Pilotto, Duncan et al. 2007), and therefore strongly relates to the practice of JMOs interprofessionally, particularly in IMGs. Neither interaction nor communication relies totally on the spoken word. Aside from spoken language, common to both is written language and body language. To be effective in interacting

with patients, their families and carers, professional colleagues and other members of health care teams, language skills, both spoken and written are critical to quality and safety. It is not enough to assume understanding has occurred. Communication is a two-way interaction and agreed understanding is at the core of effective communication. This can be a problem even in situations where English is the first language of communicators. In the case of IMGs, where English is more usually the second, or even the third language, the potential for misunderstandings of significance is far greater and likely to impair their relationship with patients, as well as the web of health team members they interact with daily (Mintzberg 1979). It has been shown that:

“... substantial research into doctor-patient communication indicates that poor communication skills contribute to problems in history-taking, diagnosis, management, and provision of information to the patient.” (Smith 2008)

For IMGs, the implication of this bears directly on their understanding of the role of IPP in medical practice, and the benefits sought through the practise of IPP, including shared decision making about optimal outcome based plans for the treatment and care of patients. While oral communication skills are fundamental, skills in written communication are required for clear documentation of assessment and diagnosis. They are required for writing initial and ongoing treatment plans, for referral, and directions for follow-up care. These are all constituents of importance within the context of IPP and patient quality and safety (Braithwaite and Travaglia 2005; Mooney 2007; Smith 2008). It has been reported that limited research had been undertaken to specifically evaluate proficiency levels in the spoken English of IMGs (Boulet, Rebbecchi et al. 2004). Barriers to effective communication range from differences in language and culture, to low health literacy.

“Health literacy is the degree to which individuals can obtain, process, and understand the basic health information and services they need to make appropriate health decisions. But health literacy goes beyond the individual. It also depends upon the skills, preferences, and expectations of those health information providers: our doctors, nurses, administrators, home health

workers, the media, and many others.” (Department of Public Health and Environment Colorado, 2008:1)

The riskiness of the hand over process to patient safety is a further concern if it is not clearly managed and understood (Hastie and Paice 2003). English language proficiency and communication skills enter the fundamentals of effectiveness in this area as well, particularly where supervision is lacking. Supervision from senior members of multidisciplinary teams may counteract the risk of IMGs managing individual handovers, where errors or misunderstandings may not be detected, particularly in patients with complex co-morbidities. A proper orientation before the beginning of new rotations for IMGs as well as AMGs is further counteraction to avoiding patient error (Mulroy, Rogers et al. 2007).

Other elements associated with communication are collaboration, respect and trust, interpersonal trust being one of the foundations of all relationships (Cooper and Spencer-Dawe 2006). Collaboration and trust link to the process of delivering health services, the safe progress of patients during that process, and to effective outcomes. What occurs along this progressive pathway of the patient journey is instrumental to the status of those outcomes in terms of patient safety and error prevention (Begun, Tornabeni et al. 2006; Braithwaite, Iedema et al. 2007).

2.7 Collaboration and teams

Collaborative practice has been defined as “An interdependent association of health care personnel including nurses, MDs, and other allied health care workers – all committed to the common goal of providing patient care” (Martin, O'Brien et al. 2005:325). Similarly, interprofessional collaborative practice is described as, “When multiple health workers from different professional backgrounds work together with patients, families, carers and communities to deliver the highest quality of care” (World Health Organization 2010:2). Within these broad definitions can be added, recognition of the respective practice domains of all health professionals, shared problem solving and joint

decision-making, all factors intrinsic to collaboration (Braithwaite and Travaglia 2005). “Working ‘together’ rather than working ‘alongside’ can energise people and result in new ways of looking at old problems” (Davies 2000:1021).

The complexity of interprofessional collaboration, by its nature, a “multifaceted and dynamic activity” (Reeves and Lewin 2004:219) serves only to exacerbate this problem for all JMOs. IMGs lacking an orientation to IPP and the notion of interdependency, may be confronted with a barrier where, through lack of awareness, expectations of collaboration in approaches to patient care are unmet. IMGs faced with the challenge of appreciating the nature of collaborative IPP, have the added difficulty of possibly relating it only to work that takes place with medical colleagues, which in itself, can be a problem for AMG as well as IMGs (Reeves and Lewin 2004).

The impact of interactions between health professionals, in particular, physicians and nurses was investigated by Reiheld (2006), who found that studies had indicated demonstratively improved patient outcomes resulted from collaborative physician-nurse relationships. Furthermore, improved patient outcomes were seen to have a positive impact on morale and in turn, personnel retention amongst nurses. Benefits were realised for management as well as staff and patients. Collaboration facilitated continuity of care adding to quality and safety of patient care. A similar correlation was found, by Zwarenstein and Bryant (2000), between improved collaborative efforts and patient safety and outcomes, together with better staff satisfaction and reduced costs. However, on the point of improved patient outcomes, Zwarenstein and Bryant (2000) added a degree of caution, suggesting that more evidence was needed to add strength to this aspect of their findings. Nevertheless, the findings provided further grounds for IMGs to have an understanding of the additional benefits for staff and organisations, as well as patients, if an environment of collaboration and collegiality exists, which in turn, fosters the uptake of IPP. With the percentage of IMGs working in western health care systems continuing to increase, it is appropriate to add to the body of work on their understanding of the nexus between collaborative IPP, safety, and improved patient outcomes.

Although mainly focusing on collaborative physician-nurse relationships, Reiheld (2006), acknowledged the reality that health personnel interact with countless other individuals in the delivery of health care. The recognition of this, is integral to better patient care and health service outcomes. The integration of IMGs into a health system constantly adapting to the changing nature of acute to chronic medical problems requires them to collaborate with a range of other health professionals such as allied health professionals, who have special skills and knowledge. “The resulting proliferation of health professionals tends to blur and obscure the central role of the physician and illustrates the necessity for conscious teamwork in health care” (Baldwin, Royer et al. 2007:38).

Reference to the blurring of roles is noteworthy and difficult to ignore in a climate of patient centred health care, where the receivers of care now have expectations that may only be met through collaborative effort. Whether the health system is moving to a point where the term health professionals embraces all those involved in health care delivery is still debatable. However, according to Davies (2000), The National Institute for Clinical Excellence UK (NICE) does not single out any particular group within health care delivery, all are referred to as health professionals. Their rationale is that “no one who works alone can stay at the forefront of knowledge given the speed of organisational and clinical change” (NICE1993:3). This may add to the difficulties of IMGs coming from cultures where the role of the physician predominates, overriding any notion of sharing and collaboration. If health professionals do not have an understanding of the nature of the system in which they are working, it is likely to result in competing priorities between the individual professional identities (Nolan, Dunn et al. 1998).

Links between IPP and collaboration have come to attention more recently through findings from long running inquiries in Australia, and beyond, into systemic failures in the management of patient safety (Hindle, Braithwaite et al. 2005; Mooney 2007). Drawing on the findings of the Bristol Royal Infirmary Inquiry (2001), Stinson et al. (2006), noted that a combination of factors contributed to the paediatric cardiac deaths which led to the inquiry. These factors included, lack of insight, failure to communicate

and work together in the interest of the patient, lack of leadership and of effective teamwork amongst health care professionals. In other words, much of the failure resulted from an absence of collaborative effort on the part of health care professionals.

The ability to work in teams and to integrate and manage the quality and safe provision of care was a recommendation from the New Zealand Health Workforce Advisory Committee (2010). A perspective proposed by Davies (2000), draws attention to the importance of recognising that collaboration is about the differences rather than the commonalities between people. This suggests that it is the differences, which underscore the power of collaboration. In that sense, it is meaningful to consider that effective teamwork results from the ability of individuals to withhold their own assumptions when working in groups, in order to maximise the opportunity for collective thinking through genuine dialogue (Senge 1990; Schein 1992). The fundamental message here, links directly to the complex way in which cultural and communication barriers countenanced by IMGs can be problematical in the context of IPP. For example, attempts at teambuilding can be inhibited by role confusion (Ferlie, Fitzgerald et al. 2005; Mahajan and Stark 2007) common to IMGs, together with more universal problems which weaken efforts to work collaboratively, such as “... the effects of professional socialisation, power and status differentials” (Reeves and Lewin 2004:218). Isolation is more than likely to result from these effects and to extend to inhibiting opportunities for learning. It may be compounded through the learning that has occurred in a different country and in a culture, not comparable or inherently different, to that of where the IMG comes to practice.

In the study of IMGs training in paediatrics, conducted by Mahajan and Stark (2007), one of the barriers identified was the difficulty IMGs had in working as a team. Not knowing where they fitted in or understanding their roles and responsibilities were the greatest causes of the stress reported by IMGs. This study highlighted issues related to isolation in association with a lack of orientation to IPL and therefore a lack of understanding about IPP. Learning in isolation is thus akin to practising in isolation. A consequence of IMGs working in isolation was the missed opportunity for gaining benefits through IPP, for developing knowledge and fostering ideas for their ongoing

improvement. The precursor to collaborative IPP to this extent is likely to occur through IPL. The inter-connectedness of IPL and IPP is apparent and the link to the plausible inadequacies of, and barriers to IMGs, expounded.

Medical professional affiliation is therefore important for IMGs as well, not only in relation to clinical matters, but also in terms of confidence, familiarity with professional culture and to a degree, orientation to the general society from which their patients come (McCallin 2001). Affiliation with medical professional colleagues also predisposes to working in a collaborative manner with collective understanding. For this to occur, IMGs need to communicate effectively so that barriers related to reservations about working collaboratively are more likely to be overcome (Stinson, Pearson et al. 2006). As far as cultural differences are concerned, familiarity may develop through health professionals focusing on patients together, providing opportunities for appreciating what and how someone is actually contributing as a health professional to the welfare of the patient, rather than viewing and judging that person as an individual provider of care. The optimal aim is to provide safe patient care through the means of “*dynamic harmony*” amongst the providers of care (Amalberti, Auroy et al. 2005:757).

For systems related issues and the functioning of teams, the roles and responsibilities of team members lie within the environment of a foreign, difficult to understand, health care system for IMGs. This applies within and beyond the hospital setting or, where the two converge. Convergence may be at the point of discharge planning whereby identification of the multifaceted services in the community, essential for continued care and support, have the propensity to be somewhat confusing for IMGs as well as AMGs (Hall, Keely et al. 2004). The importance of system-supported teams comes to bear; a system that supports the values of team members as well as the value of teams, for the benefit of patients as well as staff (Rothman and Cusimano 2001).

The integration of IMGs into a health system adapting to the changing nature of acute to chronic medical problems calls for IMGs to enter a health care environment in which “the complex structures and behaviours of health care organisations are increasingly recognised as critical factors in determining the quality of care” (Pope, van Royen et al.

2002:150). In teaching hospitals, IMGs are confronted with an array of bounded health professionals and a highly specialised working milieu (Ferlie, Fitzgerald et al. 2005). Where there is blurring of professional boundaries, particularly affecting the authority and centrality of the role of physicians, concerted teamwork and effort in delivering health care is required (Hall 2005; Baldwin, Royer et al. 2007). Preparation for collaboration is seen as a necessary means to IPP for health professionals, who “without education in collaborative methods are frequently unable to share these affectively so that the patient benefits” (Prideaux and Alexander 2000:823).

A common theme in the literature signals that to achieve better health service delivery, there needs to be greater collaboration and respect between all health professionals. The instigation of respect at the JMO level is likely to be predicated on an understanding of IPL and IPP making it difficult for IMGs who lack an orientation to IPL and IPP. The management of IMGs lacking an orientation to IPL firstly, and secondly, lacking therefore an orientation to IPP, becomes an important area to examine, within the context of quality of care and patient safety.

2.8 Competency, safety and quality, professionalism

“The skills that together constitute core competence must coalesce around individuals whose efforts are not so narrowly focused that they cannot recognize the opportunities for blending their functional expertise with those of others in new and interesting ways.” (Prahalad and Hamel 1990:82)

Broadening this statement further, competency relates to “... problems of acquiring new skills, of dis-acquiring old ones, of adapting knowledge and skills to fit changing circumstances and utilizing performance feedback” (Leathard 1994:55). Professional competence concerns essential elements which directly affect patient safety. Competencies in this regard link to “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily

practice for the benefit of the individual and community being served” (Epstein and Hundert 2002:226).

In discussing the theme of competency, two perspectives are included here: clinical competency relating to outputs, or competence in performance as a result of training, and professional competency which is “neither visible nor tangible” (Barondess 2003:7). The latter is concerned more with inputs pertaining to personal attributes required to perform with competence (Hoffmann 1999). The two are interconnected components of the overall competency required and expected of medical practitioners and therefore JMOs. For the purpose of this work with its focus on IMGs, clinical competency is referred to mainly in the context of differences in clinical competency among IMGs and concern over the assessment of their clinical competency. Professional competency, on the other hand, is viewed from the perspective of JMOs being practising members of the medical profession, whose conduct and performance, reflects all that is expected in the delivery of patient care in terms of both quality and safety, in the pursuit of optimal patient outcomes. To maximise the likelihood of achieving optimal outcomes, it is argued that IPP is a core component in that realisation.

Further associations with IMGs and competency are questions of standards and safe practice raised by many in the literature (Hawthorne and Birrell 2002; McGrath 2004; Rider and Keefer 2006; Searight and Gafford 2006; Thind, Freeman et al. 2007; Tromp, Rademakers et al. 2007; Whitehead 2007; Penington 2008; Wong and Lohfeld 2008). Along with these concerns is the problem of assessing the competencies of IMGs from such a diversity of countries, backgrounds and experiences, in order to determine their various training and up skilling needs (McGrath 2004). The variation in the level of English language skills of this diverse group also militates against the benefits implicit in IPP. It follows then, that the supervision of IMGs goes hand in hand with these questions and concerns and while not the focus of this work, is an area of interest which it is hoped can be built upon out of this work.

A recurrent theme of concern about the quality of IMGs and their competencies was reported by Rao, Kramer et al. (2007) who, from a review of the literature on IMGs,

noted that the professional medical literature is usually clinically based, and directed towards the betterment of patient care. However, while clinical expertise is paramount in terms of clinical competency, there is much more to competency as we have seen. The concerns raised here pertaining to the professional competencies of IMGs in delivering clinical care, and consequently their impact on patient centred care and clinical outcomes, are all intrinsically connected to IPP. Braithwaite and Travaglia's (2005) review of the literature on IPL and IPP is of interest in this context. From their review, Braithwaite and Travaglia (2005), found that competency standards for health professionals, parallel those of interprofessional competencies, and that at the heart of IPP, are abilities which include: creating and maintaining professional relationships with patients as well as colleagues; communicating effectively in different contexts with a diversity of people; and possessing teamwork competencies associated with effective collaboration.

Of five essential health professional competencies identified by Walton and Elliott (2006), two of these are the ability to provide patient-centred care and to work in interdisciplinary teams. Inadequacies of IMGs in these two areas have already been discussed, for example competence in interacting effectively with a range of people and to deal with doctor-patient relationships equitably and reliably (Pilotto, Duncan et al. 2007; Tromp, Rademakers et al. 2007).

Citing Rocco Gerace, a former Canadian Registrar of the College of Physicians and Surgeons of Ontario, Foster (2008), reiterates criteria necessary to avoid compromising performance standards in the context of IMGs. These criteria are: "knowledge, skills or competence and clinical judgment as measured during interaction with patients" (Foster 2008:19). Associated with this, is the factor of discipline-specific training and practice in countries such as Australia, which may be vastly different in scope from IMGs' countries of training. Arising from these concerns are the difficulties and complexities in determining and evaluating competent performance of the standard required and expected in developed countries, sharing similar health profiles, although not always similar health systems.

Differences in medical training programs from country to country, result in variability in the levels of training, education, and experience of IMGs. The differences are manifested in their clinical skills, their depth of knowledge as well as other competencies expected in Australia, such as the use of technology and an understanding of the health profile of the Australian population (Hawthorne and Birrell 2002; Thind, Freeman et al. 2007). The competencies associated with patient safety are at the core of patient-centred care and therefore IPP. For IMGs uninitiated to IPP, this becomes a major concern.

2.8.1 Safety and quality

“Patient safety transcends all competencies desired in doctors.” (Singh, Naughton et al. 2005:1195)

Links between IPP and collaboration have been brought to light through findings from long running inquiries into systemic failures in the management of patient care (Braithwaite, Hindle et al. 2006; Mooney 2007). The outcome of findings from inquiries into breaches of patient safety in English speaking countries has been discussed in the context of what was revealed about common factors of significance for delivering safer patient care. These factors relate to issues concerning interprofessional communication and the integration of patient care services (Braithwaite, Hindle et al. 2006). From a patient safety perspective, the importance of developing a professional’s ability to collaborate effectively across occupational and discipline groups was reported by D’Amour, Ferrada-Videla et al. (2005). Their findings and recommendations reiterate the extent to which an orientation to IPL and an understanding of practising interprofessionally are pre-requisites to achieving greater patient safety. JMOs, particularly IMGs from different cultural backgrounds and experiences, require the necessary competencies to realise the benefits to patients from working collaboratively to achieve the continuity and reliability required for optimal patient care (Carlisle, Cooper et al. 2004; Reeves and Lewin 2004).

The impact of the inflow of IMGs on the quality of medical care in America was raised as far back as 1974 and has continued (Dublin 1974). Quality was addressed from the viewpoint of the varying standards and comparability of medical education and training received by these medical graduates across different countries. Difficulties in determining their competencies was an expressed concern, with matters arising from uncertainty including the degree of, and extent of, supervision required, the ramifications for patient safety and general health outcomes. Over thirty years later, these concerns regarding quality continue (Fiscella and Frankel 2000; Hawthorne and Birrell 2002; Cooper and Spencer-Dawe 2006; Narasimhan, Ranchord et al. 2006; Pilotto, Duncan et al. 2007; Whitehead 2007). The scope for IPP becomes evident because it is through strong collaboration, support and cross-communication that matters relating to safety and quality may be positively addressed.

In more recent times the community has come to expect, and now demands, a high level of safety and quality in health care. There is an acknowledged need to support those delivering health care, including the continuous assessment of safety and quality across a diverse health system, which is well recognised as being complex (Barracough and Birch 2006). The diversity of the health system must include diversity amongst those who deliver health care, at the forefront of whom are medical practitioners, reliant on the expertise of many other health professionals. Fundamental to this premise of support, is the importance of all JMOs having an understanding of IPP and knowledge of how its practice links directly to patient safety and quality of care. For example, reporting incidents and collecting data, while essential to learn from, may not always capture the root causes of problems. This issue was raised by van der Weyden (2005), with reference to adverse events between 2003-2005 at the Bundaberg Hospital in Queensland, a state of Australia, where almost 25% of doctors are IMGs. It leads to concerns relating to the risks posed in terms of the suitability of IMGs to the local culture, and whether IMGs hold the necessary clinical skills to meet practice expectations.

However, the major safety breaches are founded on failures in communication and barriers to teamwork (Barraclough and Birch 2006). In these two areas rest fundamental safeguards to safety and quality including: the handover of patients; the adequacy of patient notes; the ability and willingness to listen to the opinions of team members involved in patient care; and having adequate modelling, training, supervision and feedback from liaising with senior staff (Grant 2007; Lancashire, Hore et al. 2009; Wakefield, McLaws et al. 2010). While these failures identified may represent special barriers to be overcome by JMOs lacking an understanding of IPP, there is a question about the extent of support available to assist JMOs in developing such an understanding. Perversely, IPP in itself is one way of assisting in this process, particularly through clinically and psychosocially based communication.

2.8.2 Professionalism

“Professionalism is medicine’s most precious commodity ... central to the improvement of health.” (Horton 2005:1985)

The diversification of professionals in the delivery of health care services brings with it, questions of professionalism and the continuing challenges associated with professionals working within and across bureaucratic organisations. These challenges were identified by Friedson (1984), with reference to the erosion of professional autonomy and issues related to trust, control, and to the traditional prestige enjoyed by professionals such as doctors. Specialised knowledge, linked to prestige, no longer lies solely in the realm of the medical professional. It requires a commitment to “working in partnership with the wider health care team” (Horton 2005:1985).

Viewed in this way, professionalism requires a conduct that is becoming of each profession, beyond the specialised knowledge and clinical skills of the respective professionals, to one of shared knowledge and understanding and a broadened scope of practice (Brand 2003). Personal qualities associated with professionalism include, “... honesty, judgement, work habits, maturity, psychological stability and adaptive capacities” (McGaghie 1991:4).

IPL can lay the foundations for professionalism and IPP can see professionalism enacted through the capacity of JMOs to adapt to working collaboratively. Valuing social capital in organisations, empowering professionals through training and education, fostering respect between professionals and ensuring they know one another rather than operating with anonymity, are all aspects of professionalism (McNair 2005; Klein and Forni 2011). The effect of these behaviours on IPP is critical for JMOs, whether IMGs or AMGs.

As reliance upon the emergent skills, knowledge and technical competence of other health specialisations has grown, health consumers are more informed, and the asymmetry of information between doctors and their patients is less powerful (Freidson 1984; Blumenthal 1994). This perspective reflects the expansion of, and changes in, the health workplace, in workplace settings “often confounded by greater racial, gender and ethnic diversity among professionals” (Leicht and Fennell 1997:215). It is the complexity of the health system, and the sophistication of treatment in highly specialised teaching hospitals, which has given rise to the interdependent relationship between health professionals. Emergent from these changes has been the whole notion of IPP to advance patient care through collaborative team effort. The practice of multiple health professionals is usually conducted within the administrative structures, controlled by health management professionals, often holding economic power and control in the bureaucratic milieu of hospitals. This is the contemporary environment confronted by IMGs entering hospitals within the Australian health system. The question arises as to how they view themselves as professionals working with other professionals, particularly in the heterogeneity and complexity of the hospital setting, and whether this might constitute a further barrier to IPP.

2.9 Conclusion

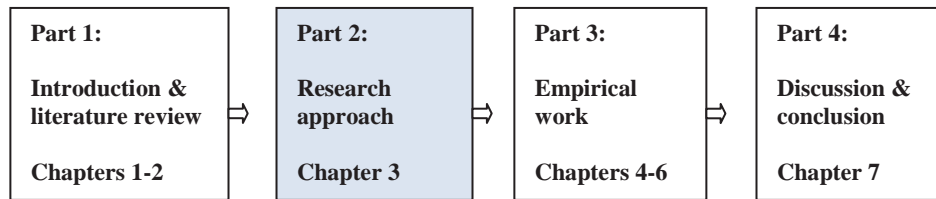
The lack of integration of medical education in Australia has been discussed and concerns raised about JMOs’ readiness or preparedness to practice, the core competencies required by them, and the measurement of those competencies (McGrath, Henderson et al. 2011). Despite the existence of a national, common assessment for

IMGs, I would argue that this is only the beginning for IMGs and that so many other factors related to readiness to practice need to be taken into account as well. Medical knowledge per se is not the only indicator of how an IMG may perform in hospitals and other health service settings as “not all features of professional practice can be quantified” (Barondess 2003:7).

From factors identified in the areas explored, there is much to consider in relation to preparedness to practice interprofessionally. The factors relating to the themes of the study are integral to the practice of IMGs working with their AMG counterparts and other health professionals in the Australian health system. The overarching consideration is the degree to which the individualistic training and experience of IMGs affects their efforts to collaborate interprofessionally. This includes the nature of IMGs’ prior experience and their understanding of IPL and IPP. It links to their acceptance of collaborative work practice, and how that *modus operandi* works in the hospital system and within the health system. Additionally, the input of management in hospitals is important in generating an environment supportive of IPP. However, hospitals differ and require IMGs, and indeed all JMOs, to adapt to their cultures. These situational aspects reflect the fact that “hospital work settings have distinct attributes that influence the behaviour of physicians independently of physicians’ qualifications” (Rhee 1977:15).

A common theme in the literature signals the message that to achieve better health service delivery there needs to be greater collaboration between health professionals. Collaboration embraces both learning and practice and an interprofessional focus “facilitates different professional groups working together” (Leathard 1994:48). An interprofessional focus may also be the facilitator to help IMGs establish themselves in new health systems. However, the overall findings from the literature suggest that IMGs lacking an orientation to IPP are faced with numerous pitfalls and barriers which actually militate against the adoption of IPP.

Part 2. Research approach



Chapter 3: Method

3.1 Introduction

In the first part of this chapter, the rationale for the research approach is explained and the study design described. The formulation of the research questions is discussed, and the clinical settings for the research. The second part details the qualitative research methods employed and a description of the research instruments used. It includes an overview of the populations selected and the respondents. In the final part, a description is given of the fieldwork processes. The methods employed in the collection of data from interviews, the survey and from observations, are explained. A description of the analysis of the data follows and aspects relating to rigour, ethics, reflexivity, and the limitations of the research complete the chapter.

3.2. Rationale for the research approach

“The special appeal of triangulation is that it makes it possible to go beyond the limitations of a single method by combining several methods and giving them equal relevance.” (Flick 2002:16)

In view of the aims of the research to investigate the experience, understanding, and attitudes, of IMGs and AMGs to IPP, consideration was given to the methods most likely to enable rich and deep data collection for analysis. I wanted participants to reveal the complexities associated with their experience and the dynamics of the interactive aspects of their daily working life. It was deemed qualitative research offered the opportunity to probe, capture and describe “problematic moments and meanings in individuals’ lives” (Spradley 1980:3). The approach was considered appropriate because it concerned people and their professional behaviour, within an institutional setting. Professional people ostensibly working in the same profession but with the influence of cultural differences. I wished to explore their similarities and differences in depth, using feedback from interviews, responses from a questionnaire survey and through ethnographic observation of behaviour. Drawing on the qualitative research literature, the study would involve multi-methods to triangulate findings (Spradley 1980; Bosk 1985; Duffy 1987; Snow and Thomas 1994; Strauss and Corbin 1998; Mays and Pope 2000; Thurmond 2001; Denzin and Lincoln 2002; Flick 2002; Kuper, Reeves et al. 2008).

The advantage of using a triangulated research strategy is that it counter-balances the strengths of different methods with each other (Creswell and Miller 2000; Rice, Zwarenstein et al. 2010). Through combining methods, I sought therefore to focus on seeking information through different means, while still using ‘why’, ‘how’, ‘when’, ‘what’ and ‘where’ as the fundamentals for questioning, observing, interpreting and creating associations (Whetten 1989; Snow and Thomas 1994; Kuper, Reeves et al. 2008). Interviews rely heavily on “... the opinions, perspectives, and recollections of respondents” and while allowing for in depth inquiry, may not uncover professional interactions as observation can.

Because the sample groups were small and as much information as possible was sought, the semi-structured nature of the interviews allowed for in-depth data to be collected by listening closely to respondents and entering their worlds (Britten 1995; Emerson, Fretz et al. 1995). This allowed participants to speak about themselves drawing on their

experiences, and to consider the deeds and attitudes of their professional colleagues and their own feelings towards them (Snow and Thomas 1994). The intention then of using interviews was to gather richer and more substantive material “... to interrogate the tacit, taken for granted understandings that underpin everyday life” (Chew -Graham, May et al. 2002). Through direct observation, details of workplace situations and behaviour within these environments, added context to the meanings and perspectives created from the interviews and survey (Mintzberg 1979; Martinko and Gardner 1985; Snow and Thomas 1994). Conducting observation in the field allows the researcher to “... watch, listen and use their own feelings and responses to guise their interpretations of what is going on” (Bosk 1985:13). In terms of the data captured from participants in the three hospitals, the distinguishing aspect of the survey as another tool was that the same issues would be collected from each participant in the sample surveyed (Bowling and Ebrahim 2005). The meta-perspectives elicited from participant JMOs interviewed, together with distinct responses from the surveys provided material for testing against data gathered from observation. Being privy to their communications and witnessing evidence of collaboration were important, together with perceptions associated with their competency and professionalism.

Related research has been conducted on similar topics using a variety of methods. As shown in Table 3.1, the research includes: studies of similarities and differences in IMGs and USA medical graduates (Gozu, Kern et al. 2009); characteristics and attitudes of IMGs in the USA (Morris, Phillips et al. 2006); cultural democracy in Canada (Foster 2008); communication skills and cultural challenges in Canada (Hall, Keely et al. 2004; Wong and Lohfeld 2008); spoken English proficiency of IMGs in Canada and the USA respectively (Rothman and Cusimano 2001; van Zanten, Boulet et al. 2007); attitudes and practice of medical consultants and IMGs in the UK (Wawdhane, Saraf et al. 2007); recertification training experiences in Canada ; professional behaviour in The Netherlands (Tromp, Rademakers et al. 2007); perceptions of NZ hospital staff on the training needs of IMGs (Narasimhan, Ranchord et al. 2006); IMGs and their understanding of the allied health system to multidisciplinary care (McGrath,

Henderson et al. 2011); and quality of IMGs and their competencies (Rao, Kramer et al. 2007).

Table 3.1: Relevant studies and their research methods

Country	Topic	Research method	Authors
USA	Characteristics and attitudes of IMGs	Secondary data analysis comparing USA medical graduates and international medical graduates	Morris, Phillips et al. 2006
Canada	Foreign trained doctors: cultural contingency and cultural democracy	Examination of the relationship between culture and power as a critical foundation for understanding the credentials devaluation of foreign-trained doctors	Foster 2008
Canada	Communication skills and cultural challenges	Needs assessment design to assess IMGs' communication skills	Hall, Keely et.al. 2004
Canada	English proficiency of IMGs	Assessment data from a one-year (2006) cohort of graduates of international medical schools (IMGs) Ratings of communication and interpersonal skills along three dimensions	van Zanten, Boulet et al. 2007
USA	English proficiency of IMGs	Assessment and comparison of quality of ratings of oral English proficiency of IMGs provided by physician examiners and by standardised patients	Rothman 2001
USA	Similarities and differences between IMGs and USA Medical Graduates	Cross sectional survey of residents	Gozu, Kern et al. 2009
UK	Attitudes and practice of medical consultants and IMGs	A survey of the attitudes and practice of medical consultants and IMGs	Wawdhane , Saraf et al. 2007
Canada	Recertification training experiences	Interpretative phenomenology describing the training experiences of IMGs	Wong 2008
Netherlands	Professional behaviour	Four phase qualitative study	Trompe, Rademakers et al. 2007
NZ	Perceptions of hospital staff on the training needs of IMGs	Survey questionnaire	Narashimhan, Ranchord et al 2006
Australia	IMGs and their understanding of the allied health system to multidisciplinary care	Qualitative study - in depth interviews by speaker phone	McGrath, Henderson et al. 2011
International	Quality of IMGs and their competencies	Annotated bibliography of professional literature on IMGs	Rao, Kramer et al.2007

3.3 Study population

The study population was drawn from the professional group of medical practitioners. From that profession, two sub-groups working in three tertiary referral and teaching hospitals were sought for the study. IMGs and AMGs at the JMO level, that is, doctors in their postgraduate medical education and training years, employed as interns, residents or registrars. The intention was to find matched samples of five IMGs and five AMGs in the three teaching hospitals to enable intra, as well as inter-hospital comparisons to be made. The difficulty in recruiting participants resulted in samples that were not as equally matched as planned but which were, nevertheless, representative of the two groups and allowed for comparison.

3.4 Research settings: the three hospitals

The setting of tertiary referral and teaching hospitals was purposeful. The multifaceted makeup of tertiary referral and teaching hospitals, the range and levels of professionals working and teaching in these hospitals and the array of services they provide, offered the complex environment necessary for the study. All three hospitals are affiliated with the same university. They pride themselves on their history, their excellence in research and related achievements and the quality of the health care offered to patients. The three hospitals enabled comparison of the settings in which JMOs were training and transferability to other sites (Charles, McKee et al. 2011).

3.4.1 Hospital A

Hospital A, the smallest and oldest of the three is a 350-bed facility, and the oldest established organisation with a rich history of tradition and stated values including compassion and human dignity. The mix of patients is broad, reflecting the socio-economic extremes within its recognised patient catchment area. Patients are referred from across the state, nationally and internationally, for highly specialised investigations and treatment. It is a major centre for immunology and for transplants

including heart and lung, and bone marrow. The hospital is affiliated with a major national research centre.

3.4.2 Hospital B

Hospital B, a 440-bed principal referring hospital has a relatively small but significantly complex caseload and an ED with a high number of presentations. The hospital has strong community links and outreach rural services. It has developed from a repatriation hospital to a general, and now tertiary teaching hospital, covering a large demographic area. The hospital has an established Phase 1 clinical trial research facility.

3.4.3 Hospital C

Hospital C, a 660-bed hospital is one of the largest and oldest hospitals in NSW, serving patients beyond its immediate catchment area from other parts of metropolitan Sydney, across the state and nationally. It is a designated major trauma service facility, offering emergency surgery and critical care. The hospital's provision of services covers a large catchment area with 35% of residents coming from non-English speaking backgrounds. It has a full range of services including women's and children's health. The hospital has strong community health affiliations and an active research program.

3.5 Engagement and consent of participants

Liaison with hospital JMO managers identified potential subjects who met the study inclusion criteria. JMOs were informed about the research and invited to contact the researcher to express participant interest in the research. Participants were also recruited with the assistance of Site Specific Supervisors (SSS) at each hospital and through word of mouth recommendation from JMO colleagues who had agreed to participate.

JMOs interested in participating were given further information about the aims of the research, how long the interviews were expected to take, and that interviews would be audio-taped. It was explained that consent would be required for participation and an

example of the consent form was available for review for the benefit of the prospective participants. JMOs were advised that data collected during the course of the research would be confidential and de-identified. Discussion took place about the most suitable times and places for interviews.

3.6 Methods employed in the collection of data

Data were collected from interviews, a questionnaire survey and observation. At the beginning of each interview participants completed a 'doctor profile' form. Information collection included: country of birth and country of medical training; period of time in Australia; level of postgraduate training; and current clinical rotation. All data were collected on-site at the respective hospitals.

3.7 Temporal aspects of the data collection

The data collection period took place between December 2009 and October 2010. The new clinical year began at each hospital in the first week of January 2010. At the start of a new clinical year, new interns are inducted to join other JMOs, who are normally re-employed at a higher level, either in their existing hospital or at another hospital. At the end of the first year of residency as interns, eligible JMOs move from having conditional registration to full registration with the New South Wales Medical Board (since July 2010, known as the Medical Council of New South Wales). IMGs who have passed the AMC examinations are introduced at the equivalent level of an intern and referred to as AMC graduates in NSW. To put this in context, an IMG's progress through the JMO training pathway at the time of this research, is compared with that of an AMG in the simplistic illustration displayed in Figures 3.1 and 3.2.

Figure 3.1: IMG training pathway as a JMO

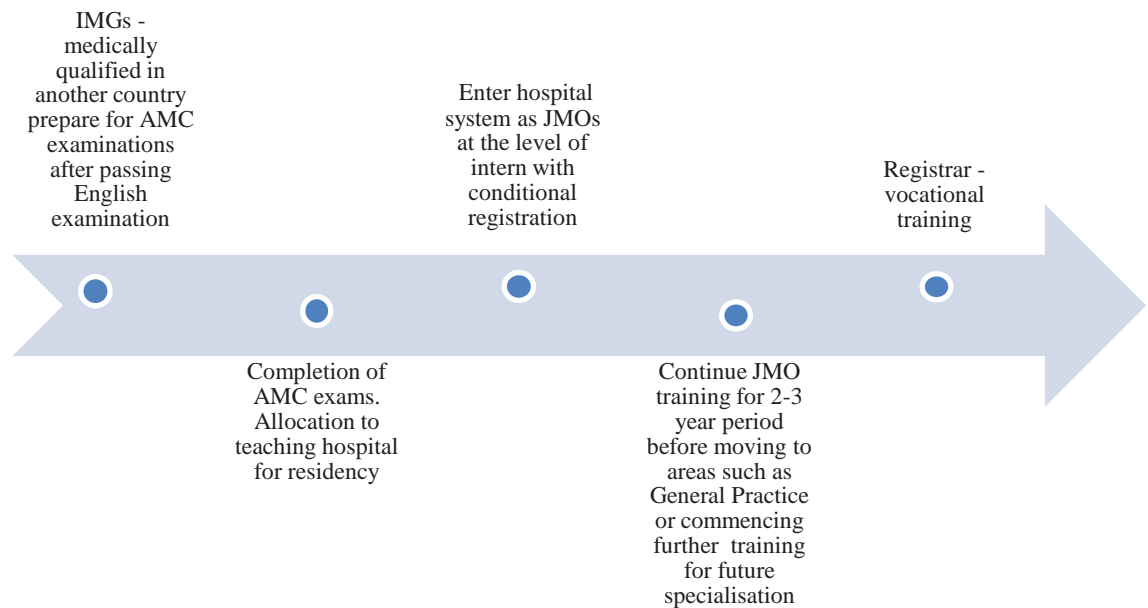
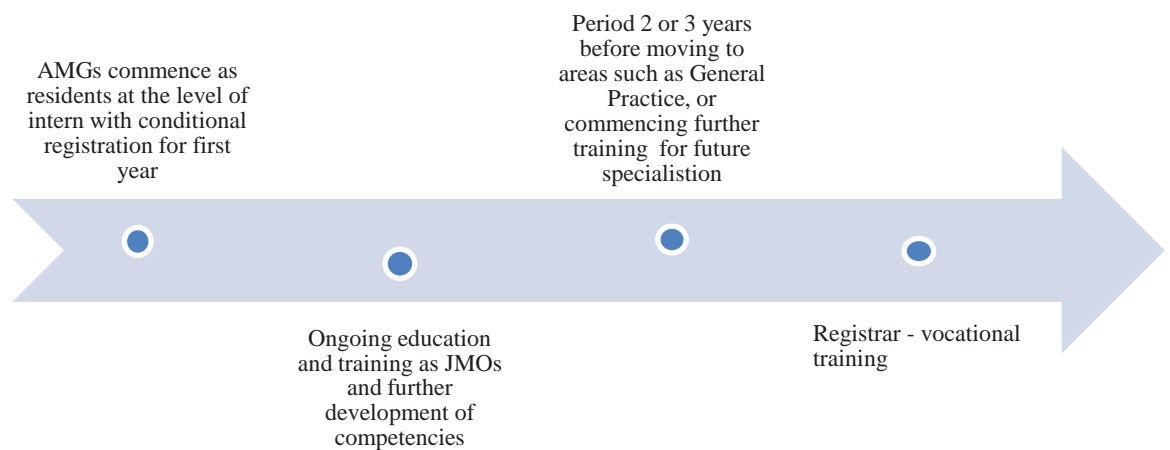


Figure 3.2: AMG training pathway as a JMO



**Sources: Confederation of Postgraduate Medical Education Councils, 2008.
New South Wales Government Clinical Education & Training Institute, 2011.**

3.8 Formulation of research tools

The four themes identified from the literature review provided the framework for developing the interview and survey questions and the premise for the observation of JMOs. Questions relating to each theme were formulated and used in the design of the questionnaire and in guiding the interviews (Table 3.2).

Table 3.2: Questions used in the design of the survey and for guiding semi-structured interviews

	Questions
1	Understanding and experience of IPL and its purpose
2	Understanding of what IPL involves
3	Degree of contact during medical training with students studying in other health professional fields e.g. nursing, physiotherapy, allied health, pharmacy
4	Extent (if any) of any shared learning that took place with these other students
5	Attitudes towards shared learning
6	Awareness of cross cultural issues
7	Role of communication and interaction in patient care and patient safety
8	Understanding of collaborative work practice as in IPP
9	Experience of working collaboratively with other health professionals, as a clinician, since graduation, for example, jointly planning the treatment and ongoing management of patients
10	Perceptions of how quality and patient safety may be improved through IPL and IPP

3.8.1 Semi-structured interview questions

A semi-structured interview format was elected to allow scope for freedom of thought, and for deeper responses and perspectives to be revealed, in an effort to add strength to the dialogue (Freidson 1984; Heinemann, Schmitt et al. 1999; Hyer, Fairchild et al. 2000; Hall, Keely et al. 2004; Tromp, Rademakers et al. 2007; Greenfield, Nugus et al. 2010). The 21 item scale, *Attitudes Towards Health Care Teams*' (Hyer, Fairchild et al. 2000), adapted from the scale of Heinemann, Schmitt et al. (1999), for a study of health professionals teams, was useful in the development of questions. The inter-relationships

between variables such as attitudes, participation and functioning among health care teams, forms the basis for the general attitudes scale of Heinemann, Schmitt et al. (1999). The Hyer, Fairchild et al. (2000) questionnaire focuses on assessing attitudes towards teams, and communication about the composition of team-based care. The effect of attitudes on behaviour, may influence willingness, or not, to begin to understand IPP and to motivate the collaborative functioning required in the interest of optimal patient-centred care. Cultural sensitivity was significant in the design of the survey instrument developed by Tromp, Rademakers et al. (2007), to assess the behaviour of IMGs in the Netherlands, not only in terms of language and cultural barriers but also professional behaviour. This survey also provided relevant input to the formulation of questions.

3.8.2 Survey questionnaire

The 30 survey questions were based on the same four themes and questions used to guide the semi-structured interviews. A six point Likert scale was employed in the design of the questionnaire to offer participants a range of responses. The scale ranged from six, “*strongly agree*” to one, “*strongly disagree*”. Formulation of questions for the survey was based on the literature and designed to complement the interview questions. Careful attention was paid to the style of questioning, with respect to the six options for responses, to avoid ambiguity. Clarity was another consideration in attempting to avoid any confusion in the meaning of the questions, particularly for those from non-English speaking backgrounds. IMGs were included in the pilot testing of questions as explained in the process of interviews, surveys and observation at section 3.9.

3.8.3 Organisation of observation in the hospitals

The use of observation as a third method, was to gather first-hand data on the actions and interactions of a sample of JMOs from those interviewed and surveyed. Because the fieldwork did not commence until the month of December, one of the provisos for participating in the research was that participants must have accepted a position in the

same hospital for the following clinical year, commencing in early January. This ensured that participants would still be available, if selected, to be observed in the same hospital. JMOs were randomly selected from the three hospitals, an IMG and an AMG from each one. The advantage of observing JMOs was to become immersed in their domain through side by side presence with them during their shifts, and to chronicle their behaviour and their overall working environment. Use of this method necessarily involved a close and trusted relationship with the JMOs being observed.

One of the distinguishing features of conducting observational studies is that this method allows for the generation of "... meanings and perspectives not attainable by most other research methods" (Martinko and Gardner 1985; Snow and Thomas 1994:459). This was seen as particularly important for the population studied in observing at first hand, the *modus operandi* of JMOs during their shifts.

3.8.4 Validation of interview and questionnaire tools

Questions for the semi-structured interviews and the survey questionnaire were pilot tested with three IMGs studying health management at UNSW and with a panel of five academic members of staff, one a whom was an AMG. The exercise resulted in some amendments and refinements. The changes related to the length of the interview questions and clarification of some of the survey questions.

3.9 The interview, survey, and observation processes

It was essential to engage with the participants at the outset of the interviews, to develop mutual trust, and allow participants to feel relaxed. Because over half the participants were from non-English speaking backgrounds, it was important to follow their pattern of speech as part of the engaging process and to note any non-verbal language not captured on the digital recordings of the interviews.

3.9.1 Interview and survey process

A decision was made to administer the questionnaires on site at the time of, and in conjunction with, the semi-structured interviews, as a way of optimising the response rate for questionnaires (Pope and Mays 2009). A further situational reason considered was the *time poor* nature of the JMO day-to-day working life. Once interviewed and a relationship established, participants were more than likely to spend extra time completing a survey.

Interviews were recorded by digital recorder to ensure that the views and related experiences of the participants were collected accurately. Recording the interviews allowed the researcher to focus on facilitating the interview. The process and mechanisms of maintaining confidentiality and the reasons for recording the interviews were explained. Participants were given an opportunity to consent in the knowledge that the recording could be stopped at any time and erased if requested without negative consequences. Interviews were recorded with privacy in mind and to avoid interruption, save urgent pages or calls. It was re-iterated to participants that no information about them, or provided by them, would be revealed to anyone within or outside the workplace of the employees; furthermore that interview questions were of a nature that should not affect workplace relationships but may assist in improving them. In addition to audio-taping, some hand written notes were also taken to assist at the time of transcription. The survey questionnaire offered participants a means of self-reporting on areas related to matters covered in the interviews.

3.9.2 Observation process

Observation of JMOs was conducted at hospital sites during their shifts, on the wards, in ED and other areas where they were working with medical colleagues and other health professionals. Additionally, communication with patients was witnessed where possible, ward rounds and meetings were attended and minor procedures observed. The

role of observation in the research was fully explained to the head of staff on wards or clinical sites within the hospitals, after initial contact and agreement via signed consent. Note taking was conducted in an open, transparent manner and as appropriate, patients were asked by JMOs for their agreement about being observed. Every activity and interaction was documented together with the locus of activity. Detailed notes were written while watching and listening to the JMOs carrying out their work and interacting with colleagues, other health professionals and patients. Particular attention was paid to conduct relating to IPP and the four main underpinning themes of the research.

The purpose of gathering further information through observation was for the researcher to be the observer in the day-to-day working world of a sample of JMOs who had been interviewed. The benefit of this was to observe their interactions and behaviours and then to look at the degree to which this did, or did not, corresponded to what was stated in interviews and reported in the survey. Through the use of observation, what was seen and heard was happening in real time. It was spontaneous while it was routine; it could not be rehearsed. The disadvantage was the risk of generalising from observing a day in the life of the JMO participants.

My role was one of being an observer in an environment where I was unsure about how I might be perceived. That is, how conscious were those being observed of my presence, and for how long? What effect might this have on their behaviour? What affect did my presence have on others working with the observed, as they themselves became part of the field of observation? These were the unknowns to deal with and supported the use of the other two methods in the study, to capture data from different perspectives and environments by using the triangulated approach.

3.10 The data collection period

Data collection took place between December 2009 and October 2010. Although the major part of data collection occurred between this period, other contributing data were gathered during 2008-2009. Time was spent in this period visiting the three hospitals to

negotiate support and cooperation from JMO managers in recruiting participants for the study. Further time was spent meeting with the Site Specific Supervisors at each hospital site, whose roles are described below. These visits provided useful occasions for gaining an overview of the hospital sites and their respective organisational and physical environments. The sequence of data collection stages, is presented in Table 3.3.

Table 3.3: Sequence of data collection stages

Stage 1. 2008-2009 Preliminary gathering of information	Stage 2. 2009-2010 Interviews and survey questionnaire	Stage 3. 2010 Observation
Orientation at sites and preliminary observation	Hospital A	Hospital A
Collection of information about each site	Hospital B	Hospital B
Interaction with managers of JMOs	Hospital C	Hospital C

3.10.1 Stage 1

In Stage 1, data collection began through an orientation to each hospital and preliminary observation of the different sites. This activity included the process of formalising approval for access to the hospitals from the respective research governance officers, meeting with SSSs, organising security passes and liaising with JMO managers at the preliminary stage of engaging participants. The SSSs were required as part of the ethics approval process. These senior clinicians acted as hospital supervisors and first point of contact, if needed by the researcher or the participants during the data collection period.

3.10.2 Stage 2

The second stage of data collection involved on-site, face-to-face interviews and the administration of the surveys. This stage commenced at Hospital A and continued sequentially with data collection at Hospital B and then Hospital C. Interviews were

organised this way because of the difficulty in recruiting participants. Similar considerations were taken into account for the third stage of data collection, the observation stage because of participant availability related to timing issues. These issues included JMOs being on annual leave, night duty, or on a rotation at another hospital.

3.10.3 Stage 3

The third observational stage of data collection was conducted at a mutually agreeable time in the wards and areas where participants were working with medical colleagues and other health professionals. The role of observation in the research was fully explained to managers on wards or clinical sites within the hospitals, after initial contact and agreement via signed consent. Note taking was conducted in an openly transparent manner. Notes were recorded continuously. General information collected included: the specialty or specialties of the ward or unit; the staff numbers; the number of inpatients, and the physical environment. This general information was recorded on individual, formatted sheets (Appendix 6). The second and third stages and components of the data collection, and participant numbers, are presented schematically below in Table 3.4.

Table 3.4: Data collection schema

	Participant numbers N = 32	JMO type	Style	Participant selection	Sample	Number of questions	Data collection
Position	JMO level (Intern, Resident, Registrar)				Samples from each JMO group		
Stage 2				Convenience 3 hospitals IMGs & AMGs			
Interviews		IMGs AMGs	Semi- structured		15 IMGs 17 AMGs	28 for reference within themes plus 'lead on' questions	Audio- recording and note taking
Questionnaire survey		IMGs AMGs		Convenience IMGs & AMGs		30	Self administered survey. Likert scale
Doctor profiles		IMGs AMGs				17	Self completion. Demographic & training details
Stage 3 Observation		IMGs AMGs	Non- participant	Random selection from participants	1 IMG and 1AMG from each of the three Hospitals, A,B & C		Non- participant observation

Source: Adapted from Hyer et al. (2000:251)

3.11 Data transcription, coding and analysis

Full transcriptions of recorded data files were written by the researcher to provide rigour, deeper familiarisation with the data and to ensure that data of relevance was not omitted (Miles and Huberman 1984). During transcription, the speed of the recordings was regulated to slow and some sections replayed for maximum accuracy. When transcribing from interviews conducted with IMGs, some utterances were unable to be understood and notations duly made. This in itself was a reminder of the difficulty it might pose in the hospital workplace, particularly during communication by telephone.

Transcribed data from the interviews were entered into QSR NVivo 9, a software program for the organisation and management of data. The software facilitates the analysis of data. Coding was derived from reading through the transcripts line by line and creating *free nodes* (an NVivo term). The *free nodes* were drawn from the four main themes of the research, the research questions, and other factors revealed about the experience, attitudes and behaviour of JMOs. The unexpected, provoked new thoughts and different ways of perceiving what might have been otherwise taken for granted (Wilson and Hutchinson 1991; Morse and Richards 2002). To add rigour to the process, some of the interview transcriptions were analysed and independently coded by a panel of experienced researchers from health and social science fields. All researchers were familiar with NVivo.

The *free nodes* were further broken down to *sub-nodes*. For example, when a *free node* was created for communication and interaction, *sub-nodes* were added for doctors, nurses and allied health. A *free node* created for organisation had *sub-nodes* for clinical rotation, shift, staff roles, size of hospital and hospital culture. An illustration of the *free node* for activities and *sub-nodes* is shown in Table 3.5.

Table 3.5: Free node with sub-nodes

Free node	Sub-nodes
Activities	Characteristics of work
	Education and Training
	Learning through working together
	Shared lectures - undergraduate
	Multidisciplinary meetings
	Patient care planning
	Teaching or directing

All data from the interviews were coded in this manner. Data from the surveys were entered onto Excel spreadsheets and exported to the NVivo file for coding in the same manner. Hand written observation notes were transcribed and entered into the NVivo

file and consistent coding applied. This resulted in all data being stored on one file, named Patient Safety Program, but separated by each method of research. Because of the consistent pattern of coding applied to the three sets of data, the process of running a query resulted in data being drawn and displayed from the data sets. Using the example of a query about communication and the subheading of doctor, all data coded under these headings could be displayed.

The data from the interviews were strengthened by the addition of observation material, bearing in mind unavoidable differences in context (Denzin and Lincoln 2002). For example, the relative security of a personal interview is very different from being openly observed over a period of over eight hours in front of one's peers, seniors and other health professionals. This underscores the unique privilege granted to the researcher as observer.

An adaptation of Spradley's (1980) framework for reporting ethnography, was used in the analysis of data gathered during the observation process, together with concurrently recorded reflective field notes. Data were treated as individual narratives and analysed against the themes and questions. They were presented in a time and narrative form. The purpose of this was to convey the sense of reality evoked through the presence of the observer immersed in the domain of the participants. Where evident, references were made to points of confirmation or refutation about what JMOs had revealed in interviews or in their responses to survey questions. The inclusion of relevant quotes from JMOs and others was important in capturing their manner of communication and interaction, both significant to the research questions (Atkinson 1995).

Evidence of the approach adopted in my research appears in sections devoted to the process of gaining ethics approval, access to hospitals and participant doctors. It extends to the gathering of data in the field through the interviews, surveys and observations. Furthermore, it continues with the systematic and careful analysis and interpretation of the data. The findings were inductive, emerging from a process of data interrogation, and grounded in the detailed analysis process (Glaser and Strauss 1967; Kuper, Reeves et al. 2008).

3.12 Reliability and validity through triangulation

The importance of reliability and validity in qualitative research has been expounded in response to criticisms of how findings are able to be judged for their transferability and replication (Spradley 1980; Atkinson 1992; Polkinghorne 1995; Pope and Mays 2009). It is manifested through careful detail in the manner of collection and analysis of data, and their examination. The characterisation of qualitative research through the choice of methods used must be one that strives to produce, as I have set out to do, an honest and trustworthy account of the research findings.

Use of the terms credibility and verification, validity and reliability has been the subject of discussion in addressing differences of rigour in qualitative inquiry over quantitative inquiry (Lincoln and Guba 1985; Denzin and Lincoln 2002; Morse and Richards 2002). The use of triangulation as a strategy to promote credibility, reliability and rigour in the research process is one response to such discussion (Creswell and Miller 2000; Mays and Pope 2000). The result of using triangulation for this research has been the creation of multiple sets of data from interviews, surveys and observations in the two groups of JMOs in each of the three settings. This has allowed for better interpretation of the data and through the evidence presented, a counterbalance to convergence or divergence during the analysis process (Lingard, Albert et al. 2008). An alternative to the term triangulation, “*crystallisation*” has been suggested to emphasise the complementary aspects of multi-method research (Barbour 2001). Others propose that the “introduction of parallel terminology and criteria” (Morse and Richards 2002:8) creates the risk of marginalising qualitative research, giving support to continued use of the terms reliability and validity.

In Chapter 5, in which the observational findings are presented, coded references of participants, whether they were IMGs or AMGs, and their postgraduate level, are included. This has added further evidence of veracity in the research process.

3.13 Audit trail

This chapter demonstrates an audit trail through the provision of a detailed description and rationale for the research method adopted. The formal process of ethics approval and the engagement of participants is explained. The strategies employed for the process of data collection are presented and explained. Codification of data is described and examples given of how QSR NVivo 9 software was used in the organisation and management of data, to assist with data analysis leading to the findings. The strategies were implemented and the analysis process follows, identifying and drawing together the findings.

3.14 Rich, thick description

The findings chapters are presented as rich, thick descriptive accounts produced from the fieldwork (Lincoln and Guba 1985; Emerson, Fretz et al. 1995; Creswell and Miller 2000). In seeking verisimilitude, advocated by Van Maanen (1988), I strove to capture and depict context and in-depth detail of the experience, attitudes and behaviour of the two groups of JMOs in the three hospitals. From this detail, the thesis particularises the outcomes from the exploration of barriers to IPP and the resultant effects on quality of care and patient safety.

3.15 Reflexivity

Other strategies for achieving rigour include reflexivity and an account of the researcher as an instrument, as described in Section 3.19. These elements of rigour are included to disclose to the reader informative background, allowing insight to the platform from which this research emanated. I add that as the researcher, I was under no illusions as to the fluidity and ever changing nature of the contextual environment in which each individual component of the research was conducted (Barbour 2001).

3.16 Peer review and presentations

The element of peer review was a further aspect of rigour (Creswell and Miller 2000). During the course of the research, regular reviews of progress were conducted. Presentations were made to research colleagues, and to the chief investigators of the National Health and Medical Research Council Patient Safety Program Research Grant, which funded the scholarship for this research. Presentations were also made at seminars, conferences and an international congress in NZ (Table 3.6).

Table 3.6: Conferences, seminars and presentations, 2009-2011

2011	<p>Milne, J. Greenfield, D. Braithwaite, J. How well do junior doctors engage with their health professional colleagues? Perspectives on interprofessional practice in teaching hospitals? <i>7th Health Services and Policy Research Conference, Adelaide South Australia, December 2011</i>. Abstract accepted for poster presentation.</p> <p>Milne, J. Braithwaite, J. Greenfield, D. International medical graduates and their interprofessional learning orientation: pitfalls and barriers enabling interprofessional practice and quality and safety in the delivery of health care. <i>Australian Institute of Health Innovation National Health and Medical Research Council (NH&MRC) Patient Safety Grant: PhD presentation, University of New South Wales, November 2011</i>.</p> <p>Milne, J. Greenfield, D. Braithwaite, J. Interprofessional practice, patient safety and Junior Medical Officers: will they ever be united? <i>28th Conference of the International Society for Quality and Safety in Health Care, Hong Kong, September 2011</i>. Abstract accepted for poster presentation.</p> <p>Milne, J. Greenfield, D. Braithwaite, J. Working towards shared goals through interprofessional practice: are doctors really on the team? <i>ACHSM/NZIH 2011 International Congress - Rotorua, New Zealand, August, 2011</i>. Peer reviewed abstract and oral presentation.</p> <p>Milne, J. Braithwaite, J. Greenfield, D. <i>PhD Progress Review</i> June 2011. Oral presentation to PhD review panel.</p>
2010	<p>Milne, J. Braithwaite, J. Greenfield, D. Enhancing quality and safety: a comparative study exploring interprofessional learning and interprofessional practice in international medical graduates and Australian medical graduates. <i>National Health and Medical Research Council (NH&MRC) Patient Safety Program, PhD presentation. University of New South Wales, December 2010</i>.</p> <p>Milne, J. St.Vincent's Hospital <i>Department of Clinical Pharmacology and Toxicology Therapeutics Centre Seminar</i>. Guest Presenter, Journal Club Meeting. Discussion of journal article and presentation on PhD research, November 2010. Oral presentation.</p>

	<p>Milne, J. Braithwaite, J. Greenfield, D. What do doctors really think about working interprofessionally? Lessons to improve clinical practice. <i>School of Public Health and Community Medicine Postgraduate Research Conference, University of New South Wales, October 2010</i>. Oral Presentation.</p> <p>Milne, J. Braithwaite, J. Greenfield, D. Interprofessional practice: what does it mean to doctors? <i>5th Annual Emerging Health Policy Research Conference: Menzies Centre for Health Policy, University of Sydney, Australia, August 2010</i>. Abstract and presentation.</p> <p>Milne, J. Braithwaite, J. Greenfield, D. <i>PhD Progress Review</i> June 2010. Oral presentation to PhD review panel.</p> <p>Milne, J. Braithwaite, J. Greenfield, D. What happens to relationships when many of the doctors are trained elsewhere? Reflections on a many-faceted problem in inter-professional practice. <i>All Together Better Health 5 (ATBH5) - International Interprofessional (Education, Practice and Research) Conference: Australasian Interprofessional Practice and Education Network (AIPPEN), Sydney, Australia. April 2010</i>. Peer reviewed conference abstract and presentation.</p>
2009	<p>Milne, J. Braithwaite, J. Greenfield, D. <i>PhD Progress Review</i> May 2009. Oral presentation to PhD review panel.</p>

3.17 Limitations of the research

Discussion of perceived limits to the research focuses on four main areas. The first limitation is the number of participants from each hospital in the study. It became apparent in the process of recruiting participants that it would have been ambitious to seek larger numbers of participants for three reasons: the difficulty of recruiting JMOs, the limited time in which to recruit them and the delayed timing of the recruitment due to the drawn out process of gaining ethics approval. The delay resulted in the recruitment process commencing at an inopportune time; the beginning of a new clinical year when JMOs are adopting, and adapting to, new positions.

The second limitation relates to the one-sided nature of involving only the medical profession in the research. The inclusion of nurses and/or allied health professionals would have provided a counter balance to this bias. It would have required more time

and extra resources to include other health professionals, but it does offer scope for further research as does the third limitation.

A third limitation is the absence of patient participants in the research. Because the focus of inquiry was linked to the enhancement of patient outcomes, the involvement of patients would have added another relevant dimension to the research. The inclusion of patients would have presented further challenges in gaining ethics approval, in addition to practicalities associated with time and resources.

Finally, a limitation associated with a single researcher and possible subjectivity. Every effort has been made to reveal the perspective from which this research was undertaken through details provided about my background and previous involvement with JMOs at one of the hospitals in the study, eight years before the study commenced. Over the intervening period, there have been changes. A larger number of IMGs have entered the hospital workforce and as explained in the findings at the beginning of Chapter 4, the overall make-up of medical graduates has become more diverse. The complexity of patient conditions and treatments and the growth in the acuity of their care has increased over that time, and continues to do so. These changes have been associated with greater complexity in the organisation and administration of hospitals and a more pressured working environment.

3.18 Ethics issues

Aspects of ethics have been referred to above, however the continuum of the ethics process involved is included here to fully demonstrate the protracted nature of the process. An application for ethics approval for the research was made to the Higher Research Ethics Committee of the University of New South Wales and referred to the Human Research Ethics Advisory Panel (HREA), application number 09211. Formal approval was granted and the requisite application made to a Lead Research Ethics Centre at Hospital A. The application was reviewed by the Human Research Ethics Committee (EC00140) and approved after six months.

Details of the process required before commencing the fieldwork are presented in Table 3.7. Before agreeing to participate, an explanation about the nature of my research, including the tape recording of interviews, was read before oral consent was given. At the time of interviews and surveys, participants signed consent forms. Participants were assured of confidentiality through the coding and de-identification of data and informed that they might be randomly selected for the observation phase. Further reassurance was given through providing a *withdrawal of consent* form to complete, if at any time participants wished to withdraw from the research without prejudice. No participants chose to do this.

Table 3.7: Ethics approval and negotiated ethical process

1.	Submission of application to the Higher Research Ethics Committee of the University of New South Wales
2.	Application re-submitted to the Human Research Ethics Committee and approved
3.	National Ethics Application
4.	Application to a Lead Ethics Committee
5.	Approval after six months
6.	Negotiated agreement of SSS at each hospital
7.	Ethics approval completed for all three hospitals
8.	Security clearance and the issuing of identification badges at each site
9.	Meeting and negotiation with JMO managers regarding recruitment of participants
10.	Oral consent from participants
11.	Introduction and initial approval from respective NUMs for access to their wards
12.	Signed consent forms from respective NUMs
13.	Signed consent from JMOs and forms given for option to discontinue as a participant

3.19 The researcher as an instrument

In the process of interpreting data, an open-minded approach was pursued, however, the inevitable consequences of manifold perceptions and perspectives from life experiences are acknowledged as possible unconscious intruders to the practice of this approach. For this reason, the researcher as an instrument per se is included here (Spradley 1980; Mays and Pope 1995; Strauss and Corbin 1998; Waterman 1998).

The inclusion of my own position as researcher, embedded in this work, is to offer insight to the reader about the perspective I have come from to do the research. I was guided to the research for several reasons. Firstly, an earlier clinical background as a nurse, and then academic study and teaching in health administration, all underpinned a medical administrative role later, as clinical superintendent of a major teaching hospital. During seven years in this role, I was aware of the challenges faced by JMOs and the heightened challenges faced by IMGs. I was privy to patient safety issues and incidents involving JMOs and mindful of the increasing complexity, stress and staff shortages in teaching hospitals. Secondly, I have a continuing interest in the postgraduate experience, education and training of JMOs through working with clinical training directors. Thirdly, I completed postgraduate university studies to teach *English-as-a-second-language*. Through the experience of teaching students, managers and others from diverse ethnic backgrounds and wide ranging English language levels, including IMGs preparing for medical English examinations, I gained insight to the difficulties faced by people from non-English speaking backgrounds (NESBs).

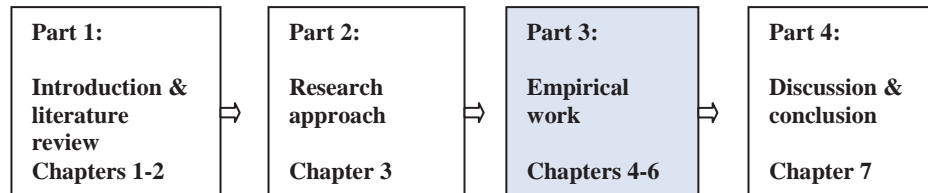
It could be assumed therefore that I came to this work with a pre-determined perspective and more than a degree of expectation about what the findings would be. This is acknowledged, as are the possible effects this may have had on facilitating data collection (Pope, Ziebland et al. 2000). However, I embarked on the research with an open mind and 11 years on, from working as a medical administrator, with all its unique insights and experiences. The effect of this was confidence in the interviewing process and the ability to gain trust from participants readily, through knowledge of the system and JMO postgraduate training. At the same time, I was not perceived by JMOs as a threat, because of my non-medical background and distance from the hospital system.

3.20 Conclusion

In concluding this chapter, it has been useful to reflect on the relatively passive process involved in establishing the stage point for generating the experiential part of the research; the action of conducting the fieldwork. The emergent findings from the

analysis of data as discussed in this chapter are presented in the following three chapters denoting the empirical section of the thesis.

PART 3: Empirical work



Chapter 4: Interviews

4.1 Introduction

Part 3 comprises three chapters reporting the findings from the empirical work conducted. The three chapters represent the three methods used in the collection of data: interviews; observations; and questionnaire survey.

The four main themes underlying the research are first re-visited and the central research questions drawn from the themes included. The hospital context in which the data were collected is briefly described to provide background to the setting for the fieldwork. This is followed by JMO responses to the preliminary questions used at the beginning of each interview. These questions were to determine IMG and AMGs' understanding of IPL and IPP, and of the Australian health system. The impact of hospital climate on JMOs, completes the introductory section.

In Section 4.2, the results from the interviews with JMOs are presented. The results are structured in four sections in concurrence with the main themes and their sub-themes, forming the framework for the study as described in Chapter 3: culture, integration, and

acculturation; communication and interaction; collaboration and teams; and competency, quality, safety and professionalism.

These were the underpinning themes for the central research questions:

- Is there a difference between the understanding and practice of IPL and IPP in IMGs and AMGs?
- What is the understanding of these two groups of JMOs about the links between collaborative effort, quality and safety?
- What capacity and willingness do JMOs have to practice interprofessionally?
- What are the barriers to collaborative effort?

4.2 The hospital context

The context within which the hospitals in the study operate has been referred to in more detail earlier. One significant aspect of context is the complex environment in which teaching hospitals function. Hospitals operate on a 24-hour basis, 365 days of the year, but the bulk of daily operational demands on resources occur between 8am and 5pm, Monday to Friday. This presents many constraints, a major one of which is the time available to complete tasks associated with patient treatment between 8am and 5pm. In an organisational sense, a further constraint is the depleted availability of staff after hours from 5pm, such as allied health professionals and staff associated with pathology and radiology reporting. The latter two involve investigative tests and therefore reports, the timeliness of which links to the flow of patients through the system, and therefore bed availability. Registrars reported the unrelenting pressure for beds, by bed managers in particular.

All these pressures influence the climate of the hospital, which in turn impacts on all staff, and effects how the patient care process operates. The climate of the organisation

into which the JMOs are acculturated affects their communication and interaction, and the pressures of work testing their competency. These factors, linked with aspects of collaborative practice, have an effect on patient safety and are therefore expounded here and in following chapters.

In the next section, findings are presented about IMGs' and AMGs' understanding of IPL and IPP, followed by their perspectives on working with, and learning from, other health professionals. Aspects of local hospital context as they affect IPL and IPP are examined. Finally, IMGs' and AMGs' understanding of the Australian health system is reported and the effect of hospital climate on JMOs.

4.3 Understanding and experience of IPL and IPP

The foundation for IPP and ongoing IPL is at the medical student level. Ideally, some experience of IPL occurs, in differing degrees, before graduating medical students enter the hospital system as JMOs. Interviews revealed a mixed understanding of IPL and IPP in JMOs. Overall, JMOs had a poor understanding of the terms. They identified the link between learning and working with others but not necessarily learning from other health professionals such as nurses and allied health professionals. The majority of JMOs either had little or no idea what IPL meant, or typically thought IPL related to learning in the medical field with other medical specialties, that is, learning intraprofessionally. The same thinking applied to most JMOs' understanding of IPP. The small number of JMOs who had experienced or understood IPL and IPP were able to explain the terms but not necessarily the rationale for IPL and IPP. Examples of the perspectives of JMOs relating to IPL and IPP follow, firstly as they relate to IMGs and then AMGs.

4.3.1 IMGs

IMGs reported less experience of IPL than did their Australian trained counterparts. The concept was unfamiliar to most IMGs, and difficult for some to grasp, even when the term was explained.

As medical students, most IMGs reported learning in isolation with their medical student peers. An IMG from India explained that medical students learn as a discrete group and with *seniors* and professors. IMGs' experience of any shared learning was also minimal. Interrelationship with nurses occurred at the time of clinical attachments, although the occurrence of teaching was always with other medical students. IMGs tended to equate IPL with specialty learning from supervisors and from colleagues, as part of their ongoing education and training. One IMG understood IPL in the context of several lectures he had given to nurses. An IMG from Egypt explained his understanding of IPL as something:

“to really help you to know what you’re dealing with in some people, like especially with a few diseases that are common amongst professions. It’s easy to understand what a person’s way of thinkings are and what they’re thinking at this stage, what their approach to stem cells or their health care system is. It’s because you see some people are less worried about their health as compared to other professionals and in that way you will be able to know what they are thinking or how compliant they are about their health and stuff.” (IMG RMO1)

An IMG from China reported that while there were ultrasonographers and radiographers in hospitals, there were no social workers, dieticians, or physiotherapists at the time of her training. She added that even now, physiotherapy is a private service and not available in the hospitals in China. IMGs from countries where there are no teams of allied health professionals lacked an understanding of the roles and the expertise of allied health professionals in Australian hospitals.

A different training environment was described by an IMG who had experienced some IPL but with nurses only. The IMG was from Russia, one of many countries where allied health professionals are unknown. In Russia, medical and nursing students studied together and it was common after three years for the medical students to work as nurses to fund their way during the remaining three years of medical school. The working and learning experience between doctors and nurses outlined by this JMO was unique amongst IMGs interviewed. In the context of IPP, the IMG commented: “... so we

haven't got that big division between doctors and nurse as you have here" (IMG Intern).

Another IMG from Pakistan recalled his postgraduate experience in the UK where the only contact made with others was on the resuscitation team when they were doing cardiopulmonary resuscitation (CPR):

"I remember very closely that that's the time when we all come together and apart from that not much with others because either they know each specialty or each like for example doctors and physios have kind of different role and things, so you have kind of different teachings for everybody rather than all together."
(IMG registrar)

The term interprofessional was poorly understood amongst IMGs, one of whom queried whether it meant *"different professional like physician and lawyer."* Another IMG did not understand that pharmacists were also called health professionals. IPP was understood by others to be self-enrichment through the exchange of experience and knowledge with their medical colleagues. In the countries where there are no teams of allied health professionals *"the family just picks up everything"*. It is part of the culture. The notion of collaborative IPP involving allied health professionals is therefore something many IMGs have not encountered before.

4.3.2 AMGs

There were differences detected in AMGs' explanation of IPL according to whether they had completed their undergraduate degree in NSW or other states of Australia. The following responses highlight some of the differences. For example, an intern, who had graduated from a university in another state, revealed a good understanding of IPL:

"I guess with IPL there are probably parts; one part is where you learn about the role of other specialties in medicine and you learn about health professionals like nurses, OTs, physios; you learn about social workers, allied

health; you learn what they do and what they can offer and I guess the other part is actually learning together or having training sessions with other disciplines.” (AMG Intern)

In a follow-up question about his understanding of IPP, the intern offered this description of IPP. This explanation is essentially atypical of his counterparts, in particular his reference to GPs:

“I think that’s just day-to-day work in a hospital and it’s one thing you notice early on, working together with other disciplines. Doctors are just one part of the team. Interprofessional means interaction between different professions, so it’s like physiotherapists and nursing staff, social workers and I guess GPs because we have to call them and ask them about patients.” (AMG Intern)

The intern had studied medicine as a postgraduate student. The university the intern had attended in Australia had introduced students to the concept of IPL and IPP. Another AMG expressed positive experiences of IPL:

“We had like teaching with nursing staff, physios, social workers, OTs and things like that and we did a few projects with them so we did like collaborative projects with them which was great because it exposed us to what they were about, their roles and what they did, quite early in our degree. It was kind of about facilitating our relationship with them and kind of thinking about health care issues together. It was really good. And also being at a university where there is early clinical exposure we were exposed to nurses and other allied health staff from the beginning and had interaction with them. I think the University kind of fosters that a bit more than others too and I think smaller hospitals are good because you get to know people better.” (Intern AMG)

By contrast, another intern understood IPP as involving communication and arriving at goals from communication *"within the profession"* (intra-professional) illustrating again some confusion about IPP. A JMO graduate from a university where there was no

school of nursing said that IPL would have been unlikely because of the "*the huge size of the cohort of medical students*". Another JMO graduate from a university in NSW recalled having a tutor in her first year who was "*a psychologist or social worker or something, not a doctor*", who tried to help students with self-reflection sessions weekly. This was the only example of IPL the JMO could recall.

An AMG from an interstate medical school reported attending five fortnightly communication skills lectures over a ten-week session, with student nurses, occupational therapists (OTs), physiotherapists and allied health professional students. The participant deemed these sessions to have been helpful. However, with no specific link to IPP, he commented about discharge planning requiring the involvement of "*so many other health professionals*." He lamented that there was not one lecture on discharge planning in the medical school he had attended and noted that this gap impacted on his practice as a new doctor.

"As an intern, you start writing down 'contact social worker' and that's it. You don't know what you have to ask the social worker about. We were taught how to take a social history but we weren't taught about who we have to speak to regarding discharge." (AMG Intern)

A registrar recalled having some shared learning in practical sessions with the pharmacology department and some clinical anatomy sessions with physiotherapy students. She added that some "*learning, or talks*" had come from NUMs and social workers (AMG Registrar).

This example offered by an intern, illustrates her understanding of IPL as intraprofessional rather than inter-professional learning:

"In terms of IPL there wasn't any real active teaching of how you relate to patients and stuff, it was just all implicated. It was just like I'd see how my superiors would relate to patients and I would think that's not very good bedside manner or that's pretty good." (AMG Intern)

Apart from these few exceptions, JMOs reported that during their undergraduate training, both lectures and bedside tutorials were delivered to medical students exclusively rather than across professional groups at the same time. AMGs reported competing demands for teaching with non-medical students who vied for clinical teaching time.

4.4 The notion of working with and learning from other health professionals

JMOs did not always recognise IPL and IPP per se, but they did recognise that they learn from working with others, in particular, nurses. Nurses are seen as being a major part of the general support network, particularly on surgical wards where registrars are often in theatre and absent from the ward for extended periods. Nurses offer advice about patient treatments in situations specific to their clinical area of expertise, charting drugs or suggesting when and who might be a good person for juniors to call upon about problems with patients.

In terms of postgraduate IPL, JMOs reported that in relation to allied health professionals, learning was informal rather than structured and occurred early in the JMO years. Informal learning was more likely to result from interaction with nurses, in particular, clinical nurse consultants (CNCs), who were identified often as the providers of assistance and knowledge. Their experience commanded respect according to some JMOs, however one intern cautioned that JMOs had to be mindful of differing opinions they may have with CNCs over the treatment of patients:

“It is not always easy to disagree with CNCs...because you are at the bottom of the pecking order in the medical hierarchy.” (AMG Intern)

The JMO considered that this was no reason to be over-ridden in one's clinical assessment. Similar comments were made about nurses generally who were not always seen as having their knowledge or opinions validated. The judgement required to manage such situations was reportedly difficult for some JMOs. Another AMG intern remarked:

“I was an orthopaedic intern in my first year. That meant my registrar was in theatre all day ... and they have a reputation for not being interested in medical things ... and I had to make decisions as if I was a registrar and often nurses would not want to do what I asked them to do. It was really hard.” (AMG RMO1)

An IMG from India reported being surprised at how much doctors rely on other health professionals such as physiotherapists, dieticians, social workers and speech pathologists. He explained that the reliance represented a dependency on their special knowledge rather than learning from them interprofessionally:

“... how much we learn from them, I think is a bit questionable, so we tend to depend on their expertise; for example, if someone needs implementing the nutrition we just tend to leave it to the dietician and forget about it. It is the same for other health professionals like physiotherapists. I mean we know about ambulance transfers and things like that but if you ask me to improve a person’s mobility I wouldn’t have a clue.” (IMG Registrar)

The registrar commented on the large number of patients presenting with multiple problems requiring multidisciplinary care. Despite his awareness of this, he seemed unable to appreciate the benefit of IPP in managing all the different needs of these patients.

As some JMOs began to develop a greater appreciation of the meaning of IPP during the interviews, they were forthcoming in their opinions about working with their health professional colleagues. For example, one JMO remarked:

“I think as doctors, we are highly pathology orientated and we don’t think about the social side of things as much as say, the psychologist or the social worker and you know that’s their field, that’s their specialty...they see things we don’t see and they come from a different perspective as well and you know, social aspects form one of the most important parts of patient care.” (AMG RMO1)

Other JMOs conceded that it was often the non-medical staff who taught them. The following example was offered about the knowledge nurses have in recognising atrial fibrillation and alerting JMOs to prescribe medication:

“...you’ve got this 24 year old giving you instructions; you’re learning from them and they’re learning from you essentially and you guide them.” (AMG RMO1)

The experience of the JMO was that much guidance occurs between these two professions, particularly after hours on overtime shifts. Working on overtime shifts was regarded as tiring and problematic for JMOs but most accepted that the overtime shifts were essential for learning.

4.5 IPL and IPP in specific areas of local context

It became evident in the analysis of the interviews that local context, in relation to a ward or department, had a bearing on the experience and perceptions of JMOs regarding IPL and IPP. For example, in a gastroenterology ward, the dietician was recognised by an IMG senior resident medical officer (SRMO), as an important part of the team, whereas in an orthopaedic ward, the physiotherapist was pivotal in the recovery of patients according to an AMG RMO1. The critical input of the pharmacist in a renal unit, was spoken about by an IMG Registrar.

Other distinct areas such as intensive care units (ICUs) were reportedly more closely-knit units with dedicated allied health professionals. An AMG explained how the allied health professionals in ICU integrate with the medical team in caring for patients:

“By default they (dieticians) see the patients every day and liaise regularly with the medical staff about feeding regimens. There is an ICU pharmacist to check the charts and physios see all the patients more than once a day because it is important for ventilated patients to have their chest physiotherapy.” (AMG Registrar)

In ED, where the patient case mix includes a high percentage of elderly patients, aged care assessment teams are critical in reviewing the independent living capabilities of patients. These teams were seen as invaluable to the department and to patients and their families or carers. A registrar explained the aged care assessment teams:

“They are so involved, I don’t actually see them as separate. What we do with the team is extremely important and we often learn from each other. Sometimes vital clues about the patients come from them rather than the patient.” (AMG Registrar)

The same registrar spoke about the contribution of the pharmacists in ED in the overall care and treatment process of patients. Their provision of comprehensive medication lists for patients, was valued because of the help it provided to the medical staff in the event of patients re-presenting. Pharmacists were also perceived as being supportive to new JMOs commencing in ED, explaining their role and who JMOs should contact for help. At this hospital, there was a pharmacy, physically located in the central area of ED allowing close liaison between pharmacists, medical and nursing staff. However, pharmacists were not dedicated solely to ED. They provided services to other areas as well.

JMOs who had worked in geriatric and rehabilitation wards reported that regular meetings take place, attended by nurses, allied health professionals and doctors. The co-morbidities of older patients in particular, require the involvement of a range of health professionals. At the meetings, the management and progress of patients, and their suitability, or not, for discharge is discussed amongst the team. The meetings offer scope for IPL and IPP. They provide a forum for interaction between the different health professionals and for the development of a greater understanding of their respective roles in patient care. An intern working on a rehabilitation term recalled the emphasis placed on a multidisciplinary approach to care at the medical school where she had been a student:

“We were told about this idea of multidisciplinary care, holistic care, so that it enhances the patient’s care overall and their outcomes. Here (in rehabilitation) that has been the emphasis as well.” (AMG Intern)

Formalised learning is conducted through teaching sessions channelled according to professional specialty, whether for doctors or for nurses, through their own in-service programs. There were exceptions but these were isolated instances, for example, an AMG resident recalled a nurse presenting a journal article about non-compliance in reaction to a doctor writing in a patient’s notes “*non-compliant*” without explaining to the nurse what this actually meant.

No other explicit, significant indication of understanding IPL or experiencing IPP was reported by other JMOs. IPL is limited to the informal learning that takes place with other health professionals in the course of day-to-day work, and at interprofessional meetings, concerning the progress and planning of patients’ care and their movement through the system. This is particularly evident in the specific areas mentioned above where many different professionals are involved in patient treatment and care. In these cases, JMOs tend to use the term multidisciplinary as their reference point, rather than IPP.

In discussing and naming allied health professionals, physiotherapists, OTs, dieticians, and social workers were referred to most often, with fewer participants mentioning speech pathologists and psychologists. Many JMOs spoke about pharmacists in a different and positive way suggesting that this professional group appears to fall into a category of its own in relation to IPL and IPP.

4.6 Understanding of the Australian health system and hospitals

JMOs from overseas countries reported their experience of different health systems. In countries such as India with different patient demographics, patients are younger and most elderly patients are precluded from entering hospital by the cost of private treatment. Presenting problems also differ and range from major infections to

significant trauma. In some countries, the government facilities are minimal and the poor, if they do go to government hospitals, still need to pay for their medications.

“To get something done may require bribing doctors and nurses in these hospitals; it [bribing] is rampant.” (IMG Registrar)

The health systems reported by many of the IMG participants were in stark contrast to the Australian health system. Inconsistent priorities reflect the reported differences. For example, where allied health services are not readily available, communication across health professionals and with patients are not considered to be a priority.

AMGs would have been expected to have had some understanding of the hospital system however, while aware of its complexity, their knowledge of the Australian health system was limited. In fact, there was little difference between AMG and IMG participants’ understanding of the Australian health system. The following comment was typical of JMOs’ responses to questions about their knowledge of the Australian health system:

“I think um yeah there’s public and private hospitals. The public is funded by the Commonwealth and um, yeah I don’t know much.” (AMG Registrar)

4.7 Hospital climate

Each hospital in the study has previously been described within the context of the health system. However, participants’ reports confirmed the hospitals’ unique environments. JMOs’ descriptions of the climate of their respective hospitals reflect their own values, attitudes and beliefs about the hospitals and the meanings they ascribe to these perceptions (Schein 1992). While views varied, a common message was that the constraints of time create a stressful, sometimes unfriendly environment, where everyone was too busy to communicate and interact, leaving scope for error. This matter is addressed in more detail in the findings related to communication and interaction.

JMOs testified that the physical working environment including whether the physical layout of the hospital was well planned and organised, or whether it was perceived as clean or not, affected the working environment of hospitals. However, shortcomings in the physical make-up of a hospital and the inefficiencies of working in a poorly planned hospital were reportedly countermanded by a friendly and supportive hospital environment.

Some JMOs considered the size of hospitals was important in relation to IPP. One of the stated benefits of working in smaller hospitals was that it was easier to get to know people. IMGs in the larger of the three hospitals found it more impersonal and had difficulty communicating with doctors they did not know, especially when requesting consultations from another team.

AMGs who had prior clinical experience in Australian hospitals as students were seen by IMGs to have advantages through knowing the hospital system, and in some cases, hospital staff. While that familiarity was helpful to AMGs, it did not necessarily translate to a smooth transition from university to hospital, as evidenced by some of the negative factors expressed. Comments ranged from reports of bullying behaviour and lack of medical administrative support, to fear of contacting senior clinical staff and reservations about making requests to NUMs. These sentiments were not expressed about allied health staff. Such challenges to a smooth transition to hospital work reported by AMGs were amplified for IMGs who had no previous exposure to the hospital wards. The ways in which all JMOs manage these challenges affect their confidence and communication in relation to patient care as further discussed in the next two sections.

4.8 Summary

Overall, the experience and understanding of IPL and IPP amongst all JMOs is weak. There is little evidence of IMGs or AMGs experiencing IPL at the medical student level and as practising JMOs. This deficiency extends to their experience and understanding of IPP but not necessarily to their appreciation of the aims of IPP.

4.9 Culture, integration and acculturation

4.9.1 Introduction

In this section of Chapter 4, results relating to culture, integration and acculturation are presented. Culture is used here in the context of national culture and ethnic background. It includes the process of enculturation which occurs throughout medical training (Louie, Roberts et al. 2007). The term acculturation applies to the manner in which IMGs and AMGs adapt in behaviour and thinking to the hospital system, and integrate into the cultures of different hospitals (Whelan 2006).

4.9.2 Diversity in JMO participants

It was anticipated that AMGs would be an homogenous group and predominantly Australian born but this was not reflected in the findings. Data gathered from the interviews revealed diversity of cultures amongst AMG participants. Some AMGs had studied as international students on a student visa or had migrated and worked in an unrelated field to health, before studying medicine.

In addition to the diversity within the AMG group created by country of origin, diversity on the basis of maturity was also apparent. This could largely be explained by the introduction of graduate entry medical training, first offered as a four year program in 1996-1997, by three Australian medical schools (Lockett 1974). As a result, graduates enter the hospital system as more mature age interns, as do many IMGs. AMGs interviewed who were in this category stated that their prior experience and maturity was helpful in their acculturation into the hospital workforce. The AMGs who studied medicine as undergraduates typically start as school leavers and graduate at the age of 24 or 25 to become interns. This in effect creates another level of graduates adding to the diversity amongst AMGs, in addition to the diversity amongst IMGs in the JMO population. Some AMG JMOs in the study who had completed medical training in another Australian state reported problems of adapting to practising in a new

environment. The diversity in the training experiences of JMO participants in the study is synthesised in Table 4.1.

Table 4.1: Diversity in medical training before commencing as JMOs in hospitals

IMG medical training experiences	AMG medical training experiences	
IMGs from different countries commencing as JMOs after completing the AMC examinations	AMGs - undergraduate training of 6 years completed in a university in NSW	AMGs - postgraduate training of 4 years after completing another degree and may have worked in non-health related jobs
IMGs working or studying in other fields before taking AMC examinations	AMGs trained in Australia but interstate i.e. a state other than NSW	AMGs from overseas countries, study conducted under a visa arrangement

4.9.3 Difficulties encountered by JMOs in acculturating to the hospital workplace

IMGs from countries which are, or have traditionally been essentially monocultures, spoke about the cultural shock they suffered in discovering the multiculturalism that is manifest in Australia. Some IMGs were not prepared for this, nor were they prepared for the cultural diversity reflected in the patient demographic of hospitals where they were working. These IMGs had no expectations of patients being other than ethnically homogeneous.

However, the diversity of cultures and languages was seen by one AMG intern as a positive factor. He had studied at a medical school where everyone spoke English and his clinical training as a student had been at a hospital where there were very few multicultural patients.

“I think it’s really fascinating to have people from all these different cultures because the cultural dynamics is so different to what they would otherwise be which is an interesting thing to kind of consider.” (AMG Intern)

IMGs believed they had to make much more effort than AMGs in order to prove themselves and earn the trust of medical colleagues and other health professionals. They acknowledged the same effort would be required of AMGs working as doctors in their respective countries.

An AMG, with parents of Chinese background, reported that some colleagues and patients tended to treat her differently because of her appearance and assumed that she was an IMG. She also felt that she did not have the support of professional colleagues who were studying for the physician fellowship exam. The AMG doctor reported that this conduct of her colleagues had affected her confidence and sense of belonging amongst this group of registrars.

As displayed in Table 4.2, IMGs in this study completed their medical training in 12 different countries. Out of 17 AMGs, six attended Australian universities as students on visas from other countries. These students, while bringing their ethnic cultural characteristics with them, had the potential advantage of being familiar with the workings of an Australian teaching hospital and the environment of hospitals, through clinical placements during their training.

Table 4.2: JMOs by hospital, by country of training, country of origin, undergraduate (UG) or postgraduate training (PG), visa student, interstate graduate, AMC graduate, and first and other languages

Hospital	Country of training	Country of origin	UG or PG training	AMG	AMG Visa Student	AMG Interstate	IMG/ AMC	First and other languages
A	Australia	Australia	PG	√				English
A	Australia	Australia	PG	√				English
A	Australia	Australia	UG	√				English, French
A	Australia	Australia	UG	√				Chinese, English
A	Australia	China	UG	√			√	Spanish, English
A	Colombia	Colombia	UG				√	English
A	England	England	UG				√	English
A	Ireland	Ireland	UG				√	English
A	Philippines	Philippines	UG				√	Filipino, English
A	Czech Republic	Slovakia	UG				√	Slovak, English
B	Australia	Australia	PG	√				English
B	Australia	Australia	PG	√				English
B	Australia	Australia	UG			√		English, Italian
B	Australia	Australia	PG	√				English
B	Australia	Sri Lanka	UG		√			Sinhala, English
B	Egypt	Egypt	UG				√	Arabic, English
B	China	China	UG				√	Cantonese, English
B	China	China	UG				√	Mandarin, English
B	Pakistan	Pakistan	UG				√	Urdu, English
B	India	India	UG				√	Urdu, Hindi, Marathi, English
C	Australia	Australia	PG			√		English, German
C	Australia	India	UG		√			Hindi, English
C	Australia	Malaysia	UG		√			English
C	Australia	USA	UG	√				Farsi, English
C	Australia	Malaysia	PG		√			English
C	Australia	Mauritius	UG		√			French, English
C	Australia	Singapore	UG		√			English, Mandarin
C	India	India	UG				√	Hindi, English
C	Ukraine	Ukraine	UG				√	Russian, Ukrainian, English
C	Sri Lanka	Sri Lanka	UG				√	Sinhala, English
C	Ukraine	Ukraine	UG				√	Russian, Ukrainian, English
C	Ireland	Germany	UG				√	German, Spanish, French, English

A lack of understanding about the health system was evident amongst JMOs overall, but particularly within the IMG cohort. This added to the challenge of acculturation for IMGs entering a hospital system embedded within a complex health care system. A sense of frustration comes through in the following remark from an IMG registrar:

“Only thing is you’ve got to have a lot of understanding of the system. Unless you get that you will be nowhere. The health care system and the hospital system as well, I see a difference whatever the team that you admit you call them. It’s bit sometime difficult because like you are admitting a patient to a specialist where you have not seen or you have not spoken, unless you have worked in this hospital for three years. I just work four months here and they wouldn’t have that much of trust in me what I say.” (IMG Registrar)

In contrast to most AMGs, IMGs had arrived in Australia after working in their respective countries for several, or in some cases, many years thus gaining clinical experience since graduating. An example was an IMG who had been an endocrinologist in what was then the Union of Soviet Socialist Republics (USSR). The IMG had waited for ten years after coming to Australia before attempting the AMC exams, succeeding, and resuming medical practice, at the level of a supervised intern. The reason cited for this long gap was that the IMG felt it was inappropriate to enter the medical profession in Australia without “*knowing*” English:

“I made a lot of effort to learn English well because I think it is very important to be perceived as a knowledgeable doctor and be trustworthy doctor and if you can understand what people say and you know basically, not the language, but the culture behind it because it’s not everything that is said, it’s how it is said and in what context it is said.” (IMG SRMO)

Such a statement is a reminder that understanding the culture of a country as well as the first language spoken, is often overlooked. The IMG had embedded herself in the culture while improving her English language skills. The example also illustrates that IMGs tend to be older. They may have postgraduate training experience in their own countries and unless accepted into specialist training via one of the specialist colleges in Australia, must take the AMC written and clinical exams before beginning to adjust to the culture of practising in a major teaching hospital in NSW, such as those in this study.

Once IMGs pass the AMC exams they are allocated to hospitals as AMC Graduates and enter the hospital system at the level of an intern. While it is a time of supervised training and learning, it can be difficult, and at times humiliating for an IMG who may have been working at a much higher (albeit unrecognised in Australia) level, such as a consultant, before coming to Australia. An indication of the frustration they may experience by starting as an intern equivalent, came from an AMG's description of the role of an intern:

“People who have been really proactive in their learning as students, all of a sudden get in a secretarial role, this role where they need to be in a more traditional model; obedient and enthusiastic about a discharge summary.”
(AMG RMO1)

A further consideration is that IMGs may not have worked in clinical practice for several years because of the difficulty of passing AMC examinations or because they may have had to wait before taking the exams for other reasons such as needing to work to pay for the examination fees. The case of the JMO from the Ukraine cited above is an example of someone who had a gap of ten years before commencing practice in Australia. Overall, there is a broad range in the postgraduate working period of IMGs in their country of training and the period of time before working as doctors in Australia (Table 4.3).

Table 4.3: IMGs by country of training, date of graduation and years in practice, and years before registered to practice in NSW

Country of training	Completion date of training	Number of years in practice since graduation	Number of years in Australia before registration
China	1990	7	8
China	1985	3	16
Colombia	2002	4	3
Czech Republic	1998	5	8
Egypt	1981	28	3
England	2000	8	6
India	2001	9	2
Ireland	2005	5	0
Ireland	2002	8	0
Pakistan	2001	8	0

Philippines	2004	6	0
Sri Lanka	1997	13	0
Ukraine	1998	2	8
Ukraine	1986	20	10

4.9.4 Preparation and support for working in the culture of the hospital setting

Despite orientation programs conducted by teaching hospitals for JMOs, preparation for entering the culture of the hospital working environment is considered to be lacking, not only for IMGs but also for AMGs. Additionally, JMOs reported that a culture of support was not forthcoming. One IMG described the struggle of working in a cardiothoracic term when he had first started as an AMC graduate at the level of an intern:

“... and there was no supervision because the registrars were in theatre all day. I didn’t come to the hospital before so that was a bit tough ...and the registrar didn’t really care at all.” (IMG Registrar)

The IMG had been under great pressure because no preparation had been offered for this highly specialised term. Further anxiety had resulted from being told by a senior registrar that his work was unsatisfactory.

Other factors relating to acculturation include differences in medical training and the expectations of the roles of other health professionals. An example was given by an IMG from China which illustrates the point:

“...in China, doctors do not intravenous cannula patients. We didn’t even do cannula in China because in China the nurses do that.” (IMG RMO)

The ability to insert an intravenous cannula is expected of JMOs in Australia but as indicated above, some IMGs are not always trained in this skill and not prepared to do

so when they start working as JMOs. Some IMGs reported conflict with nursing staff because of their assumption that nurses would cannulate patients.

Other IMGs explained the difficulty associated with not knowing about the system for ordering tests and procedures when starting. They stated that this had not been part of their preparation and orientation to the hospital:

“... it is a totally new system to us yeah, everything’s new. When I first started I didn’t know what is the x-ray request what is the...word, how to quote these people and what to say and write and universal course ...and I discovered this by harm which was very hard, especially my first registrar was she moved from another hospital to here so this was stressed because there was new to her and I was new to her.” (IMG RMO1)

4.9.5 The medical culture in hospitals

The medical culture is but one professional culture within a complex mix of layered hospital cultures. JMOs spoke of many different aspects pertaining to medical culture. Comments from both IMGs and AMGs give some insight into what effect culture has on one’s adjustment to the hospital system and working with other health professionals. For example, the status of doctors can differ depending on country of origin:

“Here doctors have a different status. In India they think doctors are like gods and know everything. Here you are just another professional.” (IMG Registrar)

For an IMG from China, the medical culture encountered in Australia was very different in terms of the management of social issues associated with hospital patients. This is an example of why it is hard for some IMGs to engage in IPP:

“Here the doctor is involved in too much things which are not medical, I mean they have to look about social things. We only look to the medical point of view only. Other social issues are dealt with by the family.” (IMG RMO1)

A medical culture lacking in support in relation to preparation for working in a hospital was mentioned more by junior JMOs, the interns and residents, and less so amongst registrars. Lack of support was reported more in the largest of the three hospitals by both IMGs and AMG:

“I think there are better places to work in. There is never support and ... I think if the staff here aren’t well supported then I don’t see any reason why they would keep working here and enjoy it.” (IMG RMO2)

“As an intern and certainly as an RMO as well, you are essentially, for the most part, carrying out other people’s decisions, ... the person who carries out decisions and then sort of talks and discusses that with other consultants and you’re kind of the middle man in a way and I think you can get abused. You certainly find that you might call other teams for consults or to get approvals for antibiotics and you’re talked to in a really rude manner because they kind of have that power. So I find that really, really quite difficult to deal with in the hospital and it’s a big reason why I want to get out of hospitals because I don’t enjoy it.” (AMG Intern)

Bullying was also disclosed by JMOs of different levels at each of the hospitals. A registrar described the bullying of a consultant who was making her life, and that of colleagues, difficult. Such was the power and behaviour of this particular consultant that the JMOs, studying for primary exams, said they felt powerless to complain for fear that their careers could be compromised.

Specific wards or units within hospitals were reported by JMOs to have unique medical cultures. These units included ED, ICU, geriatrics, and psychiatry. A registrar summed up his experience in ED:

“We have our own world out here. It’s a different world, a different working culture.” (IMG Registrar)

4.9.6 Working in a medico-legal culture in hospitals

In almost half of the interviews with JMOs at the three hospitals, concern about a culture of medical liability was divulged. IMGs and AMGs cited examples of unnecessary tests or procedures:

“Medico-legal aspects are new to me. We didn’t have anything like that. I think every doctor has at the back of their mind a thinking of whether they’ll be sued or not and it creates a whole lot of obviously unnecessary investigations, unnecessary stays in the hospitals which sometimes seem like a waste of resources, a big waste.” (IMG SRMO)

“I think there is an increasing tendency to practice where doctors organise scans just because you’re kind of scared of being sued. So there is a lot of defensive medicine nowadays. It’s at all levels whether it’s JMO residents, interns, registrars, or consultants so I think in any specialty. I’ve done many different types here, everywhere I’ve worked there is so much defensive medicine; sometimes there’s inappropriate ordering of scans which is not cost effective and not beneficial to the patient. And you know no one likes to hear complaints and obviously there’s an increasing number of law suits.” (AMG RMO2)

4.9.7 Summary

A diversity of cultural backgrounds and medical training experience is evident in the composition of JMOs in teaching hospitals. Many aspects of JMOs’ practice in teaching hospitals are effected by factors relating to the culture of the hospital as a whole and of the specific wards within that hospital. This is particularly problematical for IMGs and to a lesser extent AMGs. While training and preparation are key elements to successful acculturation, the culture and sub-cultures in which JMOs work strongly influence how well that transition and integration occurs.

4.10 Communication and interaction

4.10.1 Introduction

This section concerns two major elements of practice, critical for all doctors, particularly for IMGs from non-English speaking backgrounds, and fundamental to patient safety: communication and interaction. Aspects of communication and interaction explored in the interviews included: perspectives about the importance of communication in the role of a doctor; difficulties in communicating and interacting with other health professionals; and factors relating to safety and quality of patient care. The interviews constituted one way of determining at first hand, the competency of JMOs in communicating. They allowed JMOs to express thoughts, opinions and ideas in relation to IPP and clinical practice. JMOs, especially IMGs, told how they felt their voice was rarely heard.

4.10.2 The importance of communication

Communication was reported by JMOs as similar in importance to clinical acumen and skills. The importance of communication in the delivery of treatment and care was recognised in responses about communication with medical colleagues, nurses, allied health professionals, and with patients and their families. JMOs expressed opinions about good communication and its pivotal role in patient management, safety, patient improvement, and in some instances, to reducing overall length of stay in hospital. They discussed problems associated with communication and pitfalls in the process of communicating, including different modes of communication.

Levels of maturity and experience that JMOs bring to their clinical practice, as indicated in the previous section, have a bearing on effective communication and interaction with patients. These factors add to the manner in which JMOs cope with the intellectual and emotional demands of their training as indicated by an intern:

“I’m so lucky I’m a bit more mature, I’ve got a bit of life experience. People who went to medical school at 18 and got out at 22 are too young. When a boss shouts at them they can’t cope...” (AMG Intern)

Some JMOs reported that in medical school, poor communicators were recognisable early in their training, with little change in their communication skills at the time of graduation. Poor communication skills were seen to create problems for interns in particular. An intern described her own observation of her peers:

“...just watching my colleagues this year, the good communicators are the ones who are sort of doing very well and those who are struggling are the ones who are struggling with their communication.” (AMG Intern)

4.10.3 Day-to-day communication and interaction

Across the hospitals, the pattern revealed by JMOs about communication and interaction is one of registrars working primarily with interns and residents. Registrars spoke about their delegation of clinical tasks concerning patients to interns or residents. Residents and interns explained that they relay that information to the nurses. Apart from nurses, other health professionals are typically not included in this close knit ménage. JMOs reported communicating with allied health professionals through writing in patient notes and relying on follow-up action by nurses. The opportunity to have face-to-face interaction with allied health professionals was reportedly limited by their availability and the pressure of time to meet demands. A JMO, completing the final term of internship, spoke about interaction with other health professionals revealing a contrary attitude to IPP:

“JMOs and other health professionals operate in their own worlds which they see from their respective perspectives, rather than as shared perspectives and interconnected operations. We don’t interact much with the pharmacy world and we’re interested in our own little worlds. We’re in the medical world and I guess we think we are always right.” (AMG Intern)

At an early stage of residency an attitude such as the one expressed above is suggestive of a graduate lacking awareness of IPP and with limited respect for other health professionals. The example illustrates the difficulty associated with inculcating IPP in the minds of some JMOs.

The most frequent communication and interaction reported by JMOs was with nurses, especially NUMs. Changes in patient treatment plans or medications are communicated to the nurses by JMOs, directly speaking to nurses, and/or writing in a patient's notes. Many changes emanate from registrars giving instructions to interns and residents on ward rounds or via the telephone. Frequent communication occurs between NUMs and JMOs in relation to bed availability.

“Usually you speak to the NUM because they’re interested in beds. So all we discuss is, are you discharging anyone today, that’s their main question, and then I look through my list and say, possibly. (IMG Registrar)

JMOs who had worked in geriatrics and rehabilitation considered communication and interaction to be effective. IPP was evident from the whole team congregating daily around the white board to discuss the treatment and progress of patients. JMOs reported some IPL at these meetings in addition to learning through the communication that takes place at separate planning meetings, where the progress of patients towards being discharged is more central to the discussion.

Communication and interaction in the singular environment of ED was perceived by JMOs as different from other areas in hospitals, with more evidence of a hierarchy of doctors and a hierarchy of nurses. JMOs spoke of the nurses being highly skilled and relied upon because often there were too few doctors rostered to work, reflecting issues of understaffing. One JMO explained that there was such a large amount of writing and organising that had to be done in ED *“we hide away and write our notes”* (AMG RMO1). The AMG reported a similar situation on the wards and *“scope to get a bit lost”* emphasising the importance of the relationship with the nurse in charge and the dependence they placed on the contact nurses have with their patients.

4.10.4 Requesting consultations

Nearly all JMOs reported that one of the greatest communication-related stress inducers was the *consult*, that is, requesting a consultation or review from consultants, the head of the team and senior colleagues. Interns and residents reported this stress more than registrars, although registrars still recalled their earlier fear of requesting consultations. IMGs in particular, spoke about the anxiety associated with requesting consultations and talking to senior medical staff. The anxiety was exacerbated if they had not met the person they were calling. Some IMGs conceded that their self perception and lack of confidence was partly at fault but for others it was considered to be very hard to manage:

“The consults is very hard to talk to another registrar because um I find this difficulty now after hours too, on the phone. When I talk to one of the registrar I’m not sure is that a feeling that I felt or that’s what he feels towards me. He recognise that I’m not Australian and like if I don’t give him what he thinks of he become upset, he gives me a hard time. My registrar says do a course but I have to go through all the notes and summarise all this, so when it talk over the phone I have to give him a good summary and it takes a long time specially if I haven’t seen the patient before.” (IMG RMO1)

Some AMGs acknowledged the experience of requesting *consults* was a learning experience. They had to present the facts and justify why the *consult* was required:

“If you do it well, you feel quite good about it and that forces you to learn a little bit and I think that’s one of the hard kind of colleague interactions.” (AMG RMO1)

The significance of the situations described above is evidence presented about intraprofessional problems within the medical hierarchy and culture. Problems of communication within professional groupings may challenge the resolve of group members to communicate and interact interprofessionally.

4.10.5 Ward rounds and handover

The composition of staff attending ward rounds was predominantly doctor led, according to JMOs. Rounds were led by either the consultant or a senior registrar with RMOs and interns, or at least one of the latter attending, and sometimes medical students. Nurses are rarely present on ward rounds because of conflicting demands. Sometimes there might be a NUM, a nurse or a discharge planner attending for part of the round but usually nurses' handovers occur independently at times linked to the change-over in their shifts. JMOs may seek information from nurses if required, otherwise they complete their rounds and patient management information is then conveyed to the NUM or the nurse in charge by the most junior doctors, the interns or RMOs.

“On the ward round you’re running around and you’ve written a plan and you need to quickly communicate it to the nurse. You can’t find a nurse; you tell a different nurse and it might not get passed on.” (AMG RMO1)

The JMO quoted above, acknowledged that essential facts may be lost in the translation of that information which can result in aspects of patient care being overlooked. Another JMO described communication on ward rounds in a gastroenterology unit, emphasising the number and length of ward rounds together with further concerns about the transfer of patient information:

“Every day we have a ward round that lasts for hours. In my team it’s myself and my intern, my registrar and sometimes my advanced trainee. And sometimes we have ward rounds with the consultants during the day. So, there can be multiple ward rounds. Sometimes the nurses might come or one nurse will come to sort of know what’s going on ... so I think communication’s lost because there is not good communication with the nurse and nurses can’t pass on that message. Sometimes I think nurses don’t take the onus of passing on that message because they think it’s a medical one. I think everyone is involved in

their patients health care and nurses you can still fill things in to patients without being the doctor.” (AMG RMO 1)

Conversely, on wards such as geriatrics where there are regular ward meetings, information is directly exchanged between allied health professionals, nursing and medical staff, who usually congregate daily around the ward white board. The JMO presents all the patients and their needs are discussed, based around their projected discharge date.

“That meeting is such a good way to ask the physio to see the patient or to ask the pharmacist to talk about the Warfarin they’ve just started or talk to the dietician and that type of thing.” (AMG RMO1)

In ED, IMGs reported that communication on handover rounds can be quite confronting. Presenting a case takes longer because of language difficulties. An IMG explained that AMGs might be interrupted and told to get to the point on a round or questions might be asked but IMGs are more likely not to be interrupted and to miss out on questions and related learning opportunities. Another IMG was more sensitive about being asked questions, for fear of not understanding the question or not being able to provide an answer. Furthermore, he felt that intimidation, “*a grilling*”, can occur and the person conveying the information can be overwhelmed by the presence of surrounding medical clinicians on the round.

There was some criticism of lengthy handover rounds in ED and a questioning of whether rotating juniors are given even a brief introduction about how handovers should be conducted and what sort of information should be conveyed. Some registrars suggested that preparatory training would help to avoid essential information being lost in the detail of unnecessary information conveyed during lengthy handovers. An AMG registrar from a non-English speaking background, explained the situation in this way:

“There is an art to it (handover); not everyone does it the best way. Information can drop off and handover is a sort of whole new talk. It really needs to be done

properly too and the patient properly handed over and make sure the safety of the patient going through the department is maintained. I suppose communication comes in and is big thing in the handover.” (AMG Registrar NESB)

Another JMO spoke about poor and inadequate communication at handover in ED. At times this leads to patients being forgotten and left waiting for further attention regarding referral or discharge. In extreme cases they might be left to deteriorate. An IMG registrar said things do go wrong during handovers because of poor communication:

“That’s a time (handover) when there’s communication problems, where sometimes the person who’s handing the things wants to say something and the person who’s taking the handover, he takes something different, he misjudges and gets a miscommunication. It does happen many times.” (IMG Registrar)

4.10.6 Communication with patients

In acknowledging the importance of communicating with patients few JMOs spoke about the significance and challenges of communication for history taking, diagnosis and consent, in the manner explained by one JMO:

“Communication is the most important part of diagnosing someone and taking a history will give you like a diagnosis in a lot of cases. Communication is important with a patient because if you have bad communication that can cause much distress for the patient himself and the family if they have misunderstood something. So I would say it’s crucial especially nowadays when patients need lots of procedures done; you need to get consent from them so unless you have good communication to explain to them what they are having done, what are the side effects what they can expect then they won’t be happy if they don’t understand and if things go wrong, it can lead to complaints. You never know what’s going to happen especially in this region where you get lots of people

from different backgrounds and lots of non-English speaking people, it can be very challenging. In that case sometimes you need to have other interpreters or even other family members or doctors of that language or nurses. So it can be time consuming and challenging. For example working in ED when you don't have anyone on guard at that moment to translate for you, you wouldn't know what to do. It's very frustrating. It's never, never, never easy." (AMG RMO2)

Another AMG outlined how language difficulties in IMGs affect their interaction with patients and their carers as well as professional colleagues. The scenario revealed some sympathy for IMGs which was not always evident amongst AMGs:

"Sometimes with your own medical colleagues it's difficult communicating. As you know we've a number of overseas doctors, for example my registrar. If they are from overseas and they've just come to Australia and English is not their first language, even speaking to patients, there's lots of misunderstandings that myself I can see. And the patients themselves are not sure what is going on, so you do have to go back and re-explain to them later on. That takes time as well. But you know, it is understandable in a sense because English is probably not their primary language, they probably are medically sound but it's the way they express themselves and also because they've come here and the culture is different. Sometimes just the way they speak, their tone, they might not intentionally mean it but the patients... might take it differently and be offended as a result, but I'm sure they don't mean it." (AMG RMO2)

4.10.7 The difficulties of language

English language problems are reportedly the major stumbling block for many IMGs and one of the most difficult challenges for them to overcome. Apart from problems with day-to-day English, IMGs cited problems including, medical terminology, abbreviations, and acronyms, as well as the names of drugs. In many cases, IMGs stated that these problems affected their understanding of what is communicated to them on

ward rounds, in meetings, teaching sessions, and at handovers. It also stalled their confidence in engaging with the team.

Other difficulties reported by IMGs were the speed of spoken communication and a reticence to speak out, to question, and to ask for something to be repeated. In some instances they are helped, but IMGs reported many times being confronted with intolerance, avoidance or being spoken to in short sentences “*like some order*”. In extreme cases, several IMGs stated they would try to avoid using the telephone as much as possible because of their language difficulties in listening and speaking in English. An IMG described (and demonstrated verbatim) how difficult it is for him, as well as other staff, to effectively interact and communicate with each other:

“We always contact with the pharmacy and nurse. The nurses you know, nurse you know nurses, depends on the what the patient you take care of when you, when you, when you er did the prescription you notify the nurses and now will also communication with other physio, and if you want to we always do er most of the time do the professionally but also friendly but is is you know sometime you know just in a relaxation atmosphere. (IMG RMO1)

Some IMGs stated that they welcomed the opportunity when talking to patients to be able to ask them to repeat things several times, whereas they were loathe to ask colleagues and seniors in particular, to clarify or repeat sentences in this way. They feared what might be said to them in response, by their colleagues. These fears point to a problem in intra-professional communication; many JMOs referred to this although it was spoken about more amongst IMGs. The long quote included below is from an IMG from an English speaking background. It illustrates much about communication: concern and frustration about modes and complexities of communication; the skills for communicating effectively, and associated pressures of time.

“There’s a huge number of people that you need to communicate with and I’m not sure that we have the infrastructure in place to communicate as well as we could. We still write everything on pieces of paper, we use pagers which are

infinitely antiquated. I don't want to be phoned about everybody who's coughed twice today. I don't need to know every minute detail and that's a skill I think you have to learn. Just from seeing my peers I don't think everybody has that skill, knowing when to communicate or what's important to communicate. And then the nursing staff, they often rely on notes that are written which is often not very reliable and we have difficulty reading each other's writing and then you're often pressed for time when you're seeing somebody and you probably don't get on paper what you need to get on paper. Peoples' family doctors need to be communicated to as well which can often be challenging, just making the time to get to the phone, to phone every one of them and to write to everyone."
(IMG Registrar)

4.10.8 Written communication

Patient notes and other forms of written communication were revealed as problematical by JMOs. Frustration was expressed almost universally about the difficulty of reading handwriting and the time wasted in trying to decipher writing. AMGs sought help from colleagues or nurses nearby, or spoke to the person responsible for the writing, to explain their notes. However, one JMO stated that calling the person who wrote the notes was a waste of time and that most often this does not occur.

IMGs resorted to a range of methods in addressing this problem of deciphering writing. One IMG reported faxing the notes to the consultant's secretary for interpretation because he was too afraid to ask for help closer at hand, and did not want to upset *the boss*. At other times the notes were deduced, or *skipped altogether*. Another IMG explained that if she could not read the notes or she could not understand the anatomical terms used, she would look at the conclusions from test results to make an assumption about what was written in the notes. Failing that, she would re-take the test or re-take the history. As a final strategy, she would resort to asking the patient. Other JMOs reported that patients were useful sources of information about themselves, for example, if notes about treatment by the night staff had not been written up after a busy night.

IMGs from cultures where the doctor is the only person to write patient notes, or where there are no allied health professionals said they were not used to the profuse notes written about patients by all those involved in their care. The time taken to read and to write the notes, when English is not their first language, is a further problem. AMGs also made comments about the lengthy notes written by nurses and allied health professionals, stating that most of the time they do not read them because of the pressure to perform all their other tasks:

“Doctors are notorious for not looking at anyone else’s notes apart from the consulting doctors.” (AMG RMO1)

4.10.9 Summary

It can be seen that there are many issues relating to communication and interaction, some of which enable IPL and IPP but more often appear to be barriers, potentially interfering with quality of care and patient safety. The communication problems faced by many IMGs are challenging for them and for their health professional colleagues and patients alike. Non-English speaking patients add yet another dimension to effective communication in some situations.

The more junior JMOs, interns and residents, emerge as being the conduits for much of the information communicated from consultants and more senior registrars to the nursing staff and allied health professionals. This is information critical to the investigation, treatment, and care of patients which is left in the hands of the most junior inexperienced doctors. It is a situation which appears to be a product of the teaching hospital system.

4.11 Collaboration and teams

4.11.1 Introduction

In this section I discuss the findings from interview questions relating to collaboration and teamwork in teaching hospitals. Particular areas explored with JMOs included their attitudes to, and opinions about, collaborative team work, their willingness to work with other health professionals and perceived barriers to collaborative effort. References to collaboration made in previous discussion about communication and interaction illustrate that the two are inextricably linked.

4.11.2 Attitudes to teamwork and opinions about collaboration

JMOs perceived that some people were manifestly not team players: perhaps because they were arrogant and always thought they were right, would not listen to others, or preferred to work on their own. One JMO suggested that in some cases doctors may be so frustrated by the pressures that are put on them that there is not enough time to consider collaboration and therefore IPP. A cultural factor, referred to in a previous section, related to IMGs originating from countries where it was either customary for JMOs not to work collaboratively or where there were no teams of allied health professionals in hospitals.

There was evidence from some JMOs that their understanding of collaborative IPP did not extend beyond a practice residing solely between the medical team attending patients, and the transmission of information to nurses and allied health professionals, typified in the following comment:

“There’s not very much that I do on my own, you know I have a resident and we tend to work most closely together of course. There’s things that I need to delegate to him and he does on his own and either of us or both of us communicate to the nursing staff.” (IMG Registrar)

A lack of understanding about collaborative IPP was not confined to IMGs. An AMG spoke of his experience in a term of gastroenterology where he had worked a lot with the dieticians. His comment also revealed some patronising views on the dietician's role and expertise:

"They [the dieticians] were very nice people and we sat at the same desk so that was quiet collaborative and interactive working with them in terms of patient management. But a lot of it is really just asking for their services and having them look after the patient like, you know, do what they do with the patient."
(AMG RMO1)

Some JMOs stated that other health professionals are not interested in planning patient care with doctors and only wish to know what doctors want them to do. Another JMO described his experience of working with allied health professionals:

"If allied health want a consult sheet then I'll do a consult sheet and I'll give as much info that's relevant to them. They just pick it up. Mostly you don't talk to them and if you want physio you write it in the plan for the day 'chest physio please' and then the nursing staff sort it out, the NUM or the In-Charge on the ward go and talk to the physios. I usually hand over all those things and they will liaise with allied health and whatever. I'll say, look this patient needs social work, this patient needs physio." (AMG RMO1)

An IMG spoke about "taking help" from allied health professionals almost daily. He gave examples of how he worked with other health professionals and acknowledged their expertise:

"If someone has swallowing difficulties the first person I would think of is a speech pathologist because I wouldn't have the capacity to judge somebody's swallowing. If I needed to assess someone's mobility then I would like to see a physiotherapist, so I think other than the medical management I think we are

completely dependent on advice and opinions from allied health professionals.”
(IMG Registrar)

The interdependency of health professionals has been identified previously, for example, in geriatrics and rehabilitation. However, findings denote that independency of doctors from other health professionals prevails across the hospitals. Indicative of this independence are two comments from an intern and an RMO1:

“I think it’s really important to be able to work by yourself and a lot of what we do is working by ourselves during the day completing your own tasks.” (AMG Intern)

“...we are all interested in our own things. The physio tells us to do their thing and we tell them to do our thing. We don’t interact much with the pharmacy world or the physio world and we’re all interested in our own little worlds. They’re in their physio world and they see things and we’re in our medical world and see things and I guess we think we are always right.” (AMG RMO1)

Evidence of independency over collaborative planning came from JMOs at different levels, both IMGs and AMGs, across the three hospitals. Outside the collaboratively functioning areas identified above, the dominance of doctors in decisions about patient plans is expressed by this registrar:

“I would say all of the teams rely on us to make the decision and tell them what the outcomes should be. Like physio they would ask us whether we would like to move this patient, who is healthy from a medical point of view, to be moved for physiotherapy or not. That’s how we communicate with the other teams. So we see, like my attitude towards the teams is they are very helpful and they are usually available all the time if I need any help.” (IMG Registrar)

4.11.3 Willingness towards collaboration and teamwork

Some JMOs displayed positive attitudes towards collaboration, as illustrated in the responses below from JMOs in different hospitals. One registrar, who had studied postgraduate medicine, spoke about the expertise of other health professionals being critical to the combined care of their patients. They described collaboration in the following terms:

“You know I find it (collaboration) personally very rewarding as I feel it covers a lot of bases in terms of coming up with the best care plan. From my perspective also, I don’t have to be the know-all person who formulates the final plan or the most complete plan. I can invite others to sort of contribute and then we can work through and combine all those things together. I really enjoy it.”

(AMG Registrar)

Patient centredness was understood in the response given by an intern about collaborative effort. She indicated an awareness and appreciation of IPP and the value of working in the best interest of patients.

“I guess collaborative effort is the cornerstone of patient centred care. I think, you know, it’s the best way of meeting your patient’s goals. I think there is definitely an understanding that the best outcome for a patient doesn’t necessarily end with the best medical treatment for patients. Patients are complex, they have many other issues outside of their medical issues that need to be sorted out and I think when everyone kind of works with that kind of common goal, it just makes it easier and everyone’s reiterating the same thing to the patients and they’re not getting a lot of different viewpoints thrown at them which confuses people, especially when you’re sick and your retaining ability’s probably reduced.” (AMG Intern)

An IMG offered an appreciation of the benefits of collaboration. The integration of shared input from the patient care team was emphasised:

“We’re all trying to do what’s best for each patient on the team and working out what’s best for that patient is best done by considering the input from a range of health professionals and then integrating all those opinions and then doing what everyone has suggested. I think that’s the best way to care for patients, to involve a range of specialties you know, being medical specialties, allied health, nursing and then suggestions coming from everyone.” (IMG Registrar)

Despite speaking favourably about collaborative team effort (and personifying it when later observed), one JMO added a proviso related to time and circumstance in the milieu of patient management and decision-making:

“Ultimately you need someone to step up, take the responsibility and make a position about it. It can’t always be a group effort because sometimes the fastest and most effective way is to not necessarily congregate everyone.” (AMG Registrar)

The limited interaction with administrative staff reported by JMOs suggests a gap between management and practitioners, more evident in JMOs from the two larger hospitals. The practicalities of working collaboratively in an acute care setting were raised and examples given of constraints to IPP including constraints of time, the poor coordination of shifts by administration and the expectations placed on JMOs to organise and complete their tasks:

“... the way the system works in terms of like time constraints and coordination I find that it could be a systems problem.” (AMG RMO1)

4.11.4 Understanding the roles of other health professionals

A lack of understanding about the roles of other health professionals has already been identified as an impediment to IPP in findings reported under culture, as well as communication. The lack of understanding about roles is not restricted to IMGs as revealed in interviews with AMGs. It is more difficult for IMGs used to working only

with doctors and nurses and for IMGs who come from cultures where the doctor is the only decision maker in relation to prescribed patient care and the discharge of patients. An IMG explained his experience:

“At the beginning of last year I didn’t know what do these people do although this explained to me but I did not recognise at the time how important they are to the system ... that we could not discharge a patient unless a physiotherapist say that he can go home or an OT says he can go home. In our country I’m the man or I’m the one who says this can go home or not.” (IMG RMO1)

One JMO remarked that allied health professionals should briefly explain to doctors and nurses the purpose of what they are doing with patients and how patients will benefit from their treatments. The treatment from physios was cited as an example in relation to what apparatus is being used on patients and why.

Without understanding the expertise of non-medical professionals, the inclination for JMOs is to consider the medical team only in patient care, particularly amongst IMGs but also in some AMGs. For example, an AMG offered the opinion that collaborative effort does not work but her inference was about collaboration between different medical specialties so she was speaking from an intra-professional perspective:

“...when it comes to making referrals to other teams where you have to get different specialties involved, they just come, assess their patients, they write in the notes, put a plan there and leave it. They don’t even talk to you, they don’t even call you to say, ‘oh, I think this isn’t right, I think we should do this’. You should be having some kind of verbal, two-way communication.” (AMG RMO2)

4.11.5 Respect between doctors and other health professionals

An understanding of the roles of other health professionals was perceived by some AMGs as a step towards mutual respect between health professionals. The contribution of other health professionals to collaborative teamwork and collective decision making

was dependent on JMOs' understanding and appreciation of the individual expertise and knowledge of other professionals

“I suspect that there might be a bit of a feeling of a divide between doctors and the other health staff. I think one of the crucial elements of collaborating, would be that everyone felt that they had equal amounts to contribute to the patients’ health care. So I think it’s important for the other non medical members to feel like their input is valuable.” (AMG Registrar)

As indicated above, respect was seen as going beyond understanding the roles of other health professionals. The notion of valuing the input of other health professionals was considered by some JMOs to be just as important for collaborative IPP:

“I think it’s just mindset and attitude in respecting your peers when you approach multidisciplinary care. So I think it’s about understanding what their roles are and seeing that as valuable which I think is more evident in some specialties than others. So respect and mutual understanding are really important.” (AMG Intern)

4.11.6 Collaboration on ward rounds

The advantage of including other health professionals on joint ward rounds with doctors was acknowledged by some JMOs. There was no discussion about any potential benefits to patients that might flow from joint ward rounds. A major advantage cited was that all members of the team on the round would have the same information about patients, allowing for joint planning to occur. Despite these benefits in the transmission of information about the progress and planned care of patients, the feasibility of joint ward rounds was questioned by most JMOs similarly to this comment:

“In principle I don’t think it’s going to work. I don’t think everybody can be on the ward round. But in theory it would be nice and it would save a lot of time and it

would save miscommunication and you would have everybody there and then when you wanted them.” (AMG Registrar)

4.11.7 Discharge planning

Among JMOs, the notion of collaborative practice is linked to planning for the discharge of patients, a practice that occurs concurrently with the treatment of patients. Discharge planning meetings are seen by JMOs as effective in achieving common goals and sharing information. For example, the social worker, who was always assumed by JMOs to be female, is involved at a face-to-face level and was reported as knowing immediately if an issue needs to be cleared before a patient is discharged. Equally with the mobilisation of a patient before discharge which requires management by the physiotherapist. The opinion given by some JMOs was that the discharge process and timing of discharge is greatly improved with more collaborative team effort. There are positive signals there for hospital management.

Finally, the number of patients who are classified as *outliers*, is a challenge to collaborative team work, according to some JMOs. *Outliers* occupy beds in different wards, usually on different levels, from the specialty where they would be, if beds were available. Their displacement to another physical location away from the main ward interferes with collaborative effort because of the difficulty in the timing of attending to these patients isolated in other areas.

4.11.8 Summary

Most JMOs acknowledged the role of non-medical health professionals in patient care and the value of their contribution to the management patient care. However, a lack of understanding about the roles of other health professionals and lack of respect between doctors and other health professionals were identified as barriers to IPP. JMOs who understood the roles and expertise of other health professionals were in the minority but were more inclined to be supportive of the notion of IPP and recognised the worth of collaborative teamwork.

The ability to work as part of a team, while apparently difficult for some people, is perceived by many JMOs as being important to patient care although their understanding of the links to quality and safety was generally not evident. The latter was despite JMOs being asked about links between collaboration and patient safety during the interviews. JMOs volunteered more about their own roles and the difficulties associated with collaborative effort, than about patient safety. Aspects of safety are referred to in the following section.

4.12 Competency, safety, quality and professionalism

4.12.1 Introduction

The final section of Chapter 4 reports the findings from JMOs' responses to interview questions pertaining to competency and to aspects relating to safety, quality and professionalism. An assumption was made that all JMOs had the skills and knowledge to be clinically competent by virtue of their employment in each hospital. Questions therefore focused on JMOs' confidence in their clinical competency and other important aspects linked to the overall well-being of patients.

Aspects of competency explored included: JMOs' confidence in their clinical competency and clinical acumen; technical competencies; ongoing education and training for the further development of competencies; and competencies linked to safety and quality including medications, handover and supervision. These aspects, together with communication and collaboration, discussed previously, are components in the overall clinical performance of JMOs and their professional practice.

4.12.2 Confidence in clinical competency

Most JMOs reported confidence in their level of clinical competency as appropriate for their postgraduate level. Some AMG had reservations about their competency at the very junior level, after transitioning from medical student to intern. Reservations included uncertainties about their clinical roles, uneasiness about their new

responsibilities, and a view that their clinical skills were not as good as they could be. An AMG intern felt unprepared for a term of cardiology. She had mistakenly thought there would be time to revise “*forgotten*” clinical knowledge but found there was no time to do any study once the term had started.

Some evidence suggested that as JMOs become more senior they start to focus on specialised areas of practice and may begin to lose some of their more general skills. A registrar stressed the importance of knowing how things work through experience:

"It's a sort of savoir faire. You tend to have an appreciation of the avenues of how to get information or find things or know what's important and what's not."
(AMG Registrar)

Many IMGs felt they were not well enough prepared for working in the hospital system. This has been discussed in earlier sections but is mentioned again because of the relationship it has to aspects of competency discussed here. Some IMGs reported a time lag between the successful completion of the AMC exams required to qualify for medical registration, and their commencement in a hospital residency position. The absence from practice had caused them to feel a lack of confidence about their competencies:

"I don't think is enough training, no not enough training. My idea was we need some training we need some hospital attachments before we start work especially the permanent residents or the citizens overseas doctors. It is a totally new system to us yeah everything's new. We really need to come to the hospital to talk to patient to take history or to examine to know the paper work and this wasn't enough in twenty five days or something." (IMG RMO1)

IMGs spoke about the difficulties of understanding terminology, anatomical terms, and acronyms. Some reported a reticence to ask questions and seek clarification of their understanding. The problem is illustrated in the following remark:

“The anatomical terms, I’m still you know not good at it but at the end of that you know every report has a conclusion just look at the conclusion. I don’t think you really can ask for help. Um it’s not like they can describe like especially the CT head report, unless are looking at the picture. You know the computer is always a picture as well and the report so I think I can roughly put the picture and the name together but to be precise I think best way is go to the books.”
(IMG RMO1)

One IMG stated that his main difficulty was in observing and eliciting clinical signs from patients. He was working on his clinical knowledge and *“reading up”* and revising every day to improve his knowledge. Another IMG revealed that the more he learned the more cautious he had become:

“I am less reckless and more inclined to patient safety. Sometimes if I’m not decided which way I should go with chest pain, sometimes you don’t really think it’s cardiac but just to make sure you go for these extra investigations.” (IMG Registrar)

JMOs reported the tendency amongst medical staff, at all levels, to order tests such as scans, as a form of defensive practice against litigation. One JMO questioned the implications of this practice on the development of clinical acumen in JMOs:

“Obviously there’s an increasing number of law suits. I don’t think there is as much clinical medicine as there used to be now which is a concern. It’s more like pretty much ordering blood tests and a series of scans. Yeah, lots of scans, just because we have the facility here.” (AMG RMO2)

Consistently positive comments came from IMGs about the benefits of working in a teaching hospital and the opportunity it provided for learning. Improvements in competency had been achieved through working *“where people have good medical knowledge and know about conditions.”*

4.12.3 Judging when to seek help

JMOs acknowledged the importance of clinical acumen, for example, being able to accept when confronted with uncertainty about how to manage a problem with a patient and having the wisdom to ask for help. More interns and RMOs than registrars spoke about coping with uncertainty. Some had recognised the error of not seeking help. They described learning from what one JMO described as, the “*bitter experience*”, of continuing to make decisions on their own when out of their depth and how they were living with the consequences uncomfortably. Covering many different wards on after-hours shifts with limited support was described as “*daunting*” by JMOs. An AMG registrar spoke of concern about managing the more sophisticated problems associated with cardiac and lung transplants after hours and wanting “*to do a better job.*” IMGs were less forthcoming in talking about coping with uncertainty as related to safety. They had already revealed their hesitancy about asking for help.

The sense of security from working in a teaching hospital was not confined to IMGs as described above. An AMG registrar believed that in a tertiary hospital there should not be issues of feeling “*out of depth*”, because support was available when needed. He stressed that knowing when to seek that support was the foremost important factor for a JMO. Another AMG who had ignored asking for support, revealed how he had missed things through inexperience and failure to seek help, resulting in adverse patient outcomes.

“In retrospect I should have asked somebody else to look at the patient before I made the decision. Because of inexperience like I missed things that if I was more experienced I would have said like that’s out of place. You know, you say something that’s like you’re ticking through things mentally in your mind but when you lack clinical experience you just lack that recognition of something being abnormal. It’s that kind of recognition that you don’t have as a junior.”
(AMG RMO1)

4.12.4 Confidence in technical competencies

JMOs reported less confidence in their technical clinical competencies. Examples cited by interns and residents included lumbar puncture, venepuncture; intravenous cannulation; the insertion of naso-gastric tubes and the skill to read electrocardiogram (ECG) reports. Some registrars, one of whom was working as an ED registrar, cited a lack of confidence in managing cardiac arrests. An AMG registrar spoke about his efforts to be as safe as possible, making sure he was not making “*many errors in patient care*” when performing procedures. The following example is indicative of problems beyond language, faced by IMGs, and how they manage:

“Some of the procedures they ask you that, I mean they tell you that you know it so um in that way like one of the patients, the consultant ask me to do a lumbar puncture which I haven’t done in two years so that was just on the phone, so the consultant told me that it needs to be done but she didn’t tell me the way to do. But since it was after hours it was good that see its just getting the right people to get involved because you know you shouldn’t do something you know you’re not confident to do. So I asked the ED consultant who was there cos I’m working in ED. I told the ED consultant would you mind help me cos he patient need a lumbar puncture. My registrar and my consultant think why do we have to do this test so in that way that remembers me what the patient presented if it reminds me everything so that I can use this in my future path of career.” (IMG SRMO)

One of the concerning factors in the above extract is the level at which the JMO was working. An SRMO is usually in their third postgraduate year and would be expected to know how to do a lumbar puncture. The level of the JMO’s English language skills might have been expected to be higher, commensurate with his seniority and associated responsibility.

Surgical skills were considered to be poor by some JMOs. An IMG had not sutured for many years because he had practised in cardiology before coming to Australia. He had not updated his skills. An AMG described “*a deficit in surgical training*” for JMOs:

“It’s bad enough that we get MBBS’s with the BS on it, with people who don’t necessarily have to ever have had a surgical assessment.” (AMG RMO1)

JMOs spoke about challenges to their technical competencies when working in ED. Difficulties disclosed included examinations for obstetric and gynaecological presentations, paediatric presentations and patients presenting with injuries to the eye, such as foreign bodies:

“I never learned much about the eye and we kind of had to pick things out of someone’s eye. So that’s interesting but you know when you learn it once you are better at doing it the second time.” (AMG RMO1)

One intern emphasised the importance of getting more procedural training experience but little enthusiasm for going out of his way to get it. His hospital offered a skills weekend once or twice a year on a Saturday but he would not contemplate attending on his day off.

4.12.5 Ongoing training and education

Ongoing training and education ranged from weekly teaching sessions for RMOs and interns to clinical teaching sessions and more formalised learning, associated with specific training needs, for registrars. Overall, RMOs and interns reported having little time, if any, for further learning and reading to “*actually learn and become more competent*”, and to develop their knowledge from teaching sessions.

Weekly Grand Rounds forums were recognised as providing further opportunities for learning. Attendance was greater amongst registrars but overall, JMOs reported irregular attendance, more so in IMGs than AMGs. Reasons for not attending included:

the pressure of time to complete the tasks of the day; working on nights or late shifts; language difficulties of some IMGs; and the early morning timing of Grand Rounds in one hospital.

For interns, quarantined times of one hour a week for teaching were offered at two of the three hospitals, attendance being mandatory. Despite this, one intern had not had any teaching during the term rotation he was doing. At the third hospital, attendance was compulsory but the time was not quarantined. The value of the teaching at these sessions was not rated highly and in one hospital was criticised as being sub-optimal in terms of general learning. One reason given was the junior level of doctors teaching them and another was a medical administrative problem; an apparent lack of coordination in arranging appropriate teaching. There were other indications of inconsistency in ongoing education, outside the weekly teaching for juniors, sometimes dependent on JMOs' term rotations, as referred to in the following comment:

“Other teaching depends what term you do, so in some terms there is structured teaching and in some terms there is nothing, absolutely nothing. So the only teaching that you get is Grand Rounds. You have to study by yourself and don't expect anyone to teach you at work.” (AMG RMO1)

Bedside teaching by consultants, offering active mentorship and the opportunity to ask questions was identified as “disappointingly” lacking and substituted with “mid-level” teaching from registrars. At the bedside, AMGs found it difficult to ask questions of the consultants. IMGs with language difficulties recoiled, for fear of being misunderstood, or from not being able to answer any questions directed back to them by consultants.

After internship, the amount of teaching offered was considered to be limited, particularly teaching for RMO2s or SRMOs, despite their increased responsibilities. A reason given by an SRMO for choosing to do an extra year before becoming a registrar was specifically to learn more and gain experience and confidence. It had been expected that additional teaching would be offered as well.

In the specialised area of ED, JMOs reported more structured teaching on a regular basis and some teaching at the bedside during rounds, depending on how busy it was and how sick the patients were. At one hospital, the staff specialists in ED were always ready to offer some extra teaching in quieter moments.

Much learning is left to self directed learning through internet and intranet searches, reading texts (reported more by IMGs), and reading journals. One AMG registrar completing a rotation in endocrinology had initiated a “*sitting*” with a dietician to watch and learn how to teach carbohydrate counting. They had also asked nurse educators to demonstrate how to teach a patient to inject insulin because this had not been taught in medical school. The registrar remarked that other staff are taught these skills but not the medical staff. This was a rare example of IPL initiated by a JMO.

Learning through attending clinical or departmental meetings depended on the ward or degree of specialisation in units and the composition of attendees, with greater input by the registrars when in company with consultants. Some interns and RMOs reported attending meetings where much was discussed *over their heads*, acronyms were not explained and it was difficult to ask questions. Overall, the opportunity for learning was limited. For IMGs the experience was even more difficult. An IMG described the unease felt during such meetings:

“I avoid (clinical meetings)...we have case presentations every week; I avoid talking in. Just sit in the corner and listen. I don’t ask questions because I’m not sure is the question, is it just a silly questions. I’m going to criticise myself so I just don’t bother.” (IMG RMO1)

4.12.6 Safety and quality - medications, supervision and handover

The administration of medications was an area of concern raised by JMOs in the context of patient safety. The medication process was seen as a combination of three things: the person prescribing the medication, the charting of medications and their administration.

JMOs felt improvement was needed across all three steps in the process. One JMO cited a recent catastrophic and much publicised medication error in her hospital. An IMG felt very strongly about the risks associated with prescribed medicines as described in the following way:

“We have to understand at the medical level we are involved in patient safety at many levels not only from what we prescribe or give to patients in order for them to get better, but we also need to know that those medications can put the patient at risk at many levels. So we need to ensure that the patients actually are receiving what you intend to give them. There are many, many, many, cases of medication errors; medications that patients get prescribed by mistake, not only from people looking after them but people that get casually involved in them, say doctors that may be working over time or get involved in night shifts that do have very limited contact with patients.” (IMG RMO1)

Most JMOs valued the input of pharmacists and their constant checking of medications prescribed to patients. They acknowledged their reliance on pharmacists to detect errors and communicate with JMOs about the errors.

JMOs were not specifically asked about supervision but some (AMGs only), raised the subject in relation to patient safety. Several registrars had reservations about the competency of some junior JMOs, mainly interns and RMOs but not exclusively, suggesting they were not supervised enough and it was *“not commensurate with good patient care.”* Concerns included the trauma and risks associated with being rostered for night duty as an intern. A JMO spoke of a lack of guidance and the dangers of on-call shifts:

“We spend periods of time without adequate guidance; I think there’s too many times a week we are without a lot of guidance. I think nights is dangerous for example, and on-call shifts. I think when we’re working together though we’ve all got patient safety in mind.” (AMG RMO1)

Another RMO2 stated that he felt there was “*probably just adequate support*” at his level, attributing this to understaffing and the hospital being very busy, especially on overtime evening shifts and night shifts. His main concern was about patient care being compromised but he also found the environment stressful and difficult:

“... trying to manage acutely unwell patients while at the same time being paged about other unwell patients but having no one else on hand to call upon for help is a problem, and puts patients at risk.” (AMG RMO2)

This sentiment was supported by an RMO1 who stressed that an experienced person should always be around or at least contactable and that sometimes a judgement had to be made to call the consultant, “*as difficult as that might be for JMOs*”. He cited case presentations of badly managed cardiology patients that could be traced back to not having someone senior looking at ECGs at night when RMOs are on duty.

The skills required for a safe and effective handover were perceived by some registrars as a competency lacking in many JMOs. One ED registrar described handover as “*an art*”. If it is not done well, vital information is omitted which can affect the safeguarding of a patient moving through the department. Another registrar described the process of handing over a patient for review by a different specialty:

“I deal with a lot of calls from various teams and it can be very frustrating because the person who is calling you just has very little understanding of what’s going on with the patient and they don’t know any of the background and things and so the end result is there’s various steps where things can go wrong and in the end I’d get there and have to sort of do a bit of guessing work as to figuring out what they actually want me to do, which is a major problem.” (AMG Registrar)

4.12.7 Professionalism

Embracing the competencies discussed in this section is professionalism. Aside from clinical skills and knowledge, there are the responsibilities of practising safely, which

include JMOs having the insight to seek help when needed, communicating effectively and behaving and working in a respectful way with peers, senior staff, and other health professionals including those external to the hospital environment. In the smaller of the three hospitals, an AMG spoke about working in a professional framework:

“I think everyone should work in a professional framework and it doesn’t matter what personalities are if a basic level of professionalism is maintained but in this hospital as well, I think it’s quite apparent there is a manner and there’s difficulties between people, there are likes and dislikes; it’s always the case but there is always a basic level of professional behaviour. It’s at a good level here in this hospital.”

(AMG Registrar)

The well-being of patients lies at the heart of medical professionalism however JMOs, in general, did not make reference to this in the context of competency and professionalism. If IPP is to be enacted by JMOs, greater emphasis needs to be placed on this fundamental competency.

4.12.8 Summary

In addition to clinical knowledge and clinical skills, there are numerous proficiencies and capabilities required by JMOs for safe practice and quality in patient care. Many factors impact on the practice and the working relationship JMOs have with colleagues. JMOs have great responsibilities and much is expected of them but they are not always offered the support they need. At the more junior levels, this extends to a need for more supervision and ongoing training, especially for IMGs, but not exclusively. However, IMGs acknowledge the opportunities for learning provided through working in teaching hospitals. In the next chapter, findings are reported from the observation phase of the study.

Chapter 5: Observation

“The participant moves from the point of being an intruder or outsider to one of being ‘accommodated’ allowing the observer to witness the phenomenon as it actually occurs ... The sequence and connectedness of everyday events that contribute to the meaning of a phenomenon can be identified ... the context can be observed as it unfolds in everyday life.” (Bogdewic 1999:49)

5.1 Introduction

Chapter 5 presents the ethnographic findings of the research focusing on the observation of six JMOs, representing the broader population of JMOs interviewed. The findings are structured as six independent narratives. Observation was conducted side by side with JMOs during their shifts in the three hospitals. This provided the opportunity to capture the breadth of their work and the diversity of their practice, at different times of the day. It allowed observation of the settings they worked in, their activities, the people they interacted with, and how they carried out their professional responsibilities. The process of observing highlighted some of the challenges faced by JMOs working with other professions and within their own profession. The findings are reflective, looking at what was written in notes as well as recalling images captured through my own lens as the observer. It was advantageous to observe JMOs and to be immersed in their milieu, watching and listening as they interacted with the medical team, other health professionals, and myriad other staff. Central to my observation of them was to witness evidence of IPL and IPP, and to identify what facilitated or impeded these two aspects of interprofessionalism.

All the shifts observed are reported as discrete sections in this chapter. They are presented chronologically, as events of the JMO’s working shifts unfolded. Where relevant, reference is made to the four underlying themes of the thesis: culture, integration, and acculturation; communication and interaction; collaboration and teams; and competency, safety, quality and professionalism. Observations in narrative form were recorded for the duration of each period of observation. Additionally, a formatted

table was used to record situational and quantitative data as an aide memoire. The fields from the table are displayed in Table 5.1.

Table 5.1: Data fields for each period of observation

Hospital	IMG/AMG	Specialty	Staffing	Temporal	Themes	Core areas
Cultural factors	JMO level	Additional patient mix	Clinical Staffing	Period of observation	Communication and interaction	Evidence of IPL
Handover/ward round	Rotation	Number of patients	Itinerant staff	Time of day	Competency, safety, quality	Evidence of IPP
Environment	Shift	Number of Outliers	Adminis- tration	Events outside ward	Collaborative teamwork	Professional- ism

As previously explained in Chapter 3, time was spent generally observing and acclimatising to the atmosphere of the three hospitals leading up to and during the interview phase. This time provided the opportunity to watch the everyday happenings at the respective hospitals, noting the differences between each hospital in relation to size, location and patient demographic, as well as the differences in pace, depending on the time of day. Returning to each hospital for the specific observation phase of the research, proved to be of interest by way of comparing what I had perceived earlier with what I actually experienced and noted as a more purposeful observer.

Chapter 3 included details of how JMOs were randomly selected for inclusion in this phase of the research. Reference was made to the difficulty of finding six JMOs who were not on secondment, holidays, or otherwise engaged and once having their agreement, organising a time to be with them for a whole shift. All JMOs interviewed had been alerted to the possibility of further participation in this observation phase. Accordingly, there was no resistance to being observed. One AMG admitted to being slightly self conscious when we started the day together. She was quickly engrossed in her tasks, the immediacy of work soon overriding self consciousness. The other five

JMOs were not averse to the attention they were getting, or the attention they were drawing, in some instances. As illustrated in Table 5.2, JMOs observed, comprised IMGs and AMGs from each hospital. They included: two registrars; one SRMO; two RMO1s; and one intern.

Table 5.2: JMOs observed by hospital, IMG or AMG and level of training

JMO category	Setting		
	Hospital A	Hospital B	Hospital C
IMG	SRMO	Registrar	Intern
AMG	Registrar	RMO1	RMO1

The opportunity to spend time with each JMO brought me into contact with other JMOs and a cross section of health professionals and health care workers in different departments, beyond the JMO's wards. The exception was in the case of JMOs working in ED, one of whom was in the acute section of ED. The other JMO was working in the medical unit of an ED for half the day, and attended non-urgent ambulatory presentations for the rest of the day. The tasks of the other four JMOs took them away from their principal wards during their shifts, providing an opportunity to observe multiple situations and events. This offered liberal scope for witnessing how JMOs enacted their working day and verified challenges faced by IMGs.

5.2 The environments

The broader environments of each hospital were described in earlier chapters. Within those environments a close look within more specific internal clinical environments was enabled through the observation process. Environments ranged from calm and organised to frantic but controlled. Where relevant, aspects of these narrower environments are added. Each encounter was a unique experience. In allowing an outsider to enter their

world the JMOs displayed great trust. They were, in a way, collaborating with another professional seeking ways of enhancing patient safety.

JMO participants in the observation phase quickly adapted to being observed. There was little time for them to adjust their behaviour because of the immediacy of the tasks related to their respective roles. The behaviour of the JMOs, as revealed through observing them in the context of their clinical work, was able to be viewed from a perspective unattainable through the interview process alone. The demeanour of the JMOs, and their disposition towards their professional colleagues and patients, was openly apparent during the hours of observation spent with each one.

For example, the second JMO observed was a female AMG working as a registrar. During her interview she had spoken about being bullied by colleagues. She perceived that she was often stereotyped because she had, in her words, “*An Asian appearance*”. Her demeanour had been somewhat reserved during the interview and this reservation was borne out through watching her lack of engagement with others in clinical practice. Despite being an AMG, advanced in her training, this self perception of being stereotyped was an indicator of a cultural barrier to the level of comfort and confidence she felt working in her clinical practice. It affected her relationship with all the health professional staff she interacted with throughout the day. During the course of the shift, I accompanied the AMG to many areas of the hospital, including different wards where she had *outlier* patients, ED, cardiothoracic medicine and ICU. I attended a collaborative ward meeting with her at which all the patients were discussed and her reserved manner was consistent in the encounters she had across the various departments.

5.3. Observation at Hospital A

5.3.1 Physical aspects of the working environment

JMOs interviewed from this hospital had remarked favourably on the working environment. The ward area was light, the corridors were uncluttered and the external

outlook was pleasant. The main nurse's station was positioned in the middle of the wing comprising two corridors, with through access from each corridor. This arrangement allowed centralised service areas for the length of the ward. Along each corridor were much smaller work stations servicing several four bed wards or bays; patient folders were stored next to each work station. The physical layout separated the clinicians, and allied health staff, from the nurses in their central location. At the same time, this arrangement facilitated access to the patients, their notes and to a computer and telephone, without the need to return to the main, middle station.

5.3.2 The IMG SRMO

The JMO observed at Hospital A was a male IMG at the level of SRMO. Observation took place on a daytime shift starting just before 8am. The SRMO was working on a medical rotation covering gastroenterology (gastro), drug and alcohol, and clinical pharmacology patients. There were also colorectal surgical patients on the ward. The SRMO had one *outlier* on another ward. The SRMO is referred to as the IMG in the observations which follow.

5.3.3 The ward

The IMG conducted a ward round to check his patients and review their progress. The round was conducted on his own. He explained that there was no handover “... *except on weekends when it is twice a day. If there are problems the doctors communicate by phone.*” There was no reference to how this system of communication might have impacted on other staff such as nurses or how this might affect the needs of patients, aside from their clinical care. Furthermore, the system of communication reduced the teaching and learning opportunities for the IMG.

The IMG had worked on the ward for nearly eight weeks out of a 12-week term. This period had given him time to become familiar with the nurses and allied health professionals. However, there was little evidence of a relationship with non-medical staff as the day unfolded. A conscientious approach to his patients was apparent and

communication and interaction with his registrar evident. It was difficult to determine to what extent culture may have affected his confidence in communicating with other staff.

5.3.4 The Emergency Department (ED)

In ED there were two new gastroenterology patients to be seen in company with the IMG's female registrar. ED was not busy. The nurses were standing around in small groups talking. The IMG reviewed his patients and sat discussing them with his registrar, before finding the charge nurse and telling her about their plan for the two patients. From the manner in which the charge nurse accepted the plan, this appeared to be the normal practice for ED. That is, the nurses were told about the plan rather than being involved in the making of the plan.

We moved to the adjacent Emergency Medical Unit (EMU), for patients who were borderline admissions. This area was busier than the main ED area and very cramped. Ten staff were squeezed into a small clinical station area. The only four chairs were occupied; five people were standing and one was sitting on the desk. There were several medical students present. I was told they were from four different universities. The presence of increasing numbers of medical students was remarked on during the interviews with JMOs. They spoke about the competition for teaching time and the attention others were given "*at the expense of JMO teaching*" according to some JMOs.

Apart from the ten patient cubicles in EMU, there were five patients in reclining chairs in a central area, cluttered with trolleys. Patients in the chairs were engaged in watching television, or talking to their companions. I overheard a doctor telling a patient in a chair that he was going to get "*a lovely lady*" to see what it was like at his home and how he could be helped to manage. The *lovely*, patronised lady was the OT. It would have been respectful and professional to use her title in explaining her role in helping the patient.

We left ED and walked to the X-ray department. The IMG delivered an x-ray request form stating that, "*Hand delivery ensures speed in getting the x-ray done.*" His usual

practice was to take these requests himself to speed up the results. He was not the only JMO to do this. The delayed response time for radiology reporting was a matter raised by a JMO at one of the other hospitals. The need to hand deliver forms indicated a systems problem impinging on the fractured time of JMOs, time that could be better spent with the health care team.

5.3.5 Communication and interaction on the ward

On the ward there were more tests and procedures for the IMG to order. A nurse was told about a CT he had ordered for a patient. The IMG continued his lone round of the patients without the company of his registrar, although she was on the ward. While he checked his patients, I waited at one of the small clinical stations. There were *ring binders* containing patient files on the bench top. On the front of each folder, under the plastic cover, was a notice in bold capitals: “*DEAR DOCTORS, TO ENABLE BEST POSSIBLE PATIENT MANAGEMENT THE NURSING STAFF WOULD BE VERY GRATEFUL IF YOU WOULD PLEASE PRESCRIBE DRUGS AT THE FOLLOWING TIMES. (A SCHEDULE FOLLOWED). WE THANK YOU FOR YOUR COOPERATION. (WARD NAME) NURSES.*”

This notice indicated an ongoing communication problem over medications, and a lack of collaborative effort between JMOs and nurses. Moreover, it would be difficult to imagine doctors complying with a request to prescribe drugs at certain hours of the day.

I spoke to a person standing at one of the small stations. The badge she wore was inscribed, *Allied Health*. She said she was a dietician and when I explained my presence, she responded by saying, “*There’s not much IPP here on the ward and I don’t feel valued here. A lot of us feel that way.*” Her remark confirmed what some JMOs had revealed about their attitudes to allied health professionals, combined with a lack of understanding about their roles. For the dietician, wearing a badge that was so vaguely labelled would hardly carry much pride. In a gastroenterology ward, where a dietician is an essential part of the patient care team, this suggested severally that collaborative team work was lacking, and that the dietician was working in an isolated way. This may have contributed to her feeling of not being valued.

Further observations about communication and interaction varied little from what had already been seen. A physiotherapist came to one of the small stations to look at some patient notes. I had learnt from the NUM that, “*Physios are in beige polo shirts and always carry folders and X-ray staff always wear black.*” The physiotherapist left and a surgical registrar arrived. The IMG accompanied his registrar to see a patient and to participate in a family discussion. They returned and stood at the counter top looking at the patient’s folder of notes. The physiotherapist then returned to make an entry in a patient’s notes. They did not acknowledge each other even though they were standing side by side, elbow to elbow. This behaviour suggested a culture of people *working in their own worlds*, a description used by one of the JMOs interviewed and included in Chapter 4.

A similar scene of silence was observed at another small work station where two RMOs and a registrar were seated and two physiotherapists stood entering information in patients’ notes. The silence was only broken when a nurse walked past and called out to one of the doctors, “*You should have given that morphine*”. His response was simply, “*Sorry*”. She replied, “*That’s ok darl*”. This interaction suggested an easy working relationship between the nurse and the registrar. It illustrated the watchfulness of nurses over their patients, which many JMOs reported as being so valuable.

A medical student came to look through some patient files as the SRMO returned to write in his patient’s notes. The registrar called a consultant and then introduced himself to the SRMO to discuss a patient. Two other medical students arrived to look at patient notes. An advanced physician trainee and three medical students came to the desk and two physiotherapy students. The SRMO had remarked that there were always many students on the wards. He meant all health professional students as well as medical students.

Despite all these people congregated, they did not acknowledge each other’s presence, except for the two doctors discussing their patient. Another nurse came looking for the registrar saying, “*Hi guys, you need to increase the dosage of that drug, we can’t do it.*”

The dislocation of these smaller work areas from the main station resulted in the nurses having to seek out doctors for these standard requests.

The gastroenterology registrar and the IMG saw one more patient together and then consulted with a speech pathologist about a patient's problem with swallowing. This was the first observed instance of interaction with an allied health professional and evidence of some collaboration between the patient care team.

5.3.6 The outlier

The IMG and his registrar had an *outlier* to see two floors down in the orthopaedic ward, a drug and alcohol patient. In the presence of a nurse, the registrar sat at the clinical station checking information on the computer while the IMG stood at the bench top to write in the patient's notes. There was no exchange between any of them. The two JMOs went to see the patient, another "*difficult*" patient, while I waited in the corridor observing the behaviour of other staff. A nurse with another variation of a nurse's uniform stopped and asked if I was "*Ok*". When I explained my presence, she replied, "*We thought you were a surveyor or something, so we've been busy gelling and washing our hands.*" I had noticed this behaviour.

The registrar and the IMG returned to the station where the registrar wrote in the patient's file. No information about the patient was conveyed to the nurse. The IMG wrote some notes on his printed patient sheet, answered a call about a patient and then accessed the electronic medication ordering system, from a computer on a nearby trolley in the corridor. A nurse came to the IMG saying, "*I got all these bloods for you*". The response from the IMG was simply, "*Thanks*" without looking up. It could be seen, that the modern working environment demands time and concentration interacting electronically, at the expense of human interaction. It constitutes a barrier to one of the essential foundations for IPP, communication.

There were some moments of successful interaction. An orthopaedic registrar arrived and discussed a patient with a nurse, deliberating about whether the social worker was

needed. The patient's sons were concerned that their mother needed services after her discharge. The nurse directed the discussion. This was an example of a doctor consulting with a nurse about the possible need for a social worker, seemingly unable to ascertain the patient's needs for himself and possibly (as indicated in the interviews) unsure about the exact services provided by the social worker. In this instance, the nurse was the conduit for the social worker.

Apart from a nurse asking for antibiotics to be ordered for his patient, the IMG had not communicated with anyone. He had also spent a lot of time working on the *outlier* patient, which had taken him away from his principal ward.

5.3.7 Patterns of work and attitudes to IPP

Returning to the gastroenterology ward the IMG continued reviewing his patients, taking blood from some, with minimal, if any, interaction with others. This pattern of work, revealed a JMO who was very focussed on caring for his patients but with little time to communicate with nurses or other health professionals in order to complete his work.

In the afternoon, there were patients ready to be discharged, including the patient seen earlier in ED. The IMG asked a nurse for the patient's notes and sat in the nurse's station to write. I remained with the nurse and she talked about the ward and IPP, *"You won't see much IPP here. There is no time for IPP. Surgeons do a round at 7am, then they are in theatre all day. You can't get them. We have to go on the notes, it's very frustrating. Everyone is time poor. We often need clarification so have to wait until operating is finished and the surgeons return at 8pm. It is hard for the JMOs too. If this hospital is the benchmark, it's very sad that things have fallen to this level."* The nurse's comments were directed at surgeons rather than physicians. They supported what interns and residents had reported in interviews about surgeons and surgical registrars.

More medical students arrived in a group of four accompanied by a senior clinician. They huddled together and discussed patients before commencing a round on their own. The IMG advised that it was a teaching session. If there are suitable cases for students, the consultant is informed by the registrar and a message is relayed to the students.

From the ward, we went down several levels to the day-only ward where patients were recovering from endoscopies. The IMG sat next to a nurse, checking the computer to see what medications to prescribe for his patients, before writing their discharge notes and preparing letters. There was no interaction or exchange of information between the IMG and the nurse. He accompanied his registrar to see their patients and they discussed the results of the endoscopies. The IMG eventually informed the nurse about the discharge plans for the patients. This was the eighth week of the IMG's rotation in gastroenterology but there was no indication that he had established any rapport with staff working in this ward.

On the way back to the ward, we discussed IPP. The IMG's idea of IPP reflected the confused understanding revealed during interviews with JMOs. The IMG explained that on Mondays there was a ward meeting with the NUM, the physiotherapists and a dietician during which all patients were reviewed. That was his understanding of IPP. It was unclear whether much IPL took place at these meetings. However, an example of IPP followed.

A dietician approached the IMG about a patient who had pulled out her gastric tube. She felt the patient was too weak to hold a cup to drink. The IMG asked if the patient should have a naso-gastric tube again or whether it was possible for a nurse to feed him. He turned to the dietician and said they needed "*To get the speech pathologist in*". Here was a situation that should have been straightforward for a JMO but there was evidence that the IMG was unable to manage or make a decision without the expertise of the dietician and a speech pathologist. The IMG left the problem with the other health professionals and did not go to see the patient for himself.

At the end of his day and on the way out of the hospital the IMG hand-delivered some pathology requests to ED, explaining his method again for expediting tests and achieving a faster turnaround time for results. He said with great pride that he would be a registrar the following year. He had been accepted to commence physician training “*even though*” he was an IMG. This was a significant achievement for him and he felt that the extra year as an SRMO had contributed to his success. His statement highlighted the difficulty faced, and seemingly expected, by IMGs in advancing their careers in a different culture and a highly competitive training environment.

5.3.8 Analysis

A close working relationship between a registrar and an IMG was observed but very little interaction occurred between other JMOs, both on the wards and in ED. Even less communication and interaction occurred with other health professionals. It was reported by the IMG that JMOs convene at a weekly meeting to discuss patients and this, for him, constituted evidence of IPP. The absence of physical handovers during the week limits contact with senior clinicians and opportunities for learning. It may affect aspects of patient safety such as missed signs of clinical change and the opportunity for patients to speak to their consultant. A reliance on contact by telephone could be problematical for IMGs with language difficulties and misinterpretations could affect patient safety. Little evidence of IPP was observed or considered to exist, based on the comments made by allied health professionals and nursing staff.

Communication and interaction was mainly with medical colleagues although ignorance of the presence of other JMOs was also observed. The physical location of small stations facilitates the work of JMOs and of allied health professionals while separating them from the nurses in the main station, but the locus of control remains in the central station with the NUM or their equivalent. The bold note written on patient folders by nurses to doctors about writing up medications was an example of how nurses resort to communicating with doctors in some situations. There was evidence of uncertainty about communicating directly with allied health professionals and of not respecting them. For example, the IMG’s reference to “*getting a speech pathologist*” and another

JMO referring to an OT as a “*lovely lady*”. Lack of professionalism and respect was also seen in communication with nurses in the short responses and lack of appreciation extended to them.

The artefacts of clothing noted included the difference in attire between ward staff and ED staff. Differences in the type and colour of uniforms worn, was confusing for the uninitiated. The lack of visible identification badges constitutes a further problem to enabling IPP.

The distraction of patients in other parts of the hospital results in JMOs needing to go to where these patients are rather than being able to see them on the ward with their other patients. This removes JMOs from other members of the patient care team making it difficult to work collaboratively. It adds time related pressure to their day, as does the hand delivery of radiology and pathology requests.

5.3.9 The AMG Registrar

The AMG observed in Hospital A was a renal registrar also *covering* for vascular medicine, and stationed in a 34-bed ward. The ward included beds for other medical specialties apart from renal and vascular medicine including: haematology; bone marrow transplant; medical oncology; dermatology; immunology; clinical pharmacology; drug and alcohol; geriatrics, and rheumatology. Patients under these additional specialties were not the responsibility of the AMG. A description of the physical characteristics of Hospital A was given above. The physical layout of this ward was identical to the ward previously described where the IMG SRMO was working. In the following observations, the AMG registrar is referred to as the AMG.

The JMO’s room near the entrance to the ward was accessible via a security coded door. This was where the day began. We entered and the AMG printed out the electronically generated patient list for the day. Two RMOs were in the room but there was no greeting between any of them. In contrast to the IMG registrar observed, no ward round was conducted.

5.3.10 Communication and interaction on the wards

There were seven *outliers* on the list, several the responsibility of the AMG. One *outlier* on a ward three floors down, was the first patient to be seen. The AMG made no effort to inquire about the patient from nursing staff nor did she look at the patient's notes before reviewing him. The patient informed the AMG, and a nurse who came to the bedside, that he was fasting, a fact unknown to the AMG and the nurse. During the interviews some JMOs had reported that patients are often "*useful*" for giving this sort of information. The patient (with alcoholic liver disease) was described by the AMG as "*difficult*". I waited in the nurse's station.

The nurse's station was papered with a gallery of notices. There were notices about dietician services stuck on the x-ray viewing screen, 102 notices in all. To an observer this signalled an excessive form of one-way communication and a query about whether the notices were read, understood and up-to-date. It suggested a climate of clutter, where staff relied on notices rather than asking others and interacting with them, or were too busy to answer questions. For new JMOs, especially IMGs, a reliance on this form of communication carries the risk of information being misunderstood or simply ignored.

The registrar returned to the nurse's station to write in the patient's notes. Pathology results were checked and recorded. The NUM was sitting in the station but there was no exchange of information between them about the patient. Later the AMG was to remember she had forgotten to write something in the notes of this patient, commenting that she would need to go back and write in notes, "*for medico-legal reasons*". During interviews, JMOs had remarked on their consciousness of litigation.

Identification of all staff and their respective roles was difficult. Staff wore different uniforms and typically, as observed in all hospitals, their identification badges were worn low, clipped to their clothing. On this ward, some nurses wore red *polo shirts* and some wore more conventional, blue and white monogrammed shirts. Other staff wore different coloured *polo shirts*. The NUM, who was not wearing a uniform, explained

that the old uniform was a red *polo shirt* and the new one was a checked, cotton shirt. The other coloured shirts identified allied health professionals, such as physiotherapists.

A system like this one might work well for internal staff but for outsiders, patients and their families, it could be confusing. Further observations about attire were made later in ED where nurses wore 'polo shirts' in three different colours of blue and ED doctors wore green 'polo shirts'. Some doctors wore shabby blue jeans and trainers. Nurses wore trainers as well. Doctors on the wards would not be seen wearing trainers. These artefacts of clothing added to the unique culture of the ED observed in this hospital.

Allied health professionals observed on the ward included a dietician, who was not wearing a coloured shirt. She was identified to me by a nurse. The dietician slipped in and out of the patient bays entering information on her computer but spoke to no one. A pathology collector entered the station and quietly retrieved request forms from the box on the wall before returning to her trolley of syringes. The behaviour of each person gave the appearance of something very mechanical; clear tasks, ordered and defined but essential to patient care in their execution. In the performance of their roles they were all part of the patient care team.

In the JMO's room of the renal ward, the AMG met the senior renal registrar. Patients were discussed but not seen. There were three new patients to review. The AMG reported that a patient ready for discharge had been kept in hospital overnight. She had been unable to make contact with the consultant the night before to approve the discharge. She had still not heard from the consultant and did not know what to tell the family. For unknown reasons, perhaps associated with her timidity, she had not tried to ring the consultant again. It was an intraprofessional problem of the type reported by JMOs about interacting with senior staff. There were issues here from the perspective of patients. When patients are ready to leave hospital, family members or carers need to know what is happening in advance, to allow time for arranging to collect patients from hospital. An absence of communication internally between clinicians about a patient's discharge therefore affects a range of other people. In this case it also affected bed availability by unnecessarily keeping a patient overnight.

The two registrars discussed the technicalities of certain treatments for other *outliers* in the geriatrics ward on a different floor. This dispersion of outlier patients on other floors is a physical barrier to collaboration, communication and therefore IPP and possibly patient safety. If a patient was on the appropriate level and ward, additions to clinical notes, as reported above, would be immediately written in the patient notes, rather than having to wait until later and possibly forgetting, or risking an incident occurring because of delay.

The geriatrics ward was busy and the nurse's station overcrowded with staff including nurses, a physiotherapist and two RMOs, some standing at the high counter surrounding the station. There was no interaction between anyone, nor did the registrars identify themselves to the nurses. The registrars appeared to feel out of place because they were not part of the ward team. I overheard the physiotherapist and the nurse talking about the registrars, wondering who they were. There are twofold problems illustrated in this behaviour. JMOs, as professionals, could introduce themselves when entering another ward but this should not prevent nurses and other health professionals from initiating interaction. It is poor interprofessionalism and suggestive of a power differential.

The CNC spoke about IPP. She felt that IPP was improving but remarked, "*We (nurses) can't do ward rounds especially here with 50 patients.*" She explained that as orders for patients are given, especially *stat* or instant doses of medications, doctors communicate them orally. "*You can't check the notes all the time. They use the HATRIX system but again you can't check all the time.*" What the nurse meant was that medications are often administered in response to a spoken order which is written up later, after the medication has been given. (*HATRIX* is decision support software designed for medication management in acute care hospitals). While this might be a common occurrence, it demonstrated a reliance on accurately interpreted oral communication, leaving open the possibility of medication error. For example, IMGs confirmed in interviews that they had difficulty understanding some of the medications; they were unsure of the spelling of different medications. Some medications have similar names so this adds to the scope for error.

The CNC eventually asked the two registrars who they were after they had seen their patients. They introduced themselves and spoke about the patients. The CNC explained that the OT and the physiotherapist would see the patients routinely, but they would need referrals for the social worker. There was some conflict over the need for physiotherapy. The CNC said, “*Don’t get me started*”, but she needed registrar referrals for the social worker so restrained herself from further comment. The interdependency here was being tested and collaboration was wanting.

The OT approached the CNC and discussed the need for the patients to be reviewed by the aged care assessment team (ACAT). For this to happen they needed the referral for a social worker. The conversation between the CNC and the OT was about avoiding a refusal from the registrars to write the referrals. They needed “*to get things moving*”. Their sense of frustration with the registrars was quite palpable.

Further discussion between the registrars concerned the medications of the patients. The AMG had discovered one patient was on two contra-indicated drugs. The CNC overheard and confirmed that the two drugs should not be given together. The registrar checked the drugs on the computer and confirmed that the CNC was right. In this instance, they concurred in their opinion over an important matter of patient safety.

5.3.11 Collaboration and team work

Observation of a meeting attended by the two registrars and other health professionals provided an opportunity to listen to their discussion about patient management. JMOs reported interprofessional meetings occurring in geriatrics in particular. This was an example of a meeting in a non-geriatrics ward where there were patients from a multiplicity of medical specialties.

In their interviews, JMOs acknowledged the importance of these meetings in the progression of the patient care journey and also from an IPL perspective. Details of the meeting are therefore given in the following paragraphs about the discussion of patients by the health professionals involved in their care.

Box 5.1: Extracts from an interprofessional clinical meeting

The meeting was held in a large meeting room and I was introduced to those present. In attendance was a dietician, the NUM, and two Clinical Nurse Practitioners as well as the two registrars. Patients were discussed and reviewed, in relation to their readiness for discharge, such as one who required re-assessment by an OT before being discharged. Discussion included the status of patients in terms of their medications and what was required for some of the renal patients. One patient discussed was a problematical illegal immigrant who had incurred major expenses. He had now acquired a Medicare card because he was going through an appeal process. Other matters about patients varied and included questions pertaining to whether a patient had Power of Attorney in place because they had to be “placed” somewhere in Sydney. This was a matter for the social worker, who like the OT, was absent from the meeting.

The dietician talked about a patient who was not eating and possibly had problems with alcohol, stating, “*If his electrolytes are ‘ok’ he can be discharged tomorrow*”. The patient had admitted to drinking Scotch since being on dialysis. He had depression and was currently seeing a psychiatrist. The three new patients were then discussed by the AMG, reporting that they were in geriatrics where, she added, there were fifty patients and one consultant.

A 23 year old patient was discussed. She had leukaemia as a child and needed heart and kidney transplants. Ethics was debated in the sense that a cardiac team should not be wasted if “*they*” changed their minds – the patient had eight sisters so one would have to donate a kidney. There was a father and no mother. It was agreed that this was a difficult situation requiring help from the social worker.

Discussion then turned to a patient with dementia who lived in a nursing home. There were problems because she had pulled out her feeding tubes while strapped in bed overnight so they had decided to keep her in hospital. Finally, as the meeting closed, the senior registrar advised the team that a patient was coming in from another major hospital later in the day for dialysis.

The diversity of patients’ conditions and the input to the discussion about their care, are examples of IPL and IPP offering benefits for JMOs, especially for those interested in a career as a GP, which many IMGs choose to pursue. The discussion also revealed that the final arbiter in a patient’s readiness for discharge, in some cases, can be an allied

health professional such as an OT or a dietician, a finding relevant to IPP. No other evidence of IPP was observed on the day, after this meeting.

5.3.12 Communication in ED

In ED, the JMOs had one new patient to see and a consultation. They sat at the desk discussing their patients, checked test results and added them to the patient notes. A nurse shared the desk but they did not communicate. An ED registrar accompanied the JMOs to see the new patient. The same pattern of behaviour occurred during their time in ED. Interaction was with the ED clinicians only, despite the presence of nurses and other health professionals.

I overheard a nurse asking an ED staff specialist which ward a new patient was to be admitted to and who they should be admitted under. The AMG was busy making calls regarding the same patient's admission but had not considered liaising with the nurse and informing her directly about the plans for the patient.

The only communication observed between the AMG and a nurse was just before the AMG had left ED. She discussed her remaining patient with the nurse and handed over the patient's notes. Altogether, there had been minimal communication with doctors or nurses, despite the presence of 12 other doctors and nurses in the station.

5.3.13 Social workers in ED

A social worker explained to me her role in ED. Five dedicated social workers were rostered to cover ED until 10:30pm, seven days a week, because of the number of patients presenting with social problems. She cited problems such as drug and alcohol related problems and homelessness. The social worker confirmed a lack of collaborative effort from the medical clinicians and a felt lack of respect for the work that social workers do.

5.3.14 The ED environment

The ED environment differed from the ward areas. There was a sense of autonomy; other JMOs entering ED are not part of their team. Some JMOs had remarked on this difference during their interviews. The difference creates a certain dichotomy between ED and the wards, despite the essential interdependency required between ED and non-ED JMOs.

In one interview, a JMO from Hospital B had spoken about a tension that exists between ED and the rest of the hospital in most teaching hospitals. The tensions are manifested in different ways, not least by the wait experienced when JMOs have requested medical or surgical reviews for their patients. What might be happening in the rest of the hospital is of little concern to JMOs in ED waiting for patients to be reviewed, pending admission or discharge. The JMO had described the tension:

“It’s a war 90% of the time because of the time lag and the resistance in coming to ED to see the patients. Often, they are very resistant to come and they want this many more investigations done before they make a decision in terms of admitting, so that’s a big part of what we ask senior registrars and consultants, trying to push to get those things done. Sometimes it’s just being plain obstructive, sometimes they’re just plain overworked. They ask for a few more tests to be done just to get more time. Sometimes it’s just not wanting to review the patient and talk to the boss and all that.” So patients sit around in ED waiting. Surgical reviews can be delayed for hours if surgical registrars on-call are in theatre. That is always an ongoing problem. It blocks beds and delays waiting times and is not good for patient outcomes.” (AMG Registrar)

5.3.15 The wards

Another *outlier* was briefly checked on the way back to the renal ward where the AMG was to admit the new patient. From the nurse's station several calls were made including a call to order magnetic resonance imaging (MRI) for a patient. Other nurses were

present, including the NUM of the ward but the AMG made no attempt to talk to them or interact in any way. There had been no face-to-face clinical interaction with three RMOs who had been in the JMO's room earlier. This registrar, as with other JMOs interviewed and surveyed, had stressed the importance of communication.

The AMG advised that she would attend Grand Rounds at lunchtime, only because there was a clinical audit. We talked about the teaching offered at the hospital and she spoke about Monday handover sessions where medical registrars were "*supposed*" to hand over the "*at risk*" patients. This left open a question about quality of care and patient safety in practice, aside from opportunities for learning.

After Grand Rounds the AMG returned to the nurse's station. Discussion took place with the transplant team about the young patient discussed at the morning meeting. They were waiting to hear from the social worker. They were reliant upon her input at that stage, demonstrating the importance of the role of social workers in the patient care team.

An orthopaedic registrar arrived and discussed another patient with the AMG. They both went to see the patient who was scheduled to go to theatre for a septic arthritic shoulder. There were some possible complications that could follow the surgery. At no stage was there any discussion with the nurses about the patient.

There was a moment of expressed self consciousness by the AMG when we went to ICU. She did not want others to think there might be a problem with her performance because of my presence. We met with the senior registrar and they discussed the patient they were there to review. ICU exuded another distinct culture. Here it could only be envisioned, was an epicentre of clinical teamwork.

Returning to ED again later in the day, the AMG reviewed a patient she had seen in the morning. The patient was told she could go home with a follow-up appointment. The paper work was completed and left at the bedside. The AMG returned to the desk, told a nurse that the patient could go home, that the discharge information was next to the bed

and to send the consultant's letter in the internal mail. This was the AMG's way of communicating. It conveyed little respect for the nurse. Before leaving ED an ED handover round had started with a small group of six. They were all doctors. This doctor-only ward round in ED was observed in one of the other hospitals as well.

Another *outlier* was reviewed in the cardiothoracic/respiratory ward. The AMG asked a nurse if "*patient 33*" was still there and was given the notes. We went to the main nurse's station where the registrar sat down silently next to a social worker. There was no acknowledgement of her presence, nor with the other four staff members (the NUM and 3 other nurses) in the station. It was only when the AMG began to cough that the NUM spoke up, sharply telling the AMG that she should leave because she might have Swine Flu. There was heated discussion between them. The snappiness of the remarks between the AMG and the NUM defied any sense of a good professional interrelationship. It might have been averted had more effort been made by the AMG to respect and interact with the staff on a ward where she had an *outlier* patient.

The AMG returned to the nurse's station in the renal ward. She discussed the new patient to be admitted with a male nurse and they planned his care together. They talked about tests needed and forms to be filled out. The nurse offered to help and walked away to get some medication for the patient. It was another rare instance of witnessing some element of shared patient planning.

5.3.16 Analysis

The responsibility of registrars to review patients in ED demands much of their time, in addition to attending *outliers* on different wards in the hospital. The itinerant nature of working in this way, limits time on the main ward and time and supervising more junior JMOs. It is a barrier to working interprofessionally and it diminishes time spent with patients. Moving into other ward or department cultures can also be challenging as noted, particularly the unique culture of ED.

The reticence of the registrar to initiate communication and interaction is an obvious problem and links to a competency weakness. While this is not a one way effort, it might be expected from a professional point of view that a doctor would initiate interaction with staff when reviewing a patient in any ward or area outside their principal ward. Mutual respect for colleagues and other health professionals may be implied in some way but it is hard to determine how. Positive evidence of some collaborative team effort was observed in the meeting attended by available members of the patient care team. In this one meeting alone, the variation in patients and the discussion of their needs was an indication of how these meetings can also be forums for learning.

Overall, what comes across is a frequent lack of professional regard for others, demonstrated by not acknowledging the presence of others and failing to interact with them. Despite the pressures of time, at the very basic level, this behaviour is not helpful for practising interprofessionally.

5.4 Observation at Hospital B

5.4.1 The IMG Registrar

The IMG observed at Hospital B was a female registrar working in ED on a shift between 2pm and 11pm. In the observations which follow, she is referred to as the IMG. Before meeting the IMG, I met with the Head Staff Specialist and Deputy Director of ED to talk about my research. He expressed interest in IPP and concerns about IMGs in relation to patient safety. These concerns are relevant to the study and included as a preface to the first observation at Hospital B.

5.4.2 Preface

The Deputy Director discussed his experience of working with IMGs in ED. He identified the main barriers to IPP in IMGs as culture, knowledge, interaction, and communication. Aspects of culture, he believed, related to language. He gave examples

of language related problems: asking for clarification of speech; understanding of clinical terms, and having the confidence to question. From his perspective, the lack of confidence displayed by IMGs was linked to the status of the senior staff “*Knowing everything and therefore being above contest or questioning.*” Resultant issues of patient safety arise because speaking up or questioning could save a life or an adverse situation.

With respect to language, the Deputy Director believed that if a doctor does not understand the nuances of the language, it can lead to problems. Furthermore, the problem can be compounded when presenting patients are from other cultures. For example, an IMG communicating with an interpreter and in turn, communicating back to senior staff or colleagues. He spoke about the importance of IMGs gaining the confidence and trust of patients. In relation to knowledge, he expressed concern that IMGs often have limited knowledge of the diseases and illnesses they see in his department (ED) and have much to learn.

Before meeting the IMG, I met the staff specialist in charge of ED for the day. He spoke at length about JMOs, in particular IMGs. The sentiments he expressed about IMGs were similar to those of the Deputy Director.

5.4.3 The ED environment

The clinical station used by all ED staff was centrally positioned, and elevated to enable a broad view of the whole department. The scene was chaotic and people were rushing everywhere. Patients on trolleys were lined up on both sides of the emergency entrance corridor. At least one ambulance officer safeguarded each patient. A nurse explained that ambulance officers must stay with their patients until a cubicle is free. She said there had been 12 admissions in the last hour, which accounted for the chaos.

5.4.4 Communication and interaction

I met the IMG after she had finished examining a patient on one of the trolleys. She appeared to be slightly nervous. We moved to her next patient in a cubicle (an 81 year old with *polymyalgia rheumatica*, suffering dizziness and blurred vision). I was introduced and the patient gave consent for me to be present. The IMG examined the patient and asked her some questions. The patient asked for clarification several times but generally understood the IMG and responded accordingly.

After the examination, the IMG asked a nurse to take the patient's blood pressure and a urine sample. She returned to the bedside to write in the patient's notes. The nurse came to take the blood pressure and there was some discussion about how long to wait between measurements. In an example of learning between nurse and JMO, the nurse advised the IMG how long the time interval should be. The IMG seemed confident about asking the nurse for advice but may not have had the confidence to ask another doctor.

Doctors, nurses and a clerk were in the ED station, all working independently. The IMG discussed the patient with a staff specialist. A reticence to ask questions was evident from her remark afterwards. She checked through the patient's history, saying that it was hard to know what was wrong with this patient but she was loathe to send her home because she lived on her own. The IMG had not revealed her uncertainty to the staff specialist, who may otherwise have reviewed the patient himself with the IMG.

The IMG returned to the cubicle. Three nurses were present. The nurse who had been caring for the patient was handing over her patient to two other nurses. She told them they were still waiting for a staff specialist to review the patient but could not find one. The lack of communication between the patient care team was apparent.

In the station, there were now 13 staff; some were standing and one doctor was sitting on the desk. There were not enough chairs and the desk area was inadequate. It was very noisy and bustling with activity. A large electronic screen at one end of the station

displayed the names of all the patients, their details, cubicle number, reason for admission and other information such as test results. The NUM kept a watchful eye on the screen and continued to do so. Not once during the time I was there, did I see him talk to the medical staff, nor did I see any of the medical staff checking the screen.

The staff specialist in charge, who was the Admitting Medical Officer (AMO), asked about my research and talked about where she had trained, which was at Hospital A. When the IMG saw me talking to the staff specialist, she came over to discuss her patient. It seemed that she had been hesitant to come forward before, but seeing me talking to the staff specialist appeared to help her bridge that uncertainty or shyness. Lack of confidence about asking questions, was identified by the Deputy Director as one of the issues with IMGs, concerning patient safety. The IMG and the staff specialist discussed the patient and the IMG asked a lot more questions than she had before. There was some confusion about the IMG's use of the word syncope in association with the patient's blood pressure. The staff specialist helped to clarify the misunderstanding. The patient was already under the care of a rheumatologist, which the IMG had overlooked. They talked for a few more minutes before going together to see the patient. Much time could have been saved had the IMG communicated more effectively in the first instance because the staff specialist would have reviewed the patient earlier.

The staff specialist asked many different questions from those the IMG had asked. It was noticeable that he asked more about the patient's history and the dosage of the drug, Prednisone, she was taking. The staff specialist took a torch and looked at the patient's pupils. The IMG said she had done this but she had not done so in my presence. The staff specialist conducted many other tests and made a provisional diagnosis based on the patient's worsening headaches and previous episodes. She requested the IMG to contact the rheumatology registrar.

5.4.5 The ward round

The ward round began in an area outside the main station. The 11 medical staff gathered for the *round* included: two staff specialists, four registrars, an SRMO, four RMOs and

a medical student. No nurses participated in the round. The IMG had to present her patient when we reached the patient's cubicle. She demonstrated very little confidence in front of the team and found it difficult to speak about the patient's condition. The staff specialist, who had reviewed the patient with the IMG, took over and spoke directly to the incoming senior members of the team rather than waiting and allowing the IMG to continue any further. This was the only patient she had seen in two and a half hours. The difficulty displayed reflected a lack of competency in being able to hand over her patient, efficiently and effectively, and a lack of confidence in communicating.

During the *round* there was a transfer of information about the patients but nothing that could be called teaching. It was too busy to allow time for questions and learning. This was also the likely reason for the staff specialist cutting short the IMG's attempt to hand over her patient. IMGs had reported in interviews, a low tolerance for the time they took to hand over a patient and the associated lack of opportunity for asking a question and learning.

5.4.6 Patient care

After the round, the IMG was allocated a new patient, a 95 year old female who was still on a trolley waiting for a bed in a cubicle. The IMG asked some preliminary questions and arranged for bloods to be taken. She carefully explored the plastic bag full of medications, brought in by the patient's daughter. The IMG's communication was good and her concern for the patient evident. She went back to the station to write in the patient's notes.

After a short break, the IMG went back to check her first patient. The patient had returned from an ophthalmology review for her headaches. She discussed the patient's dizziness and headaches and returned to the station where she wrote more notes in the patient's file. Other doctors and nurses were present but no one spoke. At 6.30pm, an SRMO came to hand over her patient to the IMG. Another doctor arrived, stood for a while looking over the IMG's shoulder, reached over her and picked up the notes in front of her, saying, "*Can I grab these?*" The IMG looked up and recognised him as the

rheumatology registrar and they went to see the patient together. The manner of the rheumatology registrar was rude and unprofessional. It provided further evidence of poor communication and intraprofessional inadequacies. Throughout the period of observation, there was a continued absence of communication and interaction between the medical and nursing staff, in the station, and elsewhere.

The IMG returned to see the 95 year old patient, now in a cubicle, and to examine her. Oxygen tubes inserted into her nostrils were assisting her breathing. The IMG had not performed the procedure to insert them. A nurse came to check the patient's oxygen levels. Nothing was said between them. The IMG asked the patient to take some deep breathes. She sounded as if she was saying "*breethes*". The patient was not sure what she meant at first. The respiratory registrar arrived and the IMG described the patient's condition and reported her observations. She had not discussed the patient with a staff specialist.

5.4.7 Interprofessional relationships

The senior staff specialist in charge for the evening talked to me about communication in ED and the reason why nurses did not attend ward rounds. He said it was not unusual "*It is a problem here in ED.*" From his point of view, it was about personalities. In terms of allied health professionals, during the day there was one allocated physiotherapist and a pharmacist, the latter not dedicated to ED. He confirmed that there was little interaction between them all.

The respiratory registrar left and the rheumatology registrar returned and spoke briefly to the staff specialist before leaving. There had been very little interaction with any nurses at this point, despite them all sharing the same station. The IMG discussed the 95 year old patient with the staff specialist who discussed some signs and symptoms, giving some teaching. The staff specialist said, "*Good, good, good*", encouraging the IMG.

Elsewhere, in ED, patients had continued to come in but the earlier chaos had diminished. A nurse entered the station and asked the IMG if “5” was ready for a CT. She simply answered, “Yes.” Nearby, the NUM was continually checking the computer screen looking at the patients listed and reviewing their observations and progress. A registrar, who had been quietly writing up some notes, answered a telephone call requesting a patient admission from a rural area. As he was trying to obtain details about the patient, a nurse shouted from behind a curtain to another doctor in the station, asking for confirmation that a patient’s drip was only to be normal saline. The doctor responded loudly, confirming that it was to be normal saline, while remaining seated. The other registrar was still on the telephone talking about what had evolved as a trauma admission. He was not sure what to do and sought the advice of the NUM about the possibility of an air ambulance. The NUM shouted, “*This is not a trauma hospital.*” and said the registrar should have known. This scene provided a further example of how little respect there was between the doctors and the nurses and the barrier it posed for IPP.

There was an instance of IPL at its narrowest when a male nurse came to the station with an ECG output chart, asking for some advice from one of the registrars. The registrar explained the chart reading. Two RMOs seated opposite and talking between themselves could easily have been included in this brief learning session.

The IMG was asked to arrange for the discharge of a patient, and left the station. A nurse asked about my research. When I mentioned doctors, she laughed and said, “*I’ve been here since 1:15pm and I haven’t had to talk to a doctor once.*” As it was 7:45pm that was a time lapse of six and a half hours. The inference from her statement was that she did not want to talk to any doctors.

The patient with dizziness was still in ED. The IMG took blood from the patient to check for an infection. She was very careful and gentle with the patient but unsuccessful in taking blood at the first site and had to use the other wrist vein. She told the patient that she would be admitted for investigation. The NUM came in and interrupted the IMG “*Excuse me is patient 3 going back to the nursing home, doctor (D) did not write*

in the notes.” The IMG replied, once again with a simple, “*Yes.*” The interaction was indicative of the minimal communication that occurred between the doctors and nurses over the entirety of the shift.

The IMG was allocated a third patient, one of several waiting on trolleys. The paramedic related the patient’s pre-admission history following a fall. The 95 year old in the cubicle next to the trolley, started to get out of bed. The IMG urgently called a nurse to help. The nurse was not responsive to the urgency and replied in a rude tone, “*We are getting to her.*” The IMG left her patient just as she was about to take blood, and attended the other patient herself. This was another example of the attitude of the nurses towards the doctors, in this case, interfering with patient safety.

The latter part of the evening from 9pm was quiet. In the station, the respiratory registrar conferred with a consultant about a patient. The CNC psychiatry came in and liaised with a specialist registrar. The IMG wrote up her patient notes and handed them to a nurse with a nod and that was all. The night nurses arrived at 9.30pm and the evening nurses handed over their patients. There was no input from the medical staff. The same non-communicative attitude between the staff in the station continued until the evening shift finished.

5.4.8 Analysis

The chaos encountered at the beginning of the shift, and even the more settled department later in the day, was a direct contrast to the ward environment, confirming what JMOs had reported about the unique culture of EDs. As observed over the hours spent in ED, a communal station does not necessarily result in IPP. In this ED, there were interprofessional inadequacies. The acknowledged disharmony and poor attitudes between medical and nursing staff is a major barrier to working relationships and to advancing IPP. Both professions were able to work in the same station with minimal contact and exchange of information. For example, the nurse found it amusing that she had not had to talk to a doctor once over a period of six and a half hours, inferring that she did not want to talk to doctors. Nurses shouted at the doctors and in some instances

berated them. Poor communication between the patient care team resulted in a patient waiting much longer for a review by a staff specialist than was necessary. It was not helped by the IMG hiding her uncertainty about the patient to the staff specialist. Nevertheless, the patients moved through the system and there was no suggestion of a lack of care for patients from the nurses.

An environment lacking in collaborative support and respect for staff is more difficult for IMGs to work in, as evidenced by the IMG's lack of confidence in communication and in asking questions. Although the challenges faced by IMGs and their competency weaknesses were well known by senior staff, there appeared to be little support offered which IMGs reported in interviews. Helping IMGs to present their patients on ward rounds would be of obvious assistance to them. The antagonistic environment was not conducive to IPL between doctors and nurses although one instance of a nurse advising the IMG about blood pressure measurement was observed. The ward round attended only by doctors was considered usual and the lack of nurses in attendance was recognised as a problem in ED. Apart from a psychologist and a pharmacist, no other allied health professionals such as social workers were observed in the department.

5.4.9 The AMG RMO1

The AMG observed at Hospital B was a neurosurgical RMO1 working on a neuroscience ward. In the observations which follow, the RMO1 is referred to as the AMG. Because the IMG previously discussed was working in ED, the physical aspects of the ward working environment at Hospital B are described below.

5.4.10 Physical aspects of the working environment

The physical layout of the wards in the Hospital B was different from Hospital A. A long corridor serviced all the patient bays on one side. The service areas and several single rooms were on the opposite side. The nurse's station was on the same side of the corridor as all the patient bays. The observation of an AMG at Hospital B was conducted on a neuroscience ward. The ward occupied one floor of the building and

was divided into beds for neurology patients at one end and neurosurgery patients at the other end. A central nurse's station divided the two specialties. All nursing staff for both neurology and neurosurgery used the station. The doctor's station was adjacent to the nurse's station and openly accessible through a connecting doorway. More action was evident with this ward layout and it was noticeably noisy compared to Hospital A. However, the arrangement of the ward presented a greater opportunity for interaction between all staff involved in patient care which had a bearing on the friendly climate of the ward.

5.4.11 The ward round

I met with the AMG at 7.30 am as the surgical ward round was commencing. There were six people *rounding* (a verb used by doctors at this hospital for ward rounds and a cultural characteristic not evident at the other two hospitals); the nurse in charge; the bed nurse manager; the night RMO; the surgical registrar; the AMG, and the night nurse. The registrar, in blue theatre scrubs, was leading the round, swiftly moving in and out of the four bed *patient bays*, reviewing each patient. The patients' notes were in a trolley loaded with folders and pushed along, apace with the team, by the AMG. The AMG wrote in the patients' notes as the orders were given by the registrar. The registrar explained later that ward rounds are usually earlier at around 7 am and take three quarters of an hour, allowing approximately three minutes for each patient.

The condition of one patient was reported by the night nurse to have declined and they were unable to rouse him. The registrar ordered an urgent CT scan. As patients were reviewed, those ready for discharge were identified. Instructions were given by the registrar and the bed manager left the round with the NUM before the round had concluded. In the last bay there was a difficult and heated discussion occurring between a nurse and an Aboriginal patient; The nurse said to the team, "*We need to get social work probably more than anything.*" This comment provided an example of the dependency placed on the skills and knowledge of social workers.

JMOs had reported in the interviews that nurses do not usually attend ward rounds because they are too busy, so this ward was atypical. However, the main interest of the nurses seemed to be about which patients were to be discharged. They did not make any notes and asked few questions other than questions relating to patients ready for discharge.

After the round, the team convened in the corridor to discuss several patients and make telephone calls using their mobile telephones. JMOs were not observed using mobile telephones in this way at the other two hospitals. The night RMO queried if a patient had been seen by a consultant as requested, the day before. The registrar made a telephone call to inquire but no one seemed to know. The patient was suffering debilitating pain after a fall and the registrar had explained to him the pros and cons of back surgery but they still needed to hear from the consultant. The issues relating to this situation are about communication and quality of patient care: the lapse in communication causing a delay in decision making about treatment for a patient in considerable pain.

Before the corridor meeting disbanded, the NUM returned. The AMG walked up to her and gave her a friendly hug. They chatted and laughed. This was very different behaviour from what I observed anywhere else and demonstrated the nature of the relationship between the nurse and the AMG. The NUM and the bed manager nurse continued to discuss patient discharges and the registrar went to scrub for theatre.

5.4.12 Communication and interaction in other hospital areas

After the ward round there were visits to ICU, radiology and the CAT scan (computerised axial tomography) department. In all areas there was very little interaction or communication with anyone. In ICU, the AMG had to interrupt a staff specialist in a meeting. In front of 17 other clinicians, she presented details of the unconscious patient (identified on the ward round) in the neurosurgical ward. She confided her nervousness on the way to the radiology department where she hand

delivered an ultrasound request form to expedite a procedure for another patient. Her action to seek a faster response, was similar in purpose to the IMG at Hospital A.

The AMG expressly wanted to watch the CAT scan of the unconscious patient. In the computed tomography (CT) department we stood with her registrar, viewing the imaging screens from the CT office. The three people in the office ignored our presence, behaviour that was reciprocated by the JMOs. The patient had a small bleed in the brain. If his condition deteriorated further he would need to be intubated in ICU. There was very little interaction even with the technicians and patient attendants as we walked through the CT room to see the patient before he was wheeled back to the ward.

5.4.13 Ward tasks

On return to the ward, the AMG sat in the doctor's station to begin systematically writing in patients' notes, in between making numerous telephone calls. Included in the cases she was managing was the Aboriginal patient with drug and alcohol problems and dangerous diabetes, who needed urgent surgery. A nurse came to report that the unconscious patient had opened his eyes and obeyed commands. The AMG thanked the nurse and the nurse thanked the AMG for being there for the patient during the CT scan. Here was some evidence of interprofessional behaviour; an obvious ease of interaction and respect between the two. However, the AMG later explained that the nurse in charge that morning had not understood the unconscious patient's problem when they were on the round. She had wanted to call an arrest but this was not warranted. The nurse had to be told later when away from her peers that she had made "*the wrong call*". The AMG said philosophically, "*this happens*". She drew attention to the *DETECT* early warning system, which the nurse had not heeded. However, in the opinion of the AMG, "*the system (DETECT) takes judgement away from the nurses who worry about litigation and their responsibility. They call overnight when a patient's urinary output is down. It is trial by fire.*"

Much activity took place in the doctors' station but noticeably little communication and interaction. Two JMOs, the neurology registrar and the neurology intern came to the

station and sat next to the AMG taking over the computer she had been using in conjunction with writing her notes. There was no communication between the three JMOs. Intraprofessionally they failed to acknowledge each other. A clerk was sitting in a corner of the office, silently sorting out medical records. The clerk's presence gave an impression that the doctors were not territorial about their space.

Patient related interruptions occurred continuously for the AMG. A nurse came to discuss home care for a patient. Another call came from her registrar about the Aboriginal patient. Pre-operative and post-operative arrangements were discussed, whether the patient would need to go to the high dependency unit (HDU). Another call was about new orders for a patient and there was some discussion about the radiology NUM, *"who controls access to radiology and can be obstructive and difficult to get on with."* This comment followed a second trip to radiology to lodge another request form, when as before, the NUM had been unable to be contacted. The form was left for her with a note and the AMG's page number if needed. This gave an indication of ongoing interprofessional conflict.

5.4.14 Lack of Collaboration

The social worker came to the station and greeted the AMG by name in a friendly way, informing her about a patient who was going home and what the situation at home was like. There was a problem with the family who felt they were not ready to have the patient home. The social worker and the AMG interacted well, shared the same concern for the patient and obviously had a good collaborative working relationship.

The JMO answered a call from ICU and reported on the now conscious patient's CT result. Intubation was not needed so the ICU bed was not required. The patient would need oncology but the family had not been told. At 10 am, a neurology registrar arrived, *"exhausted"* from being on-call overnight. The neurology consultant arrived with the team registrar and the intern and ordered patient notes to be *"sent up"*. Not even a look was exchanged with the neurosurgery AMG and the other team. Another registrar came into the JMO's room, followed by the Epilepsy Fellow. The neurology team discussed a

patient's swallowing difficulties. No reference was made to a request for a speech pathology review as might be expected. The intern thought it was a neurological problem. The registrar felt they probably needed to do an MRI of the brain stem and said, "*where is this dude?*" He was referring to the patient. The intern replied that the patient was downstairs in ICU. Again, no interaction occurred between any of these JMOs. They were therefore quite unfazed by the observer sitting in the station taking notes.

5.4.15 An example of collaborative IPP

The JMO continued to make calls, arranged consultations and attend to paper work. A nurse came to the doctor's station dressed in blue theatre scrubs. A registrar walked in and out and a male OT came to look at some patient notes. There was no interaction or communication between anyone until another nurse entered saying to the AMG, "*Are you going to get rid of Mr X?*" They discussed the options. The AMG and the nurse needed to convince a family about their son's discharge and how to organise things at home. The nurse and the AMG walked through to the nurse's station and discussed the problem with the social worker and the OT. The patient was on Warfarin. This required an extra person in the house because no one would be able to cope in the event of a problem. Collectively the team of four decided on a Monday discharge rather than on this day, a Friday. The OT and the social worker turned to the AMG saying, "*You doctor talk, it will be better*". The allied health professionals seemed to doubt their ability to manage the situation effectively, preferring to defer to the AMG.

Various other people came in and out of the nurse's station and the doctor's station. The JMO continued to make telephone calls organising more consultations and speaking to the families of patients. The family of the patient who had been unconscious arrived and the AMG spoke to them about his condition. She shared all the information about the patient to a nurse in the ward before writing notes in the patient's file. Two physiotherapists were in the ward attending a patient, helping her with breathing exercises. The neurology consultant came and reviewed another patient recovering from a craniotomy. The AMG and the nurse quickly moved to attend the consultant.

5.4.16 Challenges to collaborative effort

In the doctor's station the consultant and the AMG spent time discussing test results and planned surgery for the Aboriginal patient (for a colloidal cyst). The consultant wanted to operate the following day, a Saturday. He left to go to the HDU to arrange a bed and the JMO was requested to arrange an anaesthetist for the patient. Four other doctors were in the station, including the neurology registrar and the neurology intern. Their only conversation was about the use of the telephone. There was only one telephone in the doctor's station. A nurse came to speak to the AMG about plans for the patient's surgery. There were problems over next of kin and consent. Contacting the Guardianship Board was discussed but there was no mention of contacting a social worker. The AMG and the nurse then went to see the patient together.

The nurse knew about the surgery but had to ask to be updated about the plans for the patient. In this instance, it would have been difficult to include the nurse in the planning process. From an observer's perspective, it was understandable, owing to the haste required for arranging and coordinating the operative aspects of the case, in order to proceed the following day. Further action, for example, involved the AMG going to the Ultrasound Department again. The option for sedation or a general anaesthetic for the patient was discussed with a respiratory RMO who also voiced complaints about the radiology department stating, "*There are issues with this department.*" The NUM had seen the AMG's note left earlier requesting a scan, but had ignored it.

Further potential difficulty with nursing staff followed in the Operating Theatre Department. The AMG had the task of securing an operating theatre for her patient for the next morning. The head NUM discussed the lists with the AMG and explained how things worked in a helpful manner. She advised the AMG to talk to the operating theatre's NUM about getting the patient on the list warning her, "*to take a deep breath before asking.*" However, the NUM conceded to the AMG's request. She proved not to be difficult calling the AMG "*darl*" at the end of the conversation. She took the time to describe the working system of *theatres* on Saturdays, for the benefit of the AMG. The patient having surgery in the morning would block off half the available emergency

theatre staff. The NUM did give her approval for the surgery though. The AMG felt sure that the NUM had given approval for the surgery because of my presence (just outside the door) and that the NUM might have thought I was a surveyor. However, the positive outcome may have had more to do with the AMG's manner and interpersonal skills.

5.4.17 Communication on the ward

The AMG resumed her paper work on the ward. Some patient notes were missing and the nurses were helpful in looking for them while we sat in the nurse's station. They were happy staff and the AMG interacted with them well. As a group, they were meeting that night for a Karaoke evening in a well known city establishment. Apparently it was common for all the staff to spend time together socially. Another RMO1 had said in his interview that he had been surprised at the way in which nurses, doctors and allied health professionals socialised at this hospital. He had spoken about the advantage of knowing staff when needing to contact them for consultations, creating more likelihood of favourable responses from requests, especially from a senior doctor.

The AMG appeared to be quite stressed but said she was coping well. Only then did she reveal that there was one RMO away that day, the neurology RMO1. This explained why she was looking after medical as well as surgical patients. At this point, the AMG presented all the staff with a box of Greek sweet pastries for everyone to share. This act was not because of my presence. The staff made the comment that this was typical. They considered her the best neurosurgical RMO1 they have ever had.

The AMG was too busy to take a break for lunch. Her major problem was still the patient having surgery. She was trying to sort out problems of consent but there was still no sign of a social worker who could have helped her. Others were present in the station but nobody spoke. They were all too busy. Letters and notes were written by the AMG about other patients, including those for discharge. Blood had to be taken from the "*difficult*" patient having surgery. A nurse came to talk to the AMG about the "*fractious*" patient. The AMG felt the cause was withdrawal from nicotine. The nurse

suggested a tranquiliser and the JMO agreed, acknowledging that she had not thought of trying that. A trusted working relationship between the AMG and the nurse was evident. JMOs reported learning from the knowledge and experience of nurses as exemplified in this simple example.

The afternoon proved to be quieter and the AMG continued working hard on administrative matters relating to patient reports. This necessitated accessing the computer for results and writing in patient folders. Two interns sat in the station working in a similar way. None of them spoke, nor did a pharmacist and a speech pathologist, who came in to do some work at the same desk. A nurse came to ask the AMG to write up a medication. She was given a short answer, *“Haven’t you read the notes, I’ve already written it up as the patient was for discharge”*.

An intern arrived who was rostered to relieve the AMG in her absence the following week. The AMG gave her a detailed one-on-one hand over of every patient. Her care for her patients was apparent. The day nursing staff left, exactly on time at 4pm. The AMG continued to work frantically on the computer. She had not had a chance to see any patients for some time. Other staff came to the station. The neurology registrar and her intern discussed tests together. A social worker came for a short time and left and a physiotherapist came to check some patient notes. They all did what they needed to do without any interaction.

5.4.18 Competency in procedures

A nurse reported to the AMG that a patient’s gastric tube needed to be re-inserted. The AMG went to see the patient. The CNC was present and assisted the AMG in performing the procedure, with difficulty, on a very sick patient. The CNC said to the AMG, *“I want you here for risk management.”* The CNC did not elaborate but her comment might have been interpreted as a sign of concern about managing her own risk rather than focusing on the best practice of safety for the patient.

The AMG continued her work in the doctor's station, in company with the neurology registrar and her intern who were discussing clinical matters. The registrar gave a short tutorial to the intern and the AMG about signs and symptoms for myasthenia gravis. A pharmacist came to pick up scripts, checked them, queried one order and discussed some other scripts with the JMOs. The pharmacist provided an instance of IPL with the three JMOs.

The CNC returned to report that the procedure performed by the AMG had been unsuccessful. The patient's naso-gastric tube was not *in situ*. The CNC put her hands on the AMG's shoulders as she was talking to her, advising that in all, seven attempts had been made to insert the tube correctly. The AMG immediately contacted the radiology *scrubber* about the patient's naso-gastric tube. The situation highlighted three matters. Firstly, the AMG had not been aware of so many attempts at the procedure and had not read the patient's notes. Secondly, had she known about the number of attempts, the AMG may not have attempted the procedure because of her limited experience. Lastly, the patient was very sick and had a tracheotomy. It was apparent from observation, that the repeated attempts at the procedure had put the patient through much distress. She could not speak but her look was one of fear.

5.4.19 Evening shift handover

The AMG had more work to complete on the ward before attending the 4.30pm handover in ED. She was rostered on an evening after-hours shift. As she was about to leave, the RMO she had been covering all day, arrived. The RMO had been to a course and now wanted the AMG to hand over his patients. Despite being quite stressed, the AMG remained in good grace and fulfilled everything that was asked of her.

Finally, the AMG arrived at handover in a meeting room near ED. An advanced practice nurse using the *ISBAR* system presented the handover electronically. *ISBAR* is an acronym for *Introduction, Situation, Background, Assessment and Recommendation*, used by some hospitals as a framework to simplify clinical communication between staff during handover. A consultant was in attendance and 11 others including registrars

and RMOs. All the patients with high needs on each ward were reviewed. When they reviewed an 87 year old *at risk* patient, one of the nurses remarked, “*She has been dying for days. She has an oxygen tube but doesn’t want a pleural tap for effusion and she doesn’t want PACE. She just wants love and kisses.*” *PACE* (*Patient with Acute Condition for Escalation*) was explained by the JMO as an alert signifying an urgent change in a patient’s condition. A *PACE* call requires the rostered medical emergency *PACE* team to attend immediately. A few minutes later, when the handover was almost completed, there was a *PACE* call. All the doctors’ pagers *went off*. They leapt up and rushed to coronary care, the AMG included. Her busy day on the wards had ended. Her evening shift was just beginning.

5.4.20 Analysis

Observation revealed that the AMG spent quite a lot of time on her ward, especially in the afternoon. After the morning round, she was absent from the ward to perform tasks related to the care of her patients. The AMG communicated and interacted competently in different departments and with a range of clinicians. In the afternoon, her time was spent mainly on updating patients’ notes rather than being with patients but the availability of the AMG in the doctor’s station was noticeably helpful to the nurses. The inability of the AMG to perform the procedure described, and the number of times the procedure had been attempted, illustrated a situation where quality and safety was not optimal. There was evidence of some IPP with the nursing staff and with allied health professionals and some IPL involving the pharmacist and JMOs. The proximity of the nurse’s station to the doctor’s station enabled an easy flow of interaction between doctors and nurses. Observation of the doctors confirmed that the doctors do not communicate readily with their own colleagues, remaining focused on their respective tasks. The registrar’s comment about a patient (as a *dude*) was unprofessional and disrespectful. It was a poor example to juniors.

Observing an RMO1 revealed a different pattern of work, confirming what JMOs had reported about the demands placed on junior residents. It also provided an opportunity to understand the nature of the RMO’s role as a conduit for information between more

senior clinical staff and the nursing staff, and to a lesser extent the patients. The pressure of time to complete tasks was expounded by interns and RMO1s in their interviews. Observation of this AMG confirmed their sentiments.

5.5 Observation at Hospital C

5.5.1 The IMG RMO1

The IMG observed at Hospital C was working as an RMO1 in ED. He was technically still an intern but was in his second year. This meant he was working on rotations as an RMO1 while still holding the conditional registration status of an intern. After observing him for a shift, I could understand why he still held conditional registration. He is referred to in the observations as the IMG.

5.5.2 JMO teaching session in ED

I met with the staff specialist in ED at 7.45am. The department was very quiet. The staff specialist suggested that I should attend the weekly JMO teaching session starting at 8am. Another staff specialist was scheduled to hold the teaching session in a small meeting room. Seven JMOs attended and one medical student. There were two IMGs. The IMG I was there to observe greeted me and shook hands. The topic of the teaching session was *epileptic seizures*.

During the one-hour teaching session, the contribution made by the IMG I was observing, was limited to one comment, a reference to a patient he had seen. The staff specialist asked many questions collectively of the group but the IMG either did not want to speak up, did not understand the question or did not know what to say. The other IMG, with a very thick accent, asked one question about epileptics driving cars, wanting to know if they experienced an “*aura*” (a sign) before an attack. The staff specialist misinterpreted his pronunciation of the word *aura*, so the question was never answered properly. The IMG remained silent after that moment.

Two AMGs asked and answered most of the questions about drugs of choice for different types of seizures and their administration and dosage, particularly for children. It was difficult to determine how much of the teaching session was understood by the two IMGs present. That factor alone may have directly related to them raising and answering questions. The staff specialist did not encourage them to participate, directing her attention and questions to the AMGs. She did not go out of her way to involve the IMGs by checking their understanding of her teaching. The benefit of the teaching session to the IMGs was therefore hard to ascertain and the possibility of information being misinterpreted in clinical practice was a potential, but unknown risk.

5.5.3 EMU

The IMG was rostered to work in EMU for the morning. The unit admits patients for monitoring, pending full admission or discharge. There were six patients in the open style, 12-bed ward. A registrar and a staff specialist were in a small glass partitioned station in the corner of the unit. The IMG picked up some patient notes and without reading them, went to a curtained cubicle to see his first patient. He talked to the patient for a lengthy period, asking many questions, seemingly in no particular order. He examined the patient continuing to ask searching, but still rather random questions. Many times, he made statements such as, *“You have red wee”*; *“You have back ache”*; *“You saw doctor yesterday, he want to do ultrasound of your legs.”* Regarding the latter statement, the patient replied that she knew nothing about an ultrasound. During the course of the consultation, the patient mentioned that her husband had left her but she was not unhappy about that.

After an hour, the IMG was still examining the patient. The patient was showing signs of impatience, *“Just give me the pain killers and I’ll go home.”* The IMG advised her that he wanted to do some tests. The patient suggested that he should look at the results from tests that had already been done. The IMG wrote some notes in the patient’s file, shut the folder and left the cubicle, pulling the curtains back. Nothing was said to the patient as he departed. There had been no real rapport or engagement throughout the period of over an hour. Without having the opportunity to observe this patient

encounter, it would have been difficult to discern some of the evident problems concerning the IMG's clinical practice.

The IMG sat on one side of the station writing profusely, occasionally pushing his chair across to the opposite bench to check the computer. Two registrars and one female staff specialist were in the station. No one spoke to the IMG.

A geriatrician consultant wearing a white coat, *swept* in to the station with his registrar and a student physiotherapist. He greeted the registrar and asked about the patients. One older lady was introduced as a private patient. He immediately ordered her to be transferred to the private hospital for a bone scan. The registrar quietly said to the other, "*He sniffs money.*" All the doctors, including the IMG, gathered around the patient. Another physiotherapist was already in attendance. A brief discussion took place amongst them without involving the patient. The physiotherapist was concerned about the patient's mobility and readiness for discharge. The geriatrics team left the unit. One registrar and the IMG stayed with the patient. The registrar asked questions, while the IMG listened and took notes. The registrar decided that the 90-year-old patient could go home, overriding the physiotherapists concerns. Little respect was shown to the physiotherapist.

The IMG returned to the station and continued writing his notes. It was quiet until a nurse came in with an ECG report to seek advice from the registrar. A new nurse came on duty and asked the IMG if she could see the patient's notes. It was 11am and the IMG was still working on the same patient, an example of how long the whole process of reviewing one non-urgent patient is for a junior doctor. One of the RMOs who had been at the teaching session came to discuss pleural effusion with the staff specialist. This could have been an opportunity to include the IMG in some teaching but the learning exercise was not shared with him.

The staff specialist checked the elderly patient being discharged before turning to the IMG and asking about his patient. He described her as "*an interesting patient*" and proceeded to explain her history. He made references to her being stressed several

times. The staff specialist asked if he had looked at the report of a procedure carried out on the patient a month ago. He had not but said that he would. He continued and began to talk about the present condition of the patient's parents. He either had forgotten or did not hear the patient say that both her parents were dead. He then said something about a test. The staff specialist did not understand what he was talking about because of his accent, so he had to repeat himself. This happened several times.

The staff specialist continued discussing the patient, asking the IMG about whether the patient was *a drinker*. He did not say anything and seemed not to understand what she meant. He had not asked about alcohol when taking the history. The staff specialist explained to him that the patient had stated, and it was in the patient notes, that she had a habit of consuming eight beers on Friday nights after work. Next, she inquired if the patient was eating. The IMG had not asked about this either. He checked some results on the computer while the staff specialist watched the screen with him. She read the notes he had made and cautioned him about focusing on stress too much, repeating that he should be careful in diagnosing stress. By all means *"feel for her"* she said, but *"she is actually ready for discharge with Mylantin and Zantac, to be followed up by her GP."* She added some provision and some teaching by saying that the patient could have gallstones but left side pain was unusual for gallstones and an ultrasound would be needed to rule it out. She asked what the intern was thinking at that point but he did not respond.

The IMG returned to his patient with the staff specialist who examined the patient and asked more questions. They returned to the station and discussed the patient further. The staff specialist continued to exclude stress from the diagnosis and explained that 50% of patients with unidentified abdominal pain go home with a referral to their GP. She conceded that the patient appeared to have some social problems in her life but this was not a major issue. The staff specialist ended the session by telling the intern the patient should continue on oral analgesics for 48 hours and see her GP for review. More teaching points were discussed but the IMG did not ask any questions and commenced the discharge procedures. The IMG had spent the whole morning reviewing this one

patient but he had also learnt from the teaching of the staff specialist, who was aware of his competency level.

After lunch, I returned to EMU and spoke to the registrar about the usual time expected for seeing and examining a patient. She said that RMOs are expected to see one patient per hour, commenting that the IMG was slow, given the patient's history had already been taken, but not the slowest they had ever had. I spoke to the staff specialist in charge of ED. We discussed IMGs generally and I was told that it was vital for the IMG to successfully complete this term in order to gain unconditional registration.

5.5.4 The first ED consultation

EMU had few patients left so the IMG was transferred to conduct non-urgent triaged consultations in ED, for the rest of the day. During the afternoon he saw two patients. Observation of his encounters revealed further examples of difficulties with language, communication, and competency.

The IMG's first patient was a 20-year-old female accompanied by her mother whose first language was not English. The patient presenting had fainted in the shower and her tooth had gone through her lower lip lacerating her gum and the outer skin under her lip. A description of his treatment follows to illustrate the level of competency displayed by the IMG in performing a small procedure.

Box 5.2: Description of the treatment of a patient reflecting IMG's level of competency

The IMG examined the patient and asked many questions. He put on gloves and opened a sterile pack to get some forceps for examining the inside and outside of the patient's mouth. He swabbed the laceration, loaded a syringe with saline and irrigated the area. This was a clumsy process which he did three times, with the patient trying to hold a kidney dish against her chin, to catch the solution running off. He got into a mess with the used tweezers, swabs, and the syringe, putting them all on the examination bed beside the patient, rather than in a receptacle. The patient and her mother were displaying signs of anxiety. The IMG tried twice unsuccessfully, to pull the two edges of skin together below the patient's lip in order to apply a sterile *medi-strip*. The strip was too long and covered the corner of her mouth. He could have cut the ends of the strips to shorten them. Leaving his patient, he went away and returned, still gloved, with a new sterile pack. He opened it, swabbed the wound again, removed some shorter *medi-strips* and applied them to the lip, with some awkwardness, but finally he succeeded. The waste was put on the examination bed again. Peering into the patient's mouth again, he fossicked with his tweezers and said to the patient, "*You have pieces of meat in there.*" He corrected himself saying "*flesh or skin*", telling the patient that it needed to be cut away. He took some scissors and held them in the air in front of her advising that the skin was almost dead so she would not feel anything. She lay there frightened but it seemed not to hurt her as he carefully cut three times, removing bloody pieces of gum tissue. The gum tissue was placed in a kidney dish in front of her. The mess was cleaned up and the waste put in the normal waste bin rather than the clinical waste bin provided.

The remainder of the consultation consisted of more tests. He asked the patient to give a urine sample, quietly explaining to me that he wondered if early pregnancy might have caused her to fall. He told her what to do and where to go and she went with her mother to oblige, and returned soon after. While waiting for the result, the IMG checked the patient's blood pressure and pupils. It took him a long time to take her blood pressure, which he did several times in lying and standing positions. He inflated the cuff and checked the reading numerous times muttering something about "*syncope*". He reported to the patient that her blood pressure was low (100/55), especially when she stood up, so he checked her pupils again.

The results of the urine test were negative. The IMG reported that the patient did not have a urinary tract infection. He then said, after checking that the accompanying

person was the patient's mother (he had not established this before), that the test had been done to check if the patient was pregnant. The young woman was 20. The privacy aspect was either overlooked by the IMG or unknown.

The IMG asked if the patient had any heart pain. She replied that she had "*a little*." He asked if she was stressed. She said that she did get quite stressed. He recommended that she should have an ECG, explaining that he would get a nurse to do this for him. He turned to leave the room advising her to drink water and that if she had a stiff neck and a sore back, (mumbling something about meningitis), she should immediately come back. Then he went through a list, seemingly in his mind, muttering "*a letter and spare steri-strips*."

The IMG went to the station to write in the notes. The station was shared by all the clinical staff but was under resourced in terms of space and facilities, with three computers and three chairs. Clinical staff were standing waiting for a free computer. It was 2:15pm. The IMG continued to write notes about the patient, entering data into the computer and then typing a letter to the patient's GP. The results of the ECG came back as normal. He took the letter he had written, the ECG results and an unrequested sickness certificate and gave these to his patient, forgetting the spare steri-strip dressings. He advised her to "*floss*" her mouth. She asked if he meant she should use mouthwash. He nodded but did not seem to understand her. The patient was discharged at 2:50 pm. The IMG had not discussed the patient with any senior staff member, nor had he asked anyone any questions.

5.5.5 The second ED consultation

The poor competency and communication skills of the IMG were equally apparent during his second and only other consultation for the afternoon. The patient, a middle aged male presented with chest pain.

The patient began to tell his story to the IMG, a litany of extraordinary symptoms from someone affected by a psychosis. For example, the patient reported seeing a

gastroenterologist for panic attacks related to his use of a detergent, *Trix*. The IMG did not know what he was talking about. He had his head down writing copious notes. The patient described in great detail all his illnesses and the need for a *bronchoscopy*, reaching into his bag to produce reports and diagnostic tests of confirmation. The IMG did not understand his colloquial speech such as “*panting like a dog*” nor did he understand when the patient said he had a hernia. The consultation continued for an hour along the same lines with much repetition. The longer they talked the more symptoms came to light from the patient. The IMG checked the patient’s heart and his breathing. He checked his blood pressure. Everything was normal. Finally, the IMG asked him about depression and discovered that he had been prescribed anti-depressants, but had stopped taking them. At 4pm, the intern attempted to conclude the consultation explaining that he needed to discuss his case with the staff specialist. The patient pleaded for a *bronchoscopy* and the intern asked him if it was “*for reinsurance*”.

Leaving the patient seated, the IMG found a staff specialist and relayed the history of the patient. Much was omitted but there was enough evidence, including the letters, to eliminate any real problems. The staff specialist said that the surgery the patient had described was apparently unnecessary. She suggested that the patient (who did not live in the city) should have one doctor to coordinate his care and that he needed to go back to his local GP. The IMG returned to his patient explaining that a *bronchoscopy* was not needed and that he should choose one doctor to treat him. Against the protestations of the patient, who revealed that he had been to five GPs and two specialists, asking for a *bronchoscopy*, the IMG eventually convinced him that nothing more could be done. Finally, the patient said, “*You’ll see my obituary in the Herald,*” but the IMG did not understand what he meant. The IMG reiterated his position telling him to remain while he wrote a letter to the GP. The patient became despondent and apologetic for taking up so much time. It was 5pm.

5.5.6 Analysis

The observation of this IMG in a teaching session, and three encounters in ED confirmed many of the problems faced by IMGs. The teaching session revealed the

possibility that very little of what was discussed about epilepsy was understood by the IMG, making it difficult for him to ask questions and seek clarification. The staff specialist directed her teaching at the AMGs and no effort was made to engage the two IMGs present. This supports what IMGs reported in interviews.

With the IMGs first patient encounter, many inadequacies related to knowledge, communication and competency were apparent. The patient was the IMG's only patient for the whole morning before he went to lunch. The case illustrates some of the challenges for employers in host countries, and for doctors entering a foreign health system and unfamiliar working environments. It is an example of what a patient may experience and how engagement with, and trust between, doctor and patient can falter.

The staff specialist, who was aware of the IMG's competency level, spent time reviewing his diagnosis, offering guidance and teaching. The staff specialist's own bedside examination of the patient with the IMG offered further support, which was not given in this way for the other two patients he saw later in the day.

Communication between the staff in the EMU station was minimal. During the only patient review conducted in the unit with a specialist consultant, JMOs and a physiotherapist, little regard was given to the patient and little respect shown to the physiotherapist.

Observation of the other two patient encounters confirmed issues of: cultural differences; language; communication; and competency, particularly procedural competency; judgement; and professionalism. Despite the IMGs tenuous position in terms of registration, he was offered no supervision or consultation from a staff specialist with his first patient.

The complexity of the second patient encounter experienced by the IMG presented challenges which he may not have experienced before. The complexity included the language used by the patient in the multiple stories that unfolded. As observed in the first patient encounter, no senior staff member came to check the patient or see if the

IMG needed any help. There was a reliance on his capability, including his ability to understand the patient and accurately convey information to the staff specialist for ultimate advice. Once the staff specialist had guided him through the patient's history and symptoms, to a diagnosis and plan, he managed to counter the anxiety of his patient.

Without having the opportunity to observe the IMG's patient encounters, it would have been difficult to discern some of the manifest problems concerning this IMG. His awkwardness in performing a minor procedure, his poor language skills, his difficulty in communicating, interacting and relaying information to patients and senior staff; all contributed to shortcomings in his overall competency.

5.5.7 The AMG Intern

The AMG observed at Hospital C was a female intern completing her third term of residency. She is referred to in the observations as the AMG. The AMG was working in colorectal and upper GI (upper gastrointestinal) surgery.

5.5.8 Physical aspects of the working environment

The ward layout at Hospital C was similar to the ward layout described for Hospital B. The nurse's station was half way down a long corridor, on the opposite side to all the four bed patient bays. A separate, open access JMO's room was further along the corridor from the nurse's station. On the corridor wall was a laminated sign of welcome to the ward, displayed in 15 languages: Croatian, Italian, Greek, Serbian, Turkish, Hindi, Arabic, Korean, Macedonian, Vietnamese, Chinese, Indonesian, Bosnian, Portuguese and Spanish. The diverse patient demographic of this hospital had been noted before and remarked on by JMOs in their interviews.

5.5.9 The ward climate

Observation took place during a day shift and commenced at 7.45am in the nurse's station. Present at that time were the NUM, the ward clerk, an enrolled nurse and two registered nurses (RNs). An example of doctor/nurse attitudes occurred before the intern arrived. Two male doctors came to the high bench top at the nurse's station. One greeted the NUM saying "*Hello.*" He was an orthopaedic registrar and had come with his resident to review an orthopaedic *outlier* patient. He asked the NUM if she knew anything about the sliding scale for insulin. The NUM advised that they needed to "*ask endocrinology*" as they would probably have a protocol. Without any thanks or comment, the two doctors left. One of the nurses complained to the others present about their rudeness. "*The one minute they're asking us and the next they're telling us we don't know anything.*" Further discussion took place between the staff in the station about the problem of communicating with doctors. This episode, right at the beginning of observing in this hospital, was evidence of more than an undercurrent of discord between the doctors and nurses. It was evidence of an attitude responsible for creating discord, one that acts as a barrier to IPP. It also reflected a lack of professionalism.

5.5.10 The ward rounds

The colorectal registrar and the Fellow for upper GI arrived at 8.30am to commence a ward round. The appearance of both doctors was noticeable because it was so bad. The Fellow was dressed very casually; the registrar was wearing a tracksuit top over a shirt and was chewing gum. Their look was unprofessional. Patients and others could find it hard to distinguish them as doctors. They might also feel affronted by their countenance.

The AMG arrived after attending a morning JMO teaching session for interns. She collected the patients' folders and put them in a trolley ready for the round. The round commenced with the AMG and the registrar. The clinical coordinator and two nurses joined the round later. The clinical coordinator was interested in patients who were

ready to be discharged. She left the round before it had finished, together with the other two nurses. Their participation was minimal.

The registrar had not washed his hands until the nurses joined the round, despite concern about an outbreak of gastroenterology on the wards. When he did wash them the intern remarked, "*You're being very good today.*" Overall, the registrar's infection control practices were noticeably poor, showing a disregard for quality and safety.

There were *outliers* to see in different wards on other floors. The first patient to be reviewed was in a neurosurgery ward and the next was a patient in ICU. The only evidence of interaction with nursing staff was if the registrar made a telephone call from the nurse's station.

At 10am, the round continued. On another level, there was a patient to see in a gynaecology ward. The two JMOs maintained their practice of going in and out of wards and nurses stations, with no acknowledgment of anyone present. The nurses did not initiate any communication either. The registrar's manner was arrogant, giving an impression of command and remoteness as a model of behaviour to the intern.

Leaving this ward, we went to a different wing of the hospital to the children's ward, entered only with security card access. The ward climate was different. The nurse in charge greeted the JMOs asking why they were there. She directed them to a room where there was a young adult patient, before returning with the patient's notes. The registrar had not introduced me, so I explained my presence. The charge nurse was very professional and very much in control of her ward, but the JMOs did not treat her with much respect at all.

The last patient reviewed was in the cardiothoracic ward. A nurse advised the registrar that the patient he had come to see was not eating. The registrar met the dietician in the nurse's station. The dietician was considering the possibility of gastric feeding. The registrar suggested oral feeding if the patient was able to swallow. He was told that the speech pathologist had already considered that. The dietician was concerned about the

patient lying flat in the bed and having muscle wastage around the face. They decided to nourish orally and review the patient after the weekend. This discussion with the dietician, in conjunction with the advice of the speech pathologist, was the first IPP example observed of some shared planning between the professions. The example illustrates the benefit of shared planning with the patient as the centre of care.

The extensive patient round in so many different areas of the hospital took up most of the morning. Compared to the other two hospitals, there were more *outliers* in Hospital C, resulting in the JMOs spending more time away from the majority of their patients in the main ward and from the staff caring for them. The opportunity for more collaborative care was hindered. There was a cost in time as the JMOs travelled from floor to floor to see their *outlier* patients.

5.5.11 Work on the ward

The two JMOs sat in the JMO's room writing in patients' notes and making telephone calls to consultants. Calls to consultants typically were to ask if they wanted to see patients before they were discharged. Humanising comments were made about patients while writing notes such as, "*a lovely bloke.*"

The registrar was called about an emergency and went to theatre. The AMG continued working in the nurse's station organising tests and making telephone calls. There was no interaction with the NUM or any of the nurses and an almost disregard for the numerous other staff, whose identities were explained to me by the clinical coordinator. The NUM was the only person wearing an identifiable name badge on her uniform. In this regard, the lack of staff identity at Hospital C was similar to the other two hospitals. The ambiguity of titles and roles adds a barrier to communication and therefore IPP.

In the ensuing period before midday, the nurse's station was busy with activity. A consultant and a registrar came to the station, collected some patient notes and went to see their patient. The AMG discussed a patient's readiness for discharge with the clinical coordinator and they both went to see the patient. Two physiotherapists stood

discussing a patient. A medical student wandered in and checked through the notes in a patient's folder. Another surgical registrar in theatre scrubs came to the station, to check some patient notes. A dietician picked up some patient notes and went to see her patient. The pattern observed in these and other health professionals coming to the ward was predominantly a pattern of working independently without communicating interprofessionally.

For the remainder of the day this pattern of behaviour observed amongst the ward staff and visiting staff was relatively unchanged. The AMG spent a short time in theatre with her registrar. Later she assisted in the outpatient's clinic before returning to the ward to complete more paper work relating to patient discharges. It was not possible to observe the AMG consulting with patients but the chaotic environment of the outpatient's clinic was noted, together with the many different languages spoken by patients, both seated and standing in the corridor. When some patients were called to the counter, whole families rose to accompany them, as is traditional in some cultures. This may have accounted for the queues of people and the inadequate seating available.

On the ward, the CNC spoke about the lack of interaction with doctors. Because it was a surgical ward, doctors were mostly on the ward early in the morning. She said there was a problem communicating with consultants who rarely came to the ward, unless a patient was private. She named only two consultants who did do rounds. They always came at 7am to see their patients. From the CNC's comments, and from observing the AMG and other JMOs, the opportunity for IPL and for any IPP was limited.

The AMG continued with the completion of her paperwork in the JMO's office. A nurse came to the door of the office but did not venture beyond the door. She was upset as she spoke to the AMG, "*Whoever did the operation didn't have a clue and was all over the place.*" The nurse wanted to know if she could give fluids to a postoperative, *appendectomy* patient. There had been nothing written in the notes about fluids and nothing had been said at handover. She continued telling the AMG that the person who had operated spoke "*appalling English.*" She could not tell what the postoperative orders were but the appendix was apparently difficult and the patient was very "*knocked*

around.” The AMG was unable to give a satisfactory response to her query. Issues here relate to competency and patient safety, quality of care, language, and poor communication, including oversight of the patient at handover.

Before the end of her shift, the AMG made more telephone calls from the nurse’s station. She had no interaction with any of the nursing staff or any of the allied health professionals who were present: a social worker, dietician and a speech pathologist. As before, other medical staff came in and out, checking notes, seeing patients and leaving without communicating to anyone. The CNC complained about their manner and not knowing who they were, “*They never introduce themselves.*” Her comment held true for similar behaviours observed in the other hospitals.

5.5.12 Analysis

Communication between the JMOs, nurses and allied health professionals observed is a major issue. At the beginning of the day there was evidence of a poor attitude and an undercurrent of discord between the doctors and nurses. At the end of the day, the final remark from a nurse was about medical staff never introducing themselves. The attitudes and behaviours observed are obvious barriers to collaborative effort and IPP. They reflect a lack of professionalism, which can breed a lack of respect between health professionals. At risk is the perpetuation of such behaviour, at the expense of focusing on patient centred care through IPP.

Time spent away from the ward by JMOs reduced the opportunity for contact with any patients after the ward round. The number of *outliers* in so many different areas of the hospital took both the registrar and the AMG away from the ward for a considerable part of the morning, placing an additional *out-of-ward* workload on the JMOs. The repercussions of this span the essential elements of IPP and therefore affect patient safety. The absence of communication with other staff in almost every area where they visited *outliers*, was noticeable. It is equally important for nurses and other health professionals to initiate communication with JMOs. The example of the professionalism displayed towards the JMOs by the NUM in the paediatric ward bore evidence of this.

The registrar's discussion with a dietician and a speech pathologist about a patient's feeding regimen was an example of IPL and IPP. It was an isolated example but it illustrated the benefit of shared expertise with the patient at the centre of care.

Issues related to the patient whose surgery and postoperative care were discussed between the AMG and the nurse, raise concerns about competency and patient safety, quality of care and communication. The broader aspects of communication included poor English, the paucity and illegibility of postoperative orders and the failure to hand over a patient who had just returned from surgery.

Chapter 6: Survey

6.1 Introduction

Chapter 6 presents findings from the survey administered to JMOs. The survey was the third method employed in the collection of data. The aim of the survey was to capture responses from IMGs and AMGs regarding their interprofessional behaviours and views, in order to examine and compare their attitudes towards interprofessionalism. The results of the survey are presented in the form of a descriptive analysis. The statistics are contextualised within an overarching qualitative methodology.

The chapter begins with a brief outline of the method employed before reporting the results. The results are organised in four sections, reflecting the four themes of the questionnaire: culture, integration and acculturation; communication and interaction; collaboration and teams; and competency, quality, safety and professionalism. A discussion of the main findings concludes the chapter.

6.2 Method

6.2.1 Samples

The sample groups comprised the two groups of JMOs: 15 IMGs and 17 AMGs. The rotations of IMG and AMG participants at the time of the survey and their level of postgraduate medical training at each hospital are shown in Table 6.1.

Table 6 1: IMGs and AMGs by hospital, current rotation and postgraduate level of training

Hospital	IMG/AMG	Current rotation	Postgraduate level
A	IMG	Geriatrics	Registrar
A	IMG	Haematology	Registrar
A	IMG	Psychiatry	Registrar
A	IMG	Gastroenterology	SRMO
A	IMG	Cardiology	Registrar
A	AMG	Clinical Pharmacology, Drug and Alcohol	Registrar
A	AMG	Emergency Medicine	RMO1
A	AMG	General Medicine	Registrar
A	AMG	Gastroenterology	RMO1
A	AMG	Endocrinology	Registrar
B	IMG	Renal Medicine	RMO1
B	IMG	Neurology	RMO1
B	IMG	Infectious Diseases	RMO1
B	IMG	Respiratory Medicine	Registrar
B	IMG	Emergency Medicine	Registrar
B	AMG	Cardiology	Intern
B	AMG	Anaesthetics	RMO1
B	AMG	Emergency Medicine	RMO1
B	AMG	Relief	RMO1
B	AMG	Toxicology and Emergency Medicine	Registrar
C	IMG	Gastroenterology	Registrar
C	IMG	High Dependency Unit	Intern
C	IMG	Cardiology	Registrar
C	IMG	Obstetrics and Gynaecology	SRMO
C	IMG	Renal Medicine	Registrar
C	AMG	Renal Medicine	SRMO
C	AMG	Gastroenterology	RMO1
C	AMG	Aged Care	Intern
C	AMG	Echo cardiology	Registrar
C	AMG	Gastroenterology	Intern
C	AMG	Cardiology	RMO2
C	AMG	Rehabilitation	Intern

For comparative purposes, the postgraduate training level of JMOs was collapsed to form three occupational status groups: interns, RMOs, and registrars. The work locations (Hospitals A, B, and C) and the occupational status of the two groups of JMOs (IMGs and AMGs) were compared using chi-square analyses, to determine whether these differed significantly. If they did, these factors may have contributed to any attitudinal differences found between the groups. The test comparing the occupational status of the Australian and international graduates yielded chi-square=5.32 (df 2), p=0.070. The test comparing the three different hospitals in which JMOs were working,

yielded $\chi^2=0.209$, $df\ 2$, $p=0.090$. Thus, there were not significant differences in the occupational status and hospitals of the two groups of JMOs.

6.2.2 Questionnaire

The questionnaire comprised 30 questions presented in four sections, consistent with the four unifying themes of the thesis. The questionnaire items comprised six-point Likert scales with the following response options: strongly agree; moderately agree; somewhat agree; somewhat disagree; moderately disagree and strongly disagree. A description of the development and piloting of the questionnaire is in the method chapter (3.8.4). A copy of the questionnaire survey is found at Appendix 2.

6.2.3 Procedure

The questionnaires were administered to the JMOs on-site, at their respective hospitals. The attitudes of the two groups, IMGs and AMGs were compared using t-tests for independent means, utilising the Statistical Package for the Social Sciences software (SPSS). The significance level was set at $p<0.05$.

6.3 Results

The results of the t-tests comparing attitudes of the two medical graduate groups are presented in Tables 6.2 to 6.5. The tables and accompanying descriptive analyses correspond with the four sections of the questionnaire: culture, integration, and acculturation; communication and interaction; collaboration and teams, and competency, quality and safety.

6.3.1 Culture, integration and acculturation

There were six questions in the first section of the questionnaire. They were designed to gauge aspects of junior doctors' integration into their respective hospital environments. Questions related to how JMOs personally adapted to their hospitals, including their

acculturation; their impressions of the hospital environment; and how they judged their skills in their individual clinical environments, compared to the skills of their non-medical clinical colleagues. JMOs were asked to consider if the culture of their hospital was one of caring for patients and allowing patients to participate in the management of their care.

Table 6.2: Results of t-tests for comparing the attitudes of IMGs and AMGs on culture, integration, and acculturation

Questionnaire items	Means		Standard deviations		t (df=30)	P*
	IMG	AMG	IMG	AMG		
A1 I have integrated into the health workforce culture of this hospital well	5.45	5.12	0.64	0.70	1.47	0.152
A2 I understand clearly what my roles and responsibilities are in this hospital	5.87	5.18	0.52	0.73	3.12	0.004*
A3 The atmosphere in this hospital is friendly and supportive	5.40	4.82	1.24	0.73	1.62	0.115
A4 The culture of this hospital is all about caring for patients	5.60	4.71	0.63	0.77	3.55	0.001*
A5 I feel more highly skilled than other non-medical health professionals who work here	4.53	3.82	1.68	1.01	1.46	0.154
A6 I understand the culture of including patients, families and/or carers in the planning of treatment and the management of care	5.80	5.41	0.41	0.79	1.76	0.091

*Statistically significant difference

As shown in Table 6.2, significant differences were found between the attitudes of the IMGs and AMGs in their answers to items A2 and A4. IMGs (mean=5.87) agreed more strongly than did their Australian counterparts (mean=5.18) that they understood clearly

their roles and responsibilities in their respective hospitals. IMGs (5.60) also agreed more strongly than AMGs (mean=4.71) that the cultures of their hospitals were all about caring for patients.

The groups' responses to the other four items in this section of the questionnaire did not differ significantly. The extent to which the IMGs and AMGs considered they had integrated into the health workforce culture of their respective hospitals produced similar responses of high agreement, well over the scale mid-point of 3.5. Both groups of JMOs agreed that the atmospheres at their hospitals were friendly and supportive. JMOs were asked if they felt they were more highly skilled compared to non-medical health professionals. Responses reflected similar moderate agreement from both groups that they did feel more highly skilled. The final question elicited strong agreement from Australian and international graduates that they understood the culture of involving patients and families in the planning and management of care.

6.3.2 Communication and interaction

The second section of the survey comprised six questions seeking JMOs' views about communication and interaction (Table 6.3). These questions explored the importance of attitudes about communication in patient care and interaction with other health professionals; JMOs' communication skills, proficiency in language ability, non-verbal communication and the effect of personal values when communicating with patients.

Table 6.3: Results of t-tests for comparing the attitudes of IMGs and AMGs on communication and interaction

Questionnaire items	Means		Standard deviations		t (df=30)	P*
	IMG	AMG	IMG	AMG		
B1 Interaction with patients requires understanding and trust	5.93	5.82	0.26	0.93	0.92	0.365
B2 Communication skills are essential for doctors to practise effectively	5.67	5.88	0.62	0.33	1.21	0.241
B3 In this country, good communication skills require English language proficiency	5.60	5.18	0.63	0.73	1.75	0.091
B4 Non-verbal communication is an important aspect of communicating with patients and colleagues	5.27	5.41	0.96	0.62	0.51	0.611
B5 Interacting with other health professionals is important in my role as a doctor	5.07	5.24	0.80	0.90	0.56	0.582
B6 Interacting with other health professionals is important in my role as a doctor	5.93	5.88	0.27	0.33	0.42	0.677

There were no significant differences between the attitudes of IMGs and AMGs regarding communication and interaction. The survey responses indicated strong agreement from both groups that interaction with patients requires understanding and trust. Similar views were recorded by both IMGs and AMGs about the essential skill of communication for effective clinical practice; the requirement of English language proficiency for good communication skills, and the role of non-verbal communication as important aspects of communicating with patients and colleagues. The two groups also held similar views on the importance of doctors interacting with other health professionals. The mean scores of the answers of both groups to all items in this section of the questionnaire were all over 5, indicating strong agreement.

6.3.3 Collaboration and teams

There were nine questions in the third section of the survey which focused on collaboration and teams (Table 6.4). Responses were sought from JMOs about their understanding of the roles of other health professionals, such as OTs, speech pathologists, social workers and other allied health professionals; the importance of collaborative care, and the inclusion of patients as part of health care teams. Some questions linked to collaboration; collegiality and respect. Further questions explored the views of JMOs about their role in the health care team; seeking advice from other professionals, and their appreciation of the importance of collaborative effort in treating complex patients. One question related to writing patient discharge summaries, the transfer of patient information between hospital medical clinicians and external general practitioners.

Table 6.4: Results of t-tests for comparing the attitudes of IMGs and AMGs on collaboration and teams

Questionnaire items	Means		Standard deviations		t (df = 29/30) **	P*
	IMG	AMG	IMG	AMG		
C1 I have a good understanding of the roles of other health professionals	5.57	4.59	0.65	1.06	3.02	0.005*
C2 The complexity of health care delivery requires greater emphasis on collaborative practice	5.79	5.41	0.43	0.71	1.81	0.082
C3 I find it difficult to write discharge summaries	2.71	2.24	1.73	1.09	0.90	0.379
C4 I see patients and families/carers as part of the health care team	5.50	4.18	0.85	1.18	3.49	0.002*
C5 Doctors are the most important members of the health care team	3.79	3.06	1.72	1.09	1.43	0.163
C6 Respect is shown between health professionals	5.57	4.41	0.51	0.71	5.09	0.000

here						*
C7 I often seek advice about clinical matters from other non-medical health professionals	5.21	4.59	0.89	0.87	1.97	0.058
C8 Focusing on patients' needs can assist in creating a feeling of collegiality and satisfaction amongst health professionals	5.64	5.00	0.74	0.79	2.31	0.027 *
C9 Collaborative effort is important in the delivery of health care because most people who seek medical care interact with more than one health professional	5.93	5.59	0.28	0.62	2.05	0.066

*Statistically significant difference **One participant failed to answer all items

The results of the t-tests shown in Table 6.4 revealed significant differences in the responses of IMGs and AMGs to four of the nine items. IMGs were significantly more likely to agree (mean=5.57) that they had a good understanding of the roles of other health professionals than did AMGs (mean=4.59). International graduates (mean=5.50) were much more likely than their Australian counterparts (mean=4.18) to consider patients and their families as part of the health care team. International graduates (mean=5.57) were significantly more likely than Australian graduates (mean =4.41) to consider that respect was shown between health professionals in their workplaces. IMGs (mean=5.64) agreed more strongly than did AMGs (mean=5.00) that focusing on patients' needs can assist in creating a feeling of collegiality and satisfaction amongst health professionals.

There was no significant difference between the agreement of the two groups to the statement that the complexity of health care delivery requires greater emphasis on collaborative practice. Both groups expressed similar levels of disagreement to the proposition that they found it difficult to write discharge summaries. Responses to the item asserting that doctors are the most important members of the health care team were similar and close to the mid-point of the scale indicating neither strong agreement nor

disagreement. There was no significant difference between the two groups' likelihood of agreeing that they often sought advice about clinical matters from other non-medical health professionals. Both Australian and international graduates agreed strongly that collaborative effort is an important element, in delivering care to patients requiring multi-professional interactions.

6.3.4 Competency, safety, quality and professionalism

The fourth section of the survey focused on aspects of competency in JMOs, including: confidence in their clinical ability and technical competencies; clinical judgement; learning through working with others; and attendance at ward rounds (Table 6.5). Other aspects related to safety and quality of care; professional conduct, and JMOs awareness of their legal responsibilities.

Table 6.5: Results of t-tests for comparing the attitudes of IMGs and AMGs on competency, safety, quality and professionalism

Questionnaire Items	Means		Standard deviations		t (df=30)	P*
	IMG	AMG	IMG	AMG		
D1 I am confident of my clinical competence most of the time	5.50	4.76	0.65	0.83	2.70	0.012 *
D2 If I am unsure about a patient's condition, I consult with a senior clinician	5.86	5.94	0.36	0.24	0.77	0.448
D3 My technical competencies are not as good as I would like them to be	3.14	4.00	1.61	1.46	1.55	0.131
D4 My level of competency as a clinician has increased through working with other non-medical health professionals	5.53	4.76	0.73	0.83	2.74	0.101
D5 I try to attend Grand Rounds on a regular basis	5.33	4.24	1.11	1.48	2.35	0.026 *
D6 The safety of patients and the quality of their	5.73	5.35	0.59	0.70	1.64	0.111

care underlies all that I strive to achieve as a clinician						
D7 A collaborative approach to patient care improves the quality of care and reduces the risk of errors	6.00	5.00	0.00	0.93	4.41	0.000 *
D8 I am mindful of my professional conduct and duty of care to patients	5.67	5.76	0.62	0.44	0.52	0.605
D9 I am aware of my legal responsibilities as a medical practitioner	5.80	4.88	0.41	0.86	3.77	0.001 *

*Statistically significant difference

Table 6.5 shows that in response to four of the nine items in this section of the questionnaire significantly different attitudes were expressed by IMGs and AMGs. IMGs (mean=5.50) expressed greater confidence in their clinical competence than did their Australian counterparts (mean=4.76). Participants in the IMG group (mean=5.33) were more likely than AMGs (mean=4.24) to agree that they attend Grand Rounds on a regular basis. IMGs (mean=6.00) were significantly more likely than AMGs (mean=5.00) to agree that a collaborate approach to patient care improves quality of care and reduces error. IMGs (mean=5.80) were also more likely than AMGs (mean=4.88) to agree that they were aware of their legal responsibilities as medical practitioners.

There was similar agreement expressed in both groups that if they were unsure about a patient's condition, they would consult a senior clinician. The groups' mean answers to the item, *'My technical competencies are not as good as I would like them to be'* did not differ significantly and were close to the mid-point of the scale. Both groups agreed that their clinical competency had increased through working with non-medical health professionals. Strong agreement was shown by all JMOs that as clinicians they strive to achieve quality of care and safety for their patients and similarly, that they were mindful of their professional conduct and duty of care to their patients.

6.4 Discussion

The results of the survey revealed significant differences between the attitudes of IMGs and AMGs on 10 of the 30 (33.3%) survey items. Differences occurred particularly in the sections of the questionnaire investigating attitudes toward collaboration and teams, and competency, quality and safety. In both these sections the groups differed significantly in their answers to 44.4% of items. In the section on culture, integration, and acculturation, the responses of the IMGs and AMGs differed significantly on 33.3% of items. There were no significant differences in the groups' responses to the questions about communication and interaction. The attitudes of the IMGs and AMGs were more similar than different; no significant differences being observed in their answers to 66.6% of the questions.

The strong agreement in survey responses about the importance of communication was reassuring given the importance of communication for effective collaborative IPP. Almost overwhelmingly, JMOs strongly agreed that interacting with other health professionals was important in their role as doctors. The strength of this response reveals recognition of the interdependency between JMOs and other health practitioners.

In Question A3, the combination of the terms *friendliness and support* in the text of the question, may have resulted in an inaccurate response from JMOs about support in hospitals. Broader aspects of support could be explored further, to include support in learning, administrative support, levels of clinical support, and to what degree face-to-face support was available and offered.

The stronger agreement from IMGs relating their understanding of patients, families and carers as part of the health care team may reflect the different hospital cultures of care experienced in their countries of training. For example, some IMGs spoke about cultures where multiple members of families attend their relatives in hospital and in some cultures, males make decisions for females. The general agreement of JMOs suggests that even if they may not always be able to observe this inclusive practice of

care they recognise its importance. The finding is significant to interprofessional practice because it relates to patient centred care. A further finding relevant to interprofessional practice concerned the equal division amongst JMOs in their attitudes about whether or not they felt they were the most important members of the health care team. The responses are possible indicators of JMOs' willingness, or not, to collaborate with other health professionals.

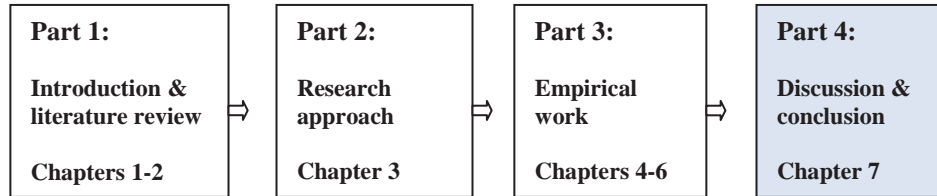
In relation to the clinical competence of JMOs, IMGs were significantly more likely than AMGs to agree that they were confident of their clinical competence most of the time. The greater confidence of IMGs may link to their professed prior experience. IMGs were also significantly more likely to agree that their competency had increased through working with other health professionals. A willingness to learn from non-medical clinicians signifies an endorsement for interprofessional learning. AMGs showed some degree of apathy towards learning from attending Grand Rounds, compared to IMGs who were significantly more likely to try to attend Grand Rounds. In the area of technical competencies, limitations reported imply that greater emphasis needs to be placed on teaching or updating JMOs' technical capabilities, for the benefit of JMOs, the quality of care they offer, and the safety of their patients. The greater awareness of legal responsibilities in the IMG group could result from the required preparation that IMGs reported undergoing, before commencing their residency. The weaker responses from the AMG group highlight a need for education to improve their awareness of legal responsibilities.

Overall, findings significant to IPP and patient-centred care included strong agreement by JMOs about their understanding of including patients in the planning of their care. JMOs indicated agreement about the benefits to patients of a collaborative approach to care. Coupled with their agreed recognition of the interdependency between JMOs and other health professionals, these positive attitudes could be considered as enabling factors of intent towards collaborative IPP. While there was no significant difference IMG (mean=5.73); AMG (mean=5.35) in agreement about the safety of patients and the quality of care underlying all that they strive to achieve as clinicians, one third of JMOs

showed only moderate or somewhat agreement compared to strong agreement in the other two thirds of JMOs. A hospital culture supportive of IPP may have shown stronger agreement in responses. Despite the assurance of confidentiality and based on evidence from the interviews, there is a possibility that JMOs, particularly IMGs, may have responded to some questions in a way that they felt might reflect favourably on them. IMGs are potentially in a somewhat more vulnerable position than AMGs with regard to their careers.

The following section forms the final chapter of the thesis. The major findings and their implications are discussed. A concluding section completes the thesis.

PART 4: Discussion and conclusion



Chapter 7: Discussion and conclusion

7.1 Introduction

Chapter 7 is the final chapter of the thesis. In this chapter, the main issues arising from the research are discussed drawing on the amalgamation of findings from the three data collection methods employed: interviews; observations; and surveys. The chapter begins by restating the premise and aims of the thesis. The original contribution of the work is distilled from discussion of factors emerging from the four themes and sub-themes of the research, which are linked to the central research questions. The interrelationship of the themes is illustrated in the discussion. Finally, the implications of these emergent factors are expounded and opportunities for future research advanced. A conclusion to the thesis completes the chapter.

7.2 The premise of the thesis

In this thesis, I set out to explore IMGs working as JMOs in the milieu of Australian teaching hospitals with their Australian trained counterparts, nurses and other non-medical health professionals. More specifically, I wanted to shed light on IMGs' understanding of, and orientation to a culture of IPL and IPP. I sought to identify barriers to these collaborative practices affecting quality of care and patient safety, and

to determine the extent to which patient safety may be compromised if junior doctors are not oriented to a culture of IPP. The thesis plan called for examining IMGs in the context of their counterparts, AMGs.

7.3 Original research contribution

To the best of my knowledge, and for the first time, research has been conducted that specifically addresses IPP in the context of patient safety, using the four themes applied to two groups of JMOs in Australian teaching hospitals, IMGs and AMGs. The framework for the research was devised and developed specifically for the studies. The composition of the framework originated from an analysis of the literature reviewed and comprised the four main themes of culture, communication, collaboration, and competency. The application of the framework allowed barriers to IPP to be identified.

The research instruments were derived from the literature reviewed and tailored for the study. The semi-structured interview questions and the survey questionnaire were developed around the four themes and their respective sub-themes of integration and acculturation, interaction, teams, quality, safety and professionalism. The observations strengthened the research by adding data from the actual, observed performance of participant JMOs, thereby complementing and enriching data collected from the interviews and survey. Combined with the unique framework developed, this methodology can be drawn upon for application elsewhere.

This research adds to the literature by importantly addressing the individual cultural variation of IMGs. It achieves this through highlighting the diverse ethnic, medical training backgrounds and experience of IMGs entering the hospital system. Applying the framework of inquiry embedded in the research method enabled rich data to be captured about the cultural problems confronting IMGs at the individual level. The data illustrated how these problems inhibit IPP and therefore affect patient safety. There is no evidence of literature reporting on IMGs other than as an homogeneous group, apart from research on diversity in the culture of medical students (Woodward-Kron, Stevens et al. 2011).

Previous research has been conducted on the learning experience of international and Australian medical students (Kuteyi, McLean et al. 2009) and on interprofessional collaboration based on interviews with 25 junior doctors and nurses (Weller, Barrow et al. 2011). The latter study confirmed problems relating to mutual respect and the limiting factors of organisational structures and the hospital working environment. This research differs from that study in its scope and method. The contribution made by this work is through the use of the framework developed, and the triangulated method applied, to two different groups of JMOs across three hospitals, with a specific focus on IPP in the context of patient safety.

A further original contribution has been made in identifying the emergent diversity of JMOs entering the hospital system in Australia and the impact this has on IPP and therefore patient safety. Diversity of cultures was previously associated only with IMGs which allowed for discrete comparisons with AMGs. However, this research identified great diversity in all JMOs, revealing commonalities applicable to their work practice as well as comparative differences.

The research explains the lived world of JMOs from an original perspective through the candidness and disclosures of JMOs in face-to-face, onsite interviews, and through the ethnographical observations. The rich data collected provided a unique insight to the action and behaviour of JMOs in their professional capacity as junior clinicians.

The work contributes original research linking IPP with intraprofessional practice in the performance of doctors in their patient management role. Through investigating IPP in medical and non-medical practitioners within the framework developed, the significance of intraprofessional practice to IPP was revealed. This additional dimension to the notion of IPP, highlights the importance of professionalism as a competency that is fundamental to the performance of JMOs and the enactment of IPP.

7.4 The manifold cultural diversity in JMOs and their working environment

A diversity of ethnic cultural backgrounds exists in the composition of JMOs. The diversity is compounded by the variability in the student medical education experience of the JMOs and their minimal experience of shared learning. In addition, the impact of the individual organisational cultures of the hospitals and of specific wards and units within them presents an underlying environment challenging to the notion of IPP, from organisational cultural aspects. The negative impact of ethnic and organisational cultures on collaborative IPP is strong, particularly for IMGs and to a somewhat lesser extent, AMGs. International students graduating as AMGs, carry with them, their ethnic cultures but have at least been immersed in the medical educational and clinical placement environments of Australian hospitals, unlike their IMG counterparts.

While training and preparation are key elements to successful acculturation and enculturation, the organisational culture and sub-cultures in which JMOs work are profound and can strongly influence the process of how well that transition and integration occurs. Training alone cannot prepare JMOs for the transitions they make in their training, nor the preparation period offered to IMGs before first embarking on hospital residency. An overarching organisational culture of IPP would, by definition, enable more collegiality and support for all JMOs entering and rotating through the hospital working environment.

7.5 The effects of culture, integration, and acculturation on the experience of JMOs

Most JMOs integrated into their working environments through trial and error with little support, apart from the formal orientation given to interns. Some JMOs encountered more difficulties than others, mainly IMGs rather than AMGs. The hospital culture had both positive and negative effects on their adaptation to the working environment, the conduct of their clinical roles and their ability to engage in IPP. Successful adaptation to IPP is rooted in the collegiality and supportive nature of the environment. These two

human factors can be linked to hierarchy within the health professional and organisational administrative hierarchy of hospitals.

JMOs are aware of the hospital cultures inasmuch as succumbing to the fact that *this is the way things are done here*. They have little recourse, at the intern and resident levels at least, to challenge the organisational hierarchy about perceived problems including ongoing education and training, supervision and support. Advocacy intraprofessionally is not strong. Some JMOs expressed real concern about this issue. Registrars in particular, hold the view that if they are seen as *complainers*, it could affect their assessments, their progress and the training positions they aspire to in hospitals (Mitchell, Markwell et al. 2011). This situation is indicative of latent intraprofessional problems. While these problems exist, they remain a collective barrier to IPP and efforts towards improving patient safety.

JMOs were professionally culturally directed to pursue an intraprofessional, not an interprofessional orientation. For registrars advancing in their training, their objective was predominantly one of self-direction towards achieving their goals of higher qualification to specialise. Their concern was the hierarchical culture of their specialty and the need to comply with that, if they wanted to succeed. They were not focused on improving communication, teamwork or interprofessional collaboration. Compounding the challenges they face, many registrars in training programs, and more junior residents, are required to leave the relative familiarity of their primary hospitals to rotate through different hospitals as part of their ongoing residency training and experience. This means they continually need to adapt to the new cultures and sub-cultures of the host hospitals and new interprofessional environments. According to some JMOs, this can be a challenging and sometimes isolating experience. The constant changes and associated stress, present barriers to developing their IPP abilities and potentially compromise quality of care and patient safety. Similarly, the transient nature of JMOs rotating to different specialty wards or units for periods of between 10 and 12 weeks requires them to quickly adapt to the environment, the authority of charge nurses (Barrow, McKimm et al. 2011) and the different medical conditions of patients. More

junior doctors, particularly IMGs, reported that by the time they became confident, or *on top of things* in their rotations, it was time to move to another setting. The pressure on IMGs to adapt is greater because of the limiting factors already discussed, such as communication and lack of support.

Further challenges are faced by JMOs rotating to smaller rural hospitals where the clinical environment is less specialised than city teaching hospitals and the hierarchy not as layered. Patient presentations in ED may differ from those in the city and for IMGs, the idiosyncrasies of language used by patients from farming communities can be markedly different from what is heard in the city. All these factors pose barriers to IPP, impeding the opportunity to enhance patient safety.

Issues relevant to the nature of interaction between doctors and nurses included the attitudes of doctors to nursing staff. These were not always respectful, but at times glimmers of gratefulness reflected the assistance given to JMOs by nurses. In some hospital units, the position of the NUM is such that the attitudes of interns and residents can be almost reverential.

The contextual aspects of the working environment which include the increasing complexity of the health service landscape and the sophistication of patient illnesses and treatments draw further on the resolve of JMOs in the performance of their day to day work (Lancashire, Hore et al. 2009; Greenfield, Nugus et al. 2010; Charles, McKee et al. 2011; Weller, Barrow et al. 2011). The nature of complexity in the present context includes the multiple elements of health systems and the interdependency of those elements, all of which may be in the name of improving patient treatments and care but which continue to grow and take on leviathan-like dimensions.

7.6 Hierarchy, intraprofessional and interprofessional communication

The day-to-day performance of JMOs requires effective communication, one of the most critical elements of IPP and patient safety (Hastie and Paice 2003; Braithwaite and Travaglia 2005; Schyve 2007; Raduma-Tomàs, Flin et al. 2011). As revealed in the findings, some of the most common issues affecting JMOs practising interprofessionally stem from poor communication and factors linked to communication. The language difficulties associated with speaking and listening were predominantly seen in IMGs but other aspects of poor communication were common to both groups of JMOs. These included difficulties in interpreting written patient notes and the tendency to read only the *headline* patient notes of doctors, against reading the more narrative style of nurses' notes (Leonard, Graham et al. 2004) and other health professionals. Poor communication in this manner is an example of how patient safety can be compromised through a failure in the transfer of patient information between the patient care team.

The lack of interpersonal communication between doctors, and between doctors and nurses and allied health professionals indicates intraprofessional as well as interprofessional shortcomings. The transfer of information is problematical in this regard. That is, from the perspective of professional boundaries and hierarchy, inhibiting IPP and standing in the way of safer patient centred care. The flow of patient information, emanating from senior clinicians, but conveyed to nurses by junior doctors is a further barrier to IPP. This system of transmitting information arises from ward rounds typically attended by doctors only, rather than a multidisciplinary team, allowing for patient information to be shared at first hand (Garling 2008; Bradfield 2010). The mutual presence and combined expertise of the patient care team in decision making are fundamental benefits of IPP and patient safety. However, the medical professionals on the ward rounds are intraprofessionally rather than interprofessionally oriented in thought and action.

Another factor affecting communication, and by extension IPP and patient safety, resides in the apprehension of JMOs, especially IMGs, in contacting senior clinicians about patients. This reflects the medical cultural norm of JMOs having to demonstrate

professional competence. Information is devolved to JMOs through instructions given about patient treatments, or instruction given to organise a consultation by contacting another senior clinician to review the condition of a patient. IMGs reported these situations as stressful. They were fearful of being asked questions they were either unable to answer, or questions that they could not understand. The underlying fear included their concern about not meeting the expectations of senior clinicians (Woodward-Kron, Stevens et al. 2011), ahead of what the consequences might be for patients, if error occurred through miscommunication. There were very few examples of JMOs expanding beyond their own concerns to express concern for patients, but there was no reason to conclude that they did not care about their patients; on the contrary. The JMOs' preoccupation to be seen as clinically competent by their peers and superiors was a significant behavioural driver. They were strongly intraprofessionally focused almost to the exclusion of other issues.

This problematical, interactional aspect of communication, emanates from an established medical hierarchical culture, distinctly intraprofessional in nature. While respect and professionalism are implicated in such behaviour, the effects of all these communication-grounded issues ultimately pose barriers to collaborative IPP, clinical competency, patient safety and the quality of patient care. Interpersonal skills and communication are integral to collaboration and effective team effort. They are essential for the sharing of information about patients across professional boundaries, and for successful shared learning and shared values amongst professionals. The degree of permeability across professional boundaries may well be an indicator of an acceptance to practise interprofessionally (Ferlie, Fitzgerald et al. 2005).

7.7 The effect of professional tribes on interprofessional team effort

The predominance of subgroups of professional tribes was evident in the hospitals (Carlisle, Cooper et al. 2004; Braithwaite, Iedema et al. 2007; Hamilton 2011). The different professions operate under the influence of their respective, and strong subcultures (Schein 2003) which may be a partial reason for JMOs' lack of understanding and respect for the contribution of other professions such as allied health

(Hamilton 2011). As revealed in the findings, and elsewhere, some allied health professionals expressed sentiments of being undervalued (Rice, Zwarenstein et al. 2010). At the most fundamental level, if collaborative interprofessional team effort and shared learning are to develop, JMOs need to know and respect the expertise of the non-medical professionals.

Hospitals remain subject to the patriarchy of doctors. Even with changes to the male-to-female numbers of doctors (Health Workforce Australia 2012), there is evidence that collectively, the manner of medical dominance persists. This was exemplified in the behaviour model of senior clinicians towards JMOs (Barrow, McKimm et al. 2011). The medical culture from which some IMGs come was reported to be more hierarchical and the behaviour of much venerated doctors was described by IMGs as autocratic. Many IMGs displayed characteristics, typical of tribal medical cultures lacking a team orientation (McNair, Stone et al. 2005). Other aspects of collaborative team work perceived by JMOs to be difficult included the arrogant personalities of some doctors within their own tribe and their indisposition to listen to others in making decisions about patient treatments and care. While these manifestations of behaviour continue to exist, any real sense of true collaboration occurring is threatened (Rice, Zwarenstein et al. 2010).

7.8 Tensions and pressures affecting team interpersonal relationships

The day-to-day routine of JMOs on ward rotations, as opposed to ED or ICU, is overall more individualised and lacks teamwork. JMOs are pressured to meet competing demands, many of which take them away from the wards to review patients in ED, to see *outlier* patients, patients in clinics, or to attend to other patient related matters (Lancashire, Hore et al. 2009). When they are present on the wards, JMOs spend much of their time organising and following up tests, writing patient notes, writing discharges or completing similar administrative tasks.

Time spent by JMOs multitasking, significantly diminishes time spent with patients, estimated in one study to be as little as 15% (Westbrook, Ampt et al. 2008). This is the

manner in which the practice of medical care is learnt and enacted. Individual doctors responsible for individual patients rather than an orientation to teamwork and collaboration. While this medical model of care has been the predominant mode of professional practice, the emergence of sophisticated and complex treatments for the multiple needs of patients in teaching hospitals, requires the collective expertise of interdependent health professionals. This is what lies at the core of IPP. For health care professionals to provide optimal patient care, the benefits of collaborative effort and shared expertise are seemingly unrecognised or indifferently viewed by the JMOs, under the authority and influence of senior clinicians. A resistance to a culture of IPP translates to a resistance to enhancing patient safety. It brings into question the most fundamental moral obligation of duty of care to patients.

A recognised problem, and a message communicated many times by JMOs, especially IMGs, was not knowing the individual members of clinical teams (Hewett, Watson et al. 2009). The anxiety experienced by JMOs in contacting senior clinicians was heightened if they had not met the person with whom they were communicating. Registrars, as well as interns and residents, reported this as an issue. It provides further evidence of poor intraprofessional practice and the impediment this creates in progressing to a culture of IPP.

On the wards and in other areas of the hospitals where doctors were observed, most of the time they failed to interact with, or acknowledge, the very close presence of other doctors. Their attitude appeared to extend to minimal interaction or dialogue with nurses and other health professionals, despite the interdependency required of them for the care and safety of their patients. JMOs arriving in wards to review an outlier patient, would typically not speak to the nursing staff on arrival or departure about the condition of the patient or patients they had come to review. These patients may be at a higher risk if there is no exchange of information between providers of their care (Goulding, Adamson et al. 2012).

There will always be exceptions but a practice of disregarding other staff should be an exception to a rule, or code of professional conduct relating to communication, which is a core of competency in the practice of JMOs. Without exception, JMOs reported that good communication was critical to their role, yet this expressed belief did not appear to include a commitment to communicate interprofessionally or even intraprofessionally. The provision of safer patient care may rest on a more “*dynamic harmony*” (Amalberti, Auroy et al. 2005:756) between the providers of patient care, as espoused in collaborative IPP.

7.9 The broader aspects of competency as they relate to patient safety and interprofessionalism

This research was not about clinical competencies per se but about JMOs’ confidence in their clinical competencies and in their technical capabilities as they relate to quality of care, patient safety, and IPP. Competency in communicating has been referred to earlier in the context of interaction with medical and health professionals but not in the context of communicating with patients in order to make a clinical diagnosis and to review progress. It is through communicating effectively and professionally, that the trust of a patient is likely to be gained and a more complete history told. For patients to be “*interactants*” in their own care also requires an empathy from doctors to appreciate the level of an individual’s comprehension (Woodward-Kron, Stevens et al. 2011:565). In their own explanation about the importance of communication, JMOs made little, if any, reference to this crucial aspect of interacting with patients, although they deemed to understand the benefit of involving patients, and their families, in the planning and management of their care.

There was little evidence of shared learning with others, apart from the multidisciplinary meetings in wards such as geriatrics. The nurses have their own education programs and in-service training and one hour, weekly education sessions of varying standards are provided for interns and residents. JMOs were likely to accomplish much of their learning on their own, which some explained was a continuation of how they had learned in medical school. The pattern of learning in this

way does not easily transfer to a practice of collaboration and shared learning. IMGs reported spending much time reading medical texts after work rather than discussing and debriefing with professional colleagues in the clinical environment. They attributed this to the long hours spent in the hospital to complete their tasks, limiting their opportunity to learn in this way. Registrars were usually in surgical or physician specialist training of some type, which involved structured programs of learning. They were more likely to attend Grand Rounds than interns and residents limiting the opportunity for the more junior doctors to develop their knowledge through discussion of material presented with their registrars and interprofessionally with non-medical staff. Grand Rounds appeared to be the reserve of doctors, typically the more senior clinicians and registrars.

The concerns reported by JMOs about technical competencies were common across the three hospitals, suggesting that they need support, particularly in the resident and intern groups. There is a reticence to call on the skills of nurses, many of whom are highly specialised. An interprofessional environment of respect and shared expertise would be likely to obviate this reticence. At the registrar level, some general skills may be lost as they progress in their training and develop more specialised skills. A lack of support for JMOs was matched by an expressed lack of supervision, particularly on surgical rotations, and in performing procedures. The implications for quality of care and patient safety are apparent and the opportunity for feedback, reassurance and the learning associated with supervision missed. JMOs understood, and accepted, that learning occurs in practice, particularly at the resident and intern levels. However, the speed of ward rounds allowed little time for questions at the bedside. The absence of nurses and allied health professionals precluded the opportunity for shared IPL. Amongst IMGs, there was the added reserve to ask questions or seek clarification because of their insecurities about language and knowledge.

Further concerns about lack of supervision extended to JMOs working on rostered after-hours shifts and night duty. The consequences included potentially diminished patient safety from uncertainty in the clinical thinking of junior doctors to judge when they

needed to seek help (Wilson and Hutchinson 1991; Farnan, Johnson et al. 2008). Some JMOs reported the anxiety of being confronted with difficult situations requiring clinical judgement, and suffering from their misjudgement by not seeking medical help or any assistance from nurses. Many AMGs at every level spoke about these situations and having to live with the consequences. IMGs reported anxiety about seeking help, more for reasons of communication and not knowing the senior clinicians in their hospitals. Some IMGs considered that prior experience in their home countries had given them the ability to cope clinically on the wards after hours, but they still lacked skills in communicating.

JMOs acknowledged that they did learn from working with non-medical health professionals. However, there was some reluctance among them to concede and seek the advice of others, particularly the advice of nurses, as they might if they were working in a culture of IPP. A culture of IPP would be likely to allay their reluctance and direct their attention to the needs of their patients.

7.10 Managing the workload associated with complex patient care

The complexity of patients' conditions and treatments in teaching hospitals challenges JMOs' patient management capabilities, which they acknowledge are crucial to patient safety but learned only through experience. While JMOs agreed that patient complexity demands greater emphasis on collaborative IPP, their indication of intent to practise collaboratively was generally thwarted for reasons explained. The main reasons given were linked to the pressures of time to complete the work of the day as soon as the ward round, in wards where there were regular rounds, was completed. Many IMGs admitted that their working days extended, not unusually until 10pm, because it took them so much longer to finish their work. Despite the obvious strain on them (many had families and lived at a distance from where they worked), IMGs nevertheless valued the opportunities for learning provided through working in teaching hospitals. In a sense, they were unwittingly talking about benefits gained through working in a teaching hospital, experiencing the interface of IPP and learning in the process of their acculturation.

Away from their patients, in their designated work areas, JMOs spend inordinate amounts of time focused on administrative work associated with ordering tests and procedures, the latter reported by all JMOs as being excessive. The trail created from ordering these investigations, results in time expended on following up (at times chasing up) test results, checking for procedural reports and updating patient notes. Beyond their primary wards, further clinical and administrative tasks were performed in various parts of the hospital. These tasks included reviewing patients in ED, attending patients in outpatient clinics and reviewing outlier patients in other wards of the hospital. In some hospitals, JMOs hand deliver pathology or radiology request forms to expedite results, an action that defies sensible use of their time and expertise. Surgical registrars were in theatre for most of the day after ward rounds and their residents, often interns, reported struggling at times to manage the post operative care of patients in their absence. The support of nurses in such situations was acknowledged, but there were limits to what could be done until registrars returned to see their patients, typically late in the day.

Finally, there are the physical demands of the day, drawing on the meagre amount of time spent by JMOs on the wards, nearer to their patients. Time taken to walk between different areas of the hospital, and to and from ED, was considerable, with doctors tending to use stairs to reach wards up to three levels away, rather than waiting for lifts. The design of the newer hospital of the three was slightly easier for JMOs in this regard. The other two hospitals were older and departments away from the wards were more widely spread out across the hospital sites. These factors further illustrate the difficulties associated with bringing teams together to work collaboratively and to learn interprofessionally. With some exceptions, such as pharmacists and social workers in certain wards or units, the nurses are the constants on the wards and in units and departments, unlike the itinerant doctors and allied health professionals involved in patient care. The scope for change as suggested by some AMGs is limited by the physical environment, the system and the present cultures in hospitals. There are many gaps to bridge.

7.11 Implications of the research

The implications of this research extend to a range of aspects of the work required of JMOs in teaching hospitals, in their postgraduate years of medical education and training. The dynamics of the JMO role constitute barriers to working interprofessionally. These barriers are compounded by professional and organisational cultures that are difficult for JMOs to overcome, leading them to practise intraprofessionally. Conceptually, JMOs are not opposed to the notion of IPP, however in reality, the day-to-day challenges of their work and workplace environments, preclude them from embracing IPP and thereby the potential to enhance patient safety.

The initial training of JMOs, whether in Australia or in other countries focuses them inwards professionally to achieve the clinical competence required to practise as doctors. The medical organisational approach to patient care exemplifies this focus as evidenced in the conduct of ward rounds, the tendency to read only the patient notes written by doctors, the tasks that remove JMOs from their wards and the pressures that drive them individually to accomplish all that is required of them in a single shift.

Medical professionalism demands more than clinical competence. The ability to work interprofessionally is grounded in good communication and interpersonal skills, collaborative team effort and mutual respect for the expertise of all health professionals, with an understanding of their roles. The interdependency of health professionals in the delivery of complex care requires them to focus on the primacy of the patient and the needs of the patient, through working interprofessionally for optimal patient outcomes.

There appears to be a gap in the preparation of JMOs, both IMGs and AMGs, for their roles in teaching hospitals, to understand and appreciate the complementary roles and expertise of so many other non-medical health professionals. An exception to this case may be the hospital pharmacists, whose role is known and whose expert knowledge is indispensable to all doctors, particularly JMOs with their limited pharmacological knowledge. A small number of JMOs considered that having pharmacists on ward rounds would be beneficial. The pharmacists could well be a catalyst for promoting IPP

because of their unique professional positioning and their vital role in the safe prescribing and administration of medication to patients.

Within the JMO working environment, there are system issues bearing on patient care which hospitals and units need to address. Some are more easily implemented, such as better identification badges that clearly identify individuals by name and professional role. Other recommendations would require more fundamental process changes. These include more efficient processes for expediting test orders and results; more systematic procedures for handovers and seeking consults; more explicit systematic processes for monitoring and evaluation of JMOs; better placement of patients to minimise outliers and more consistent procedures for handling the discharge process.

The intraprofessional problems identified in medical clinicians constitute a cause for concern. They reflect a pace and style of practice, which overrides some of the fundamentals of professionalism. The opportunities for IPP can only improve if this diminishment in interpersonal, intraprofessional behaviour is recognised and turned around. A failure to institute change will see JMOs at the beginning of their medical career, succumbing to perpetuating the behaviour that currently exists. Finally, the divide that is evident between JMOs and hospital management needs to be addressed. Managers of JMOs, as professionals, are part of the framework within which IPP resides. Administrators focused on patient safety are in a position to instigate a culture of IPP in the governance of their hospitals whereby everyone, patients and staff alike, would be the beneficiaries.

7.12 Opportunities for future research

This research lays the foundation for a comparative study in another country, such as the UK where concerns about patient safety have been raised in a report tabled in the House of Lords of the British Parliament (2011). The concerns relate to the diversity of health professionals, including doctors, entering the National Health System from European Union countries, under mutual recognition of their training. The competencies

of these health professionals, particularly language skills which are essential for IPP, and clinical acumen, have come under scrutiny because of adverse patient events.

There is scope for further study towards a model of effective supervision for JMOs. The justification for such research would be three-fold: firstly, from the perspective of patient safety; secondly for the benefit of ongoing postgraduate medical education; and thirdly to advance supervised learning for JMOs, offering them scope to diffuse their learning through IPP.

Factors affecting decision making in collaborative practice is another area for further research. The benefits of shared expertise and decision making in IPP test the bounds of responsibility rested in the different professions. The role of the doctor embracing the decisions of other health professionals collaboratively but ultimately directing patient care may warrant further study.

An opportunity exists to do an interventional study, using one cohort empowered, to improve the performance of IMGs, and another to act as a control. Further work may include the publication of these results for inclusion in the education programs for doctors, nurses, and allied health professionals.

7.13 Conclusion

This final chapter of the thesis has drawn together evidence from the combined findings that the aim of the research has been achieved. Through exploring the understanding of IPP in IMGs and AMGs, and the links between IPP and patient safety, the study has revealed significant barriers to their practise of IPP and a poor appreciation in JMOs of the connection between IPP and the safety of patients. There is a willingness amongst many JMOs to practise interprofessionally but their present training and practising environment is within a system that militates against transforming this willingness into the collaborative effort required for IPP. The system of health delivery in teaching hospitals is a victim of inertia. JMOs working within it, especially IMGs, are prey to the

perpetuation of deep-rooted behaviours and cultures not aligned to IPP, thereby inhibiting the potential synergies that could enhance patient safety.

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APPENDICES

Appendix 1 Interview format and questions for semi-structured interviews

Appendix 2 Questionnaire survey

Appendix 3 Participant information and consent forms

Appendix 4 Revocation of consent form

Appendix 5 Approval for access to unit

Appendix 6 Doctor profile form

APPENDIX 1: Interview format and questions for semi-structured interviews



The University of New South Wales

Interview format and questions concerning international medical graduates, local medical graduates and their understanding of interprofessional learning and interprofessional practice.

Thank you for consenting to participate in this interview.

I would like to begin by asking you some preliminary questions about

interprofessional learning (IPL) and interprofessional practice (IPP). Together, they are areas of emerging interest in the education and practice of medical clinicians and health professionals such as nurses, social workers, physiotherapists and psychologists.

1. What is your understanding of IPL and its purpose?
2. What understanding do you have of what IPP involves?

3. When you were a student studying medicine, what sort of contact did you have with students studying in other health professional fields eg nursing, physiotherapy, allied health, pharmacy?
4. Can you tell me about any shared learning that took place with these other students?
5. Since graduating and practising as a clinician, what has been your experience of working collaboratively with other health professionals, for example, jointly planning the treatment and ongoing management of patients?

Semi-structured interview questions

There are four sections to this interview. I will explain the purpose of each section before asking you the interview questions and at the end of each section, I will invite you to complete some survey questions. At the end of the fourth stage of the interview, you may like to offer further comments or ask questions.

Section 1. I am interested in finding out what you think about the culture of this hospital ie your feelings about working here, the attitudes of those who work here towards each other, the overall atmosphere here and what it was like when you started, compared to what it is like now you have been here for a while.

1. Culture and integration and interculturality

- 1a. Can you tell me what it is like working in this hospital?
- 1b. What are some of the differences between working in this hospital and other hospitals where you have worked previously?
- 1c. When you started working here, what were the main difficulties you encountered?
 - ci. How did you address these difficulties?

cii. Who helped you?

ciii. Which, if any, of those difficulties is still a problem for you?

- 1d. What sort of orientation program did you have when you started working here?
- 1e. Can you tell me about your perception of the culture of the medical profession in Australia?
- 1f. This hospital is part of the overall health system in Australia. What do you know about the Australian health care system?

Section 2. The second section is about communication and interaction: firstly, what it is like here communicating with colleagues and patients and secondly, how you interact with others who work here as well as with patients and their families.

2. Communication and interaction

- 2a. Can you tell me about the importance of communication in your role as a doctor?
- 2b. What sort of interaction do you have with your colleagues and other health professionals such as nurses, pharmacists and social workers, on a daily basis?
- 2c. Can you tell me about a time when you have had difficulty communicating with colleagues?
- 2d. When speaking to patients and families or carers, what sort of communication problems do you encounter sometimes?

- 2e. What do you do when it is hard to understand patient notes and other forms of written communication, such as reports following tests and procedures?
- 2f. Can you tell me about any discomfort you experience in your interaction with colleagues and patients of different gender?

Section 3. In this third section, I am interested in finding out about your feelings and attitudes towards working with other health professionals and what you think might be some of the barriers to achieving collaborative practice.

3. Collaboration and teams

- 3a. What is your attitude towards an approach to patient care based around joint practice and shared expertise with other non-medical health professionals?
- 3b. Why do think working as part of a team may be difficult for some people?
- 3c. How does collaborative effort affect patient-centred care?
- 3d. What do you consider are the essential elements for health professionals, including doctors, to work collaboratively?
- 3e. In what situations do you find non-medical professionals on the health care team to be helpful?
- 3f. During clinical meetings, how do you contribute to discussions? Who usually attends? Does much learning take place?
- 3g. Which members of the health care team do you find are easiest to seek advice from?

Section 4. In this final section of the interview, I would like to ask you about aspects of competency and discuss how they link to quality, safety and professionalism.

4. Competency – quality and safety, professionalism

- 4a. How competent do you feel about your roles and responsibilities here?
- 4b. What are some of your concerns about whether you have the skills and knowledge required of someone at your level to work here competently?
- 4c. Which personal attributes do you feel are essential to the overall quality of your clinical practice?
- 4d. What factors do you consider to be important for patient safety?
- 4e. How do you think your inter-relationship with patients and with other health professionals relates to quality and safety?
- 4f. Can you tell me about the ongoing education and teaching that you participate in here?
- 4g. How important is status to you as a medical professional?
- 4h. In what ways do you think the professional autonomy of doctors could be changing?
- 4i. At what times do you reflect on aspects of your day-to-day work?

APPENDIX 2: Questionnaire survey



Questionnaire concerning international medical graduates and local medical graduates.

Instructions: There are no right or wrong answers to the following questions. Please answer openly and honestly. Usually your first response is accurate, so please do not take too long considering each question. Please choose a response that best corresponds to your opinion about each of the following statements by circling the appropriate number (6 = strongly agree, 5 = moderately agree, 4 = somewhat agree, 3 = somewhat disagree, 2 = moderately disagree, 1= strongly disagree):

	Response				
	Strongly Agree	Moderately Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
A1. I have integrated into the health workforce culture of this hospital well.	6	5	4	3	2 1

	Response				
	Strongly Agree	Moderately Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
A2. I understand clearly what my roles and responsibilities are in this hospital.	6	5	4	3	1
A3. The atmosphere in this hospital is friendly and supportive.	6	5	4	3	1
A4. The culture of this hospital is all about caring for patients.	6	5	4	3	1
A5. I feel more highly skilled than other non-medical health professionals who work here.	6	5	4	3	1
A6. I understand the culture of including patients, families and/or carers in the planning of treatment and the management of care.	6	5	4	3	1

	Response				
	Strongly Agree	Moderately Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
B1. Interaction with patients requires understanding and trust.	6	5	4	3	1
B2. Communication skills are essential for doctors to practise effectively	6	5	4	3	1
B3. In this country, good communication skills require English language proficiency.	6	5	4	3	1
B4. Non-verbal communication is an important aspect of communicating with patients and colleagues.	6	5	4	3	1
B5. My own values have an effect on the way I communicate with patients.	6	5	4	3	1

	Response				
	Strongly Agree	Moderately Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
B6. Interacting with other health professionals is important in my role as a doctor.	6	5	4	3	1
C1. I have a good understanding of the roles of other health professionals.	6	5	4	3	1
C2. The complexity of health care delivery requires greater emphasis on collaborative practice.	6	5	4	3	1
C3. I find it difficult to write discharge summaries.	6	5	4	3	1
C4. I see patients and families/carers as part of the health care team	6	5	4	3	1

	Response				
	Strongly Agree	Moderately Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
C5. Doctors are the most important members of the health care team.	6	5	4	3	1
C6. Respect is shown between health professionals here.	6	5	4	3	1
C7. I often seek advice about clinical matters from other non-medical health professionals.	6	5	4	3	1
C8. Focusing on patients' needs can assist in creating a feeling of collegiality and satisfaction amongst health professionals.	6	5	4	3	1
C9. Collaborative effort is important in the delivery of health care because most people who seek medical care interact with more than	6	5	4	3	1

	Response				
	Strongly Agree	Moderately Agree	Somewhat Agree	Somewhat Disagree	Strongly Disagree
one health professional.					
D1. I am confident of my clinical competence most of the time.	6	5	4	3	1
D2. If I am unsure about a patient's condition, I consult with a senior clinician.	6	5	4	3	1
D3. My technical competencies are not as good as I would like them to be.	6	5	4	3	1
D4. My level of competency as a clinician has increased through working with other non-medical health professionals.	6	5	4	3	1

D5. I try to attend Grand Rounds on a regular basis.	6	5	4	3	2	1
D6. The safety of patients and the quality of their care underlies all that I strive to achieve as a clinician.	6	5	4	3	2	1
D7. A collaborative approach to patient care improves the quality of care and reduces the risk of errors.	6	5	4	3	2	1
D8. I am mindful of my professional conduct and duty of care to patients.	6	5	4	3	2	1
D9. I am aware of my legal responsibilities as a medical practitioner.	6	5	4	3	2	1

Please add any comments you would like to make here. Thank you for taking the time to complete this questionnaire.

APPENDIX 3: Participant information and consent forms



Approval No 09211

THE UNIVERSITY OF NEW SOUTH WALES

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM

International medical graduates and their inter-professional learning orientation: pitfalls and barriers to enabling inter-professional practice and quality and safety in the delivery of health care.

You are invited to participate in a research project that aims to investigate the inter-professional practice of medical graduates. Local medical graduates and international medical graduates will be invited to participate. The research seeks to explore how medical graduates have learnt about working with other professionals and how they practice together on-a day-to-day basis in a busy and complex environment. Quality and safety in patient care and health service delivery are important aspects of the research, which will be conducted in three Sydney teaching hospitals. If you decide to participate, you will be interviewed and then asked to complete a short survey. At a later stage, some non-participant observation studies will be conducted which will not directly

involve you. As part of the interviewing process you may be asked for your consent to being audio-taped. The tapes will be examined for the purposes of assessing input generally, not for any one specific person's responses. While no risks are seen in your participation, you may feel uncomfortable answering interview questions, discussing issues we raise, or being observed.

Any information that is obtained in connection with this study will remain confidential and will be disclosed only with your permission, except as required by law. Results of this study will be written up as a doctoral thesis and may be published in peer-reviewed journals and monographs and reports, and via media interviews, public lectures, presentations at conferences, scientific meetings, study sites and documented summaries. Findings may be introduced at workshops and symposia for the benefit of practitioners, policymakers and researchers. In any publication or presentation, information will be provided in such a way that you cannot be identified. A plain language summary of the research results will be made available to interested research participants.

It cannot be guaranteed or promised that you will receive any benefits from this study. No fees are provided for your participation. No costs to you are envisaged as a result of your participation. If you incur travel expenses to participate in the study you will be reimbursed. You will need to provide documentation to support your claim.

Complaints may be directed to the Ethics Secretariat, The University of New South Wales, SYDNEY 2052 AUSTRALIA (phone 9385 4234, fax 9385 6648, email ethics.sec@unsw.edu.au). Any complaint you make will be investigated promptly and you will be informed of the outcome.

Your decision whether or not to participate will not prejudice your future relations with the University of New South Wales and participating organisations. If you decide to participate, you are free to withdraw your consent and to discontinue participation at any time without prejudice.

If you have any questions, please feel free to ask us. If you have any additional questions later, Professor Jeffrey Braithwaite, Director, Centre for Clinical Governance Research, Australian Institute of Health Innovation, telephone, (02)93852590, j.braithwaite@unsw.edu.au will be happy to answer them.

This study has been approved by St Vincent's Hospital HREC. Any person with concerns or complaints about the conduct of this study should contact the Research Office who is nominated to receive complaints from research participants. You should contact them on 02 8382 2075.

The conduct of this study at St.Vincent's Hospital has been authorised by the University of New South Wales. Any person with concerns or complaints about the conduct of this study may also contact Julie Charlton, Research Governance Officer, on 02 8382 2772 and quote reference number HREC/09/SVH/137.

You will be given a copy of this form to keep.



THE UNIVERSITY OF NEW SOUTH WALES

PARTICIPANT INFORMATION STATEMENT AND CONSENT FORM
(continued)

**International medical graduates and their inter-professional learning orientation:
pitfalls and barriers to enabling inter-professional practice and quality and safety
in the delivery of health care.**

**You are making a decision whether or not to participate. Your signature indicates that, having
read the information provided above, you have decided to participate.**

Signature of Research Participant: _____ Signature of Witness: _____

(Please PRINT name) _____ (Please PRINT name) _____

Date: _____ Nature of Witness: _____

APPENDIX 4: Revocation of consent form



REVOCATION OF CONSENT

International medical graduates and their inter-professional learning orientation: pitfalls and barriers to enabling interprofessional practice and quality and safety in the delivery of health care.

I hereby wish to **WITHDRAW** my consent to participate in the research proposal described above and understand that such withdrawal **WILL NOT** jeopardise any treatment or my relationship with The University of New South Wales or other participating organisation[s] or professional groups.

Signature: _____

Date: _____

Please PRINT Name: _____

The section for Revocation of Consent should be forwarded to:
Professor Jeffrey Braithwaite,
Director, Centre for Clinical Governance Research
Australian Institute of Health Innovation
Faculty of Medicine
The University of New South Wales
Kensington, NSW 2052.

APPENDIX 5: Approval for access to unit



THE UNIVERSITY OF NEW SOUTH WALES

APPROVAL FOR ACCESS TO UNIT

UNIT :

NUM:

PhD Research Title: International medical graduates and their inter-professional learning orientation: pitfalls and barriers to enabling inter-professional practice and quality and safety in the delivery of health care.

I am conducting a research project that aims to investigate the inter-professional practice of medical graduates and local medical graduates. Part of this research involves non-participant observation of doctors working in your ward/area. The research seeks to explore how medical graduates have learnt about working with other professionals and how they practice together on-a day-today basis in a busy and complex environment. Quality and safety in patient care and health service delivery are important aspects of the research, which will be conducted in three Sydney teaching hospitals.

I seek your approval to conduct this part of the research in your ward.

Jacqueline Milne

PhD candidate

Centre for Clinical Governance Research

Australian Institute of Health Innovation

Faculty of Medicine

The University of New South Wales, NSW 2052.

Your signature indicates that you have agreed to this research being conducted in your ward.

.....

Signature of NUM

(Please PRINT name)

Date

If you have any questions, please feel free to ask us. If you have any additional questions later, my supervisor Professor Jeffrey Braithwaite, Director, Centre for Clinical Governance Research, Australian Institute of Health Innovation, telephone, (02)93852590, j.braithwaite@unsw.edu.au will be happy to answer them.

Complaints may be directed to the Ethics Secretariat, The University of New South Wales, SYDNEY 2052 AUSTRALIA (phone 9385 4234, fax 9385 6648, email ethics.sec@unsw.edu.au). Any complaint you make will be investigated promptly and you will be informed of the outcome.

This study has been approved by St Vincent's Hospital HREC. Any person with concerns or complaints about the conduct of this study should contact the Research Office on 02 8382 2075.

APPENDIX 6



THE UNIVERSITY OF
NEW SOUTH WALES

Doctor profile form

Interviewer:	Date: Time:
Gender of doctor:	Male: <input type="checkbox"/> Female: <input type="checkbox"/>
Country of birth:	
First and other languages	First: Other:
Country of medical training:	
Years of medical training:	
Completion date of medical training:	
Country where medical degree awarded	
Number of years in medical practice since graduating:	
Postgraduate qualifications:	
Specialisations:	

Number of years practising as a specialist:	
Country worked in as a specialist::	
Number of years in Australia before registration to work in a hospital:	
Types of Australian hospitals worked in:	Teaching: <input type="checkbox"/> Other: <input type="checkbox"/>
Length of time working in this hospital:	
Current position title:	
Current rotation:	