Experiences of non-UK-qualified doctors working within the UK regulatory framework: a qualitative study

A Slowther[1] • GA Lewando Hundt[2] • J Purkis[1] • R Taylor[1]

[1]Warwick Medical School, University of Warwick, Coventry CV4 7AL, UK

[2]Hundt School of Health and Social Studies, University of Warwick, Coventry, UK

Correspondence to: A Slowther. Email: a-m.slowther@warwick.ac.uk

DECLARATIONS

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Guarantor
AS

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AS designed and led the study, contributed to the analysis and wrote the first draft of the paper; GH

Summary

Objective To explore the experience of non-UK-qualified doctors in working within the regulatory framework of the General Medical Council (GMC) document *Good Medical Practice*.

Design Individual interviews and focus groups.

Setting United Kingdom.

Participants Non-UK-qualified doctors who had registered with the GMC between 1 April 2006 and 31 March 2008, doctors attending training/induction programmes for non-UK-qualified doctors, and key informants involved in training and support for non-UK-qualified doctors.

Main outcome measures Themes identified from analysis of interview and focus group transcripts.

Results Information and support for non-UK qualified doctors who apply to register to work in the UK has little reference to the ethical and professional standards required of doctors working in the UK. Recognition of the ethical, legal and cultural context of UK healthcare occurs once doctors are working in practice. Non-UK qualified doctors reported clear differences in the ethical and legal framework for practising medicine between the UK and their country of qualification, particularly in the model of the doctor–patient relationship. The degree of support for non-UK-qualified doctors in dealing with ethical concerns is related to the type of post they work in. European doctors describe similar difficulties with working in an unfamiliar regulatory framework to their non-European colleagues.

Conclusions Non-UK-qualified doctors experience a number of difficulties related to practising within a different ethical and professional regulatory framework. Provision of information and educational resources before registration, together with in-practice support would help to develop a more effective understanding of GMP and its implications for practice in the UK.

contributed to the study design and analysis, and revised later drafts of the paper; JP conducted data collection, contributed to the qualitative data analysis, and revised later drafts of the paper; RT conducted data collection, analysed the quantitative data, contributed to qualitative data analysis, and revised later drafts of the paper

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Introduction

Two reports released in February 2011, one from the House of Commons Health Committee and one from the National Clinical Assessment Service (NCAS) highlighted concerns about the professional practice and regulation of doctors qualified outside the UK.[1,2] The NCAS report indicated that non-UK-qualified doctors have higher rates of referral to NCAS for both assessment and for exclusion and suspension from work compared to UK qualifiers. Exclusions/suspensions from hospital and community practice are higher among doctors from elsewhere in the European Economic Area (EAA) compared to doctors qualifying outside the EEA.

The UK has a long tradition of international medical graduates working in its healthcare system. In 2009 36% of all doctors and 63% of non-consultant non-training-grade doctors had qualified in a country other than the UK (10% in an EEA country).[3] Since February 2008 non-EEA international medical graduates (IMGs) cannot apply for specialist training programmes but are still eligible to apply for non-training posts. There are no immigration restrictions on EEA medical graduates working in the UK health system. All doctors who work in the UK must comply with the standards set out in the General Medical Council (GMC) guidance *Good Medical Practice* (*GMP*).[4] Lack of awareness or understanding of these standards by a doctor may have adverse consequences for the doctor but it may also mean that patients receive care that is below the standard that they can and should expect.

There is evidence that ethical decision-making in medical practice varies across different jurisdictions and cultures, particularly on issues such as the role of the family, end-of-life decision-making, and consent/information sharing.[5–10] Social context, including organization of the healthcare system, influences the identification and experience of ethical dilemmas faced by clinicians.[11–13] Given the lack of restrictions on EEA doctors coming to the UK compared to non-EEA doctors, any variation of approach within Europe is of particular interest. Italian doctors appear to be much less certain about disclosing a diagnosis to a patient than doctors in UK, Norway and Switzerland.[13] A study of French and American perspectives on advance directives, found that if there was a dispute between the family and the patient wishes, the French physicians would be more likely to comply with family wishes.[14] Russian doctors were more likely than their Swedish and German counterparts to resuscitate against the patient's wishes in a hypothetical situation and reported less difficulty in decision-making.[15]

Studies reporting the experiences of international medical graduates (IMGs) integrating into different cultures identify a range of themes including lack of knowledge of healthcare systems and regulatory frameworks in the new country,[16–18] difficulties in communication,[19,20] differences in cultural perspectives on family life[21] and concepts of disease,[22] different approaches to teaching and learning,[20] and different models of the doctor–patient relationship.[21] In view of the reliance of the UK health system on large numbers of non-UK-qualified doctors it is important to consider the possible impact of these findings in the UK. In 2008 the UK GMC commissioned us to do a study of the experiences of doctors who had qualified outside the UK in their transition to working within the ethical and regulatory framework of GMP. In this paper we describe the study and report its key findings. The full report is available on the GMC website.[23]

Methods

The data presented here are part of a larger study which included a questionnaire survey of UK and non-UK-qualified doctors. Within this larger study we used individual interviews to explore in depth the lived experiences of non-UK-qualified doctors and focus groups to draw on group interactions and shared experiences. Free text responses from the survey were also included in the analysis. The main study has been reported elsewhere.[23]

Sampling and data collection

We used the GMC database to identify UK and non-UK qualifiers who had registered with the GMC for the first time between 1 April 2006 and 31 March 2008. We sent an electronic and postal questionnaire to a random sample of up to 500

doctors from each country of qualification. The survey included questions on ethical dilemmas the respondent had faced, with an opportunity to make free-text comments, and invited non-UK-qualified respondents to indicate interest in taking part in the interview study. Since questionnaire respondents might not be representative of the group as a whole we approached a fresh random sample of up to 25 doctors from each non-UK country (a total of 235 from 10 countries, five EEA and five non-EEA) inviting them just to take part in the interview study.

Those who expressed an interest were contacted by a researcher (JP or RT) to obtain consent and arrange an individual interview. We also conducted two focus groups. One group included doctors attending a training programme that prepared doctors for the Professional and Linguistics Assessment Board (PLAB) test which most non-EEA IMGs are required to pass as a prerequisite to registration by the GMC. The other group included recently GMC-registered refugee doctors on a training programme linked to clinical attachments. Finally we conducted in-depth interviews with purposively selected key informants to obtain a range of perspectives from professional organizations, NHS Deaneries, providers of education and support for overseas doctors, and the GMC. Interviews were conducted either face-to-face or by telephone depending on the participant's preference. Interviews were conducted until data saturation was reached.

Topic guides were developed for the interviews and focus groups based on available literature. The interviews with recent registrants began with open questions inviting discussion of situations where they experienced a difficult decision, a conflict of views, or a feeling of discomfort in relation to a particular case. Specific questions regarding consent, decisions about end-of-life care, confidentiality, and dealing with concerns about poor practice were asked if these issues had not arisen in the open interview. We explored how doctors identified ethical issues, resolved dilemmas, and what support mechanisms they used. Focus groups also explored doctors' views on the training provided for non-UK qualifiers particularly in relation to professional regulation and ethical standards. Key informant interviews explored perceptions of information, training, and support provided for non-UK-qualified doctors.

Interviews and focus groups were recorded with participants' consent and the transcripts were analysed using NVIVO 7 software. We used the free-text responses from the survey to supplement these data. We conducted collaborative data analysis with all authors reading the same interview transcripts independently to identify emergent themes in order to increase inter-rater reliability.[24,25] The team agreed a set of descriptive categories and transcripts were then coded by JP and RT against these categories. Through further team discussions a set of merged themes was developed that were grounded in the data. Triangulation was achieved using data from three separate sources and two different methods (interview and focus group).

Results

The survey response rate was extremely low, 109/1373 (8%) for the postal survey and 28/3911 (0.7%) for the electronic version and we have not considered the quantitative data in this paper. We interviewed 26 doctors from 14 countries (15 men, 11 women) (Table 1) from a range of specialties (Table 2). Year of qualification ranged from 1978 to 2004 with the majority (15) qualifying since 2000. We included free-text comments from the 90 non-UK qualifier questionnaire respondents who provided them. Responders were from a range of countries (Table 3). Gender

Table 1
Doctor interviewees country of qualification ($n = 26$)

Country of qualification	*n*
Pakistan	5
Nigeria	5
India	3
Italy	2
Greece	2
South Africa	1
Hungary	1
Iran	1
Poland	1
Egypt	1
Russia	1
Spain	1
Germany	1
United States	1

Table 2
Doctor interviews specialty ($n = 26$)

Specialty (current post)	*n*
Acute medicine	5
Anaesthetics	1
Cardiothoracic surgery	1
General surgery	1
General practice	3
GU medicine	1
Obstetrics and gynaecology	2
Oncology	4
Orthopaedics	1
Paediatrics	1
Public health	2
Psychiatry	2
Urology	2

distribution for the questionnaire survey was 47 men, 43 women, and year of qualification ranged from 1968 to 2007. The two focus groups also had representation from a range of countries, all non-European (Table 4).

The ethical dilemmas identified by participants were categorized under the broad headings of end-of-life decision-making; capacity, consent and refusal of treatment; confidentiality; family involvement in decision-making; and relationships with colleagues. These categories are addressed in GMC guidance and undergraduate medical teaching in the UK. The kind of ethical issues identified and experienced by the non-UK-qualified doctors in our study were not very different from what we would expect any doctor working in the UK to be faced with. What was different was their experience of engaging with these issues within a different professional, legal and social context and three main themes emerged.

Table 3
Non-UK qualifier who provided free text survey responses

Country ($n = 90$)	*n*
Dubai	1
Argentina	1
Australia	1
Egypt	3
Germany	9
Greece	8
Hungary	1
India	8
Italy	9
Nigeria	17
Pakistan	10
Poland	9
Russia	2
South Africa	5
Slovakia	1
Spain	3
Ukraine	1
USA	2

Table 4
Focus groups country of qualification ($n = 12$)

Country of training	*n*
Bangladesh	2
Afghanistan	2
Romania	1
Nigeria	1
Somalia	1
China	1
Iraq	1
Pakistan	1
Madagascar	1
Iran	1

Working in an unfamiliar world

A common view was that in the UK, processes and policies were often perceived as legally based, and much more explicit and prescriptive than in the countries in which the doctors had qualified. However there was a lack of clarity about access to and relevance of guidance.

> *'Well, the GMC referred me to some general, not specifically for ethical things, just general aspects of good standards within the GMC and to the website, and sent me some information.'* D14 (Middle East)

For some the focus on patient autonomy and rights in the UK contrasted sharply with their experience of a more paternalistic system.

> *'The way that medicine is practised in my country is far different from that in the UK and the way the*

people are asking questions and how they know their rights is far more different… In "my country" the doctor is a kind of king who can do everything that he wants to, so there were no actual dilemmas because I was brought up in a way that whatever was decided was the right thing.' I11 (Europe)

This difference was a source of anxiety in situations where doctors had received little information or training in UK legal and professional frameworks prior to working in this country.

'When you come here you definitely see the difference, it's different laws, different approach to the patient, different approach to the visitors… and because the law is different and I am not familiar with it, I find this difficult… it makes you more aware and a bit scared not to do any stupid things as you could endanger your working future.' FG1

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

'When I first started I realized that I had to explain every single detail to the patient about the decision about what I am going to do something but, I didn't have to do it in such an extent there [country of qualification].' I6 (Europe)

Approaches to and understanding of patient autonomy are also important in determining how clinicians involve patients' families in information sharing and decision-making. Many of our interviewees came from cultures where sharing information with the patient's family is considered normal practice and were surprised by the different approach taken in the UK.

'Back home there is an entirely different situation. In my country if the patient is diagnosed with ovarian cancer we will never go and tell the patient that you have ovarian cancer. We would tell the relative. Here the practice is entirely different, you would tell the patient.' FG2

Working in an unfamiliar cultural and professional context makes it difficult to identify potential ethical difficulties and responds to them. As one key informant involved in training and support commented:

'When things go wrong for our doctors it's not like they give the wrong drug or whatever, it's usually an approach to a patient or dealing with an ethical issue, and they don't see the warning signals when things are starting to go wrong.' K1

Communication difficulties

One key factor identified by participants as creating a sense of isolation among non-UK-qualified doctors was difficulty in communication at a number of different levels. Although some noted problems with language it was often other aspects of communication that created difficulties including failure to recognize or misinterpretation of non-verbal clues such as facial expression or body language, or more subtle issues relating to cultural expectations of social behaviour. Non-EEA doctors are required to pass the International English Language Test (IELT) and PLAB before registration to ensure a minimum standard of English to facilitate appropriate practice. However interviewees identified a range of difficulties in communication which included misunderstandings about the use of eye contact, tone of voice, facial expressions and gestures, none of which would be picked up in a standard English language test.

'In our country it's a natural response to establish eye contact and talk… I was told by one of our family… they never look at anybody like this… so I think I had to change myself… The other thing is tone… there is something to do with the tone I think that almost makes it sound like one is arrogant.' I9 (South Asia)

Sources of support in practice

Most interviewees felt that they were under-prepared for the realities of clinical practice but

those that had attended induction or training courses thought this had helped them. Having the security of an identified training post with both managerial and clinical lines of support was highly valued. Individuals in this position were more confident in dealing with ethical difficulties.

> *'I think that the biggest impact was my first manager, well first line manager, and I suppose while I was doing my training I think she was really the best in following ethical issues so I think she taught me a lot.'* I1 (Europe)

Conversely the absence of this kind of supportive framework led to a situation where many of these doctors felt marginalized and at risk. One participant, now in a training post and receiving excellent support, referred to prior experiences which had occurred outside of a training position as 'bullying':

> *'Just coming into the UK most people don't come into training posts so there is actually no-one looking after you. You know I am not even sure if I really had a line manager or anyone looking after me while I was in cardiac surgery… at one stage I considered contacting the Medical Protection Society.'* I4 (Africa)

Key informants involved in training and support for non-UK qualifiers recognized the stress and isolation of these doctors and suggested mentorship or supervised placements during the transition period.

Concerns about adequate preparation and support were expressed by most interviewees whether from a country within the EEA or not. Some European doctors wondered whether a preregistration assessment should be required for them, in view of their different training backgrounds.

> *'I think… doctors from the EU aren't trained in the same way – at least about ethical issues. I don't know if we may have to take part in some mini exams or something just to challenge us and to test us.'* I6 (Europe)

Discussion

Doctors who move from their country of training to work in a different social and professional environment face personal and professional challenges. Countries like the UK that rely on international medical graduates to make up a substantial proportion of their medical workforce also face challenges in ensuring that the IMGs are able to deliver the same standard and type of care that is expected of home trained graduates. Assessment of fluency in English and basic clinical competence should be relatively easy to implement subject to international agreement in the case of countries within the EEA. However training and experience in the legal, professional and social context in which healthcare occurs will be very different between countries simply because they are different countries with different cultures and regulatory systems. These are also the more difficult areas of clinical practice to assess. Our findings suggest that these doctors are well aware of the range of ethical issues that are considered important in UK medical practice but are surprised and sometimes confused by the range and specificity of regulation, and by the degree of emphasis on individual patient autonomy and its implications for practice.

The main source of information for these doctors is the copy of *GMP* that they receive on registration. However this is not always either read or understood and can be seen as difficult to interpret in practice. This difficulty is not unique to non-UK-qualified doctors. A study of UK doctors in 1999 found that although a majority were aware of *GMP* only 4% stated that they knew its contents well and 23% had read it 'fairly carefully'.[26] Although both UK and non-UK qualifiers may share an unfamiliarity with the document, the training of UK qualifiers will have been framed explicitly and implicitly by its underlying principles and hence their practice is more likely to reflect *GMP* than a doctor who has been trained in a different system.

A theoretical knowledge of the elements of *GMP* does not necessarily result in its appropriate application in practice. A study of UK medical graduates identified a lack of knowledge in nonclinical areas such as ethics and law on commencing Foundation posts.[27] If UK qualifiers require in-practice training and support in ethical

decision-making on commencing clinical practice it is likely that non-UK qualifiers will have similar needs.

Our data suggest that non-UK-qualified doctors have difficulties with communication on entering practice in the UK ranging from poor understanding of English to more subtle misunderstandings of the nuances of non-verbal communication and social and behavioural norms. The multicultural nature of UK society requires all doctors to adapt and respond to several different communication styles and this may be an added challenge for doctors who were also trained in a different culture. In 2010 11.5% (7.058/61.248 million) of UK residents were born outside the UK with 4.796 million being from non-EU countries.[28] UK undergraduate medical training includes specific training in communication skills and there is now increased public expectation of competence in communication in addition to clinical competence.[29,30] Non-UK-qualified doctors who are required to pass PLAB prior to registration will have some assessment of their communication skills in a UK healthcare context but this will be limited and EEA doctors are not required to demonstrate any proficiency in communication prior to registration.

Training posts provide an environment of supported learning and senior clinicians are expected to provide mentorship to trainees. Participants who were in training posts praised senior colleagues who provided advice in ethically difficult situations. In contrast non-training posts are often short-term with no identified line manager and an expectation that the doctor should be able to cope on his or her own. The lack of an established peer network for non-UK-qualified doctors particularly in the initial stages of employment increases the isolation experienced by many in an unsupported clinical environment. In view of the large number of non-UK-qualified doctors in non-training posts and the reduction in opportunities for training posts for these doctors, the question of support in these posts is a pressing one.

Limitations of the study

The poor response to the survey meant that we were unable to obtain quantitative generalizable data. The sensitivity of the subject area and the GMC as study funder and source of contact details may have contributed to the reluctance of doctors to respond. An improved response rate may have been achieved by using other sources for recruitment such as post graduate Deaneries or Foundation Schools (a study of UK and non-UK medical graduates exploring more general issues of transition to UK practice recruited 66 interview participants[31]). However this method is only likely to identify doctors in training posts. Within the qualitative study the number of participants from any individual country is small (in 9/14 countries represented there was only one interviewee). While it is clearly impossible to generalize from a small qualitative study our data provide a range of perspectives from doctors coming from both European and non-European cultures. There is a risk of participant bias in the interview study as only those doctors who were prepared to discuss these issues would have volunteered to take part. It is possible that the participants were more likely than their non-participant colleagues to have experienced difficulties in adjusting to the regulatory framework in the UK and so felt they had something to say. However it is also possible that doctors facing great difficulties in adapting to UK professional practice would be less likely to participate because of a concern that by articulating this they would jeopardise their future career. Notwithstanding possible concerns about the representativeness of our sample they have generated a rich data-set whose analysis can substantially advance our thinking in this difficult area.

Conclusion

We identified a number of difficulties experienced by non-UK-qualified doctors in their transition to practise within the UK ethical and professional regulatory framework including lack of relevant information prior to registration, variable levels of training and support, and isolation in non-training posts. Non-UK qualifiers are presented with the regulatory framework of GMP and supporting guidance but lack the tacit knowledge of the cultural context in which the guidance was developed. Provision of specific information and educational resources prior to registration, accompanied by in practice support would help to facilitate a more effective understanding of

GMP and its implications for practice in the UK. Our findings reinforce the NCAS recommendation that there should be 'stronger induction and support for doctors working for the NHS after qualifying outside the UK' (NCAS page 2 02/11).[2]

Our findings suggest that doctors from EEA countries experience similar difficulties in this regard to those qualifying outside the EEA. This has implications for the GMC's role in registering doctors to practise in the UK. If the standard expected of doctors registered with the GMC is that of GMP there is a question of how doctors applying for registration with the GMC demonstrate that they meet this standard. This will be the case for all doctors registering with the GMC but particularly so for those doctors who have not been trained within this professional regulatory framework.

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