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# International Medical Graduates (IMGs) in the UK—a Systematic Review of Their Acculturation and Adaptation

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**Abstract** International medical graduates (IMGs) constitute about 23–28 % of the medical workforce providing support and contribution to the UK, Canada, USA and Australia. This review will inform the need for trainers, deaneries and colleges to plan and develop strategies to enhance the potential of IMGs. The authors aim to review and

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inform the relevant authorities about the barriers faced by IMGs in training and career progression in the UK health service. Two hundred forty-eight studies were reviewed at step 1; 54 were excluded on the basis of selection criteria, and further 115 studies were excluded which did not focus on issues discussed in the selection criteria; and after reviewing 79 studies, a further 20 were excluded for methodological qualities, and finally, 59 were included. The results have been discussed under various themes which emerged as significant issues related to IMGs. Seeking better life and higher education and training are the main reasons for migration. The training process of IMGs in their own countries impacts on the transition process results in struggling career progression. The most crucial impediment in the path of career progression is the process of passing examinations which IMGs face during their career struggle. The psychological aspects of migration and legal and ethical issues are found to be significant for IMGs. They also struggle with the adaptations needed with reference to learning and teaching styles resulting in the change of multiple specialties. IMGs contributed significantly to not only filling the space of under-recruitment but also serving comprehensively in a variety of specialties. There has been a consistent decline in preferring some specialties as career option among UK medical graduates and medical students. IMGs migrate to foreign countries in pursuit of better medical education, desire for better income, general security and improved prospects for the family, but in doing so, they are confronted with psychosocial problems, cultural differences, hurdles in career progression and passing exams.

**Keywords** International medical graduates · IMGs · Migrant doctors · Acculturation · Adaptation · Training issues of IMGs

## Introduction

The British Broadcasting Corporation (Buchanan 2010) reported that shortage of junior doctors to start work in hospitals forced the National Health Service (NHS) to try recruiting doctors from India. In the year 2000, the BBC had reported similar headlines that the government was to recruit foreign doctors to help solve the staffing crisis in the NHS (BBC 2000). Daily Mail-Online reported in 2007 that hundreds of medical graduates are unemployed in the UK because many posts go to overseas doctors (Martin 2007). Recruiting into some of the specialties like psychiatry has been an issue for quite some time in the UK; a study (Goodyear et al. 2007) undertaken in West Midlands among Foundation year 1 and 2 doctors (FY1 and FY2) found that only 0.8 % of doctors aspire to take public health as a career option, followed by pathology (1.2 %) and psychiatry (1.6 %). Goodyear (2009) also reported that a lower trend is observed among UK medical graduates to opt for paediatrics as career choice; Turner et al. (2007) state that 7.2 % of doctors in the UK selected paediatrics since 1993 as career option but another survey (BMA 2009) suggested that this dropped to 5.5 %. Turner et al. (2007) also suggested that only 44 % of those who actually joined paediatrics would be working in this specialty after 10 years.

International medical graduates (IMGs) constitute about 23–28 % of the workforce providing immense support and contribution to the United Kingdom (UK), Canada, United States of America (USA), and Australia (Mullan 2005; Buske 2002). In the UK,

IMGs enjoy a successful profession making up to 30 % of the medical workforce (Sandhu 2005); another report suggests that IMGs constitute 48 % of the total workforce (The Information Centre for Health and Social Care 2008). Research has been done to look into the competencies, qualifications, demographic profile, distribution of workforce in various specialties and training experience of IMGs (Boulet et al. 2006; Crutcher et al. 2002; Wong and Lohfeld 2008). A more comprehensive approach is needed to include all pertinent issues related to IMGs and the challenges they encounter.

## Aims

The aim of this paper is to review the personal, professional and training challenges encountered by IMGs in the UK health service. The main objective of this article is to study the hurdles faced by IMGs in career progression and attaining competencies and training in the UK, which will have impact on acculturation (keeping their own home culture but also adapting and accepting a new culture) and assimilation (replacing own home culture with a new culture) in the society.

The secondary objectives include problems encountered in college examinations, training in homeland, adaptation to learning and teaching styles, psychosocial issues faced post-migration, changing of specialties, political issues and migration laws. For purpose of this review, the term international medical graduate 'IMG' will be used to denote 'overseas doctor' and 'migrant doctor'.

## Method

### Selection Criteria

1. Included reports, reviews, original research, surveys and news articles, from within and outside the UK.
2. Full articles were included; abstracts where full articles could not be traced or obtained from the authors were excluded.
3. Articles focusing on learning and teaching styles, Royal College examinations, immigration and recruitment of doctors, medical education, competencies and training of doctors were included.

### Inclusion of Studies: QUOROM Flow Chart

The literature was searched using Internet search engines like the NHS library to look for literature available on the topic of IMGs. Allied and Complementary Medicine (AMED), British Nursing Index (BNI), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Excerpta Medica Database (EMBASE), Health Business Elite, Health Management Information Consortium (HMIC), PubMed and PsychINFO were searched for relevant studies. The authors presume that the evidence to achieve the objectives of this review will come from a broad-based search of literature

not only involving NHS but other library search engines. The Staffordshire University-based research database was also searched for relevant articles using a standardized search filter. Studies were not excluded on the basis of the origin of the research and a number of international studies were included which also added to the literature support for IMGs in their country of origin and the struggle faced on migration.

Manual search was also conducted for extended literature at step 1 (see the QUORUM flow chart—Fig. 1) of the review, and contact was made with the authors of the studies to get full articles where full text was not available. Two hundred forty-eight studies were reviewed at step 1, 54 were excluded on the basis of the first and second selection criteria, a further 112 studies were excluded which were not focused

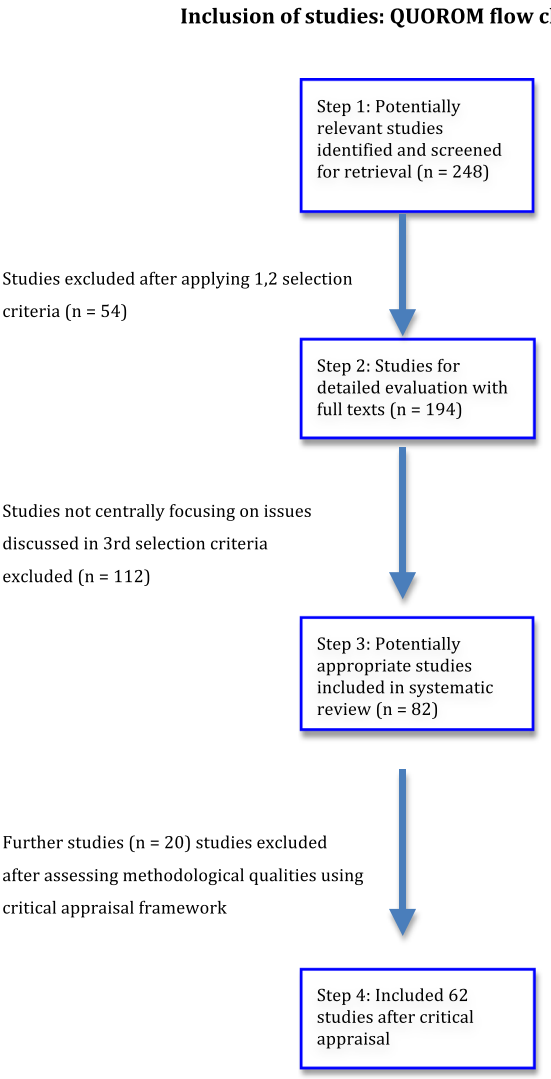


**Fig. 1** QUOROM flow chart

on the issues discussed in the third selection criteria, and after reviewing 82 studies further for methodological qualities, 62 were included in the review. Two independent reviewers assisted the selection method at steps 2 and 3 to examine the quality of the research methodology and central focus of studies. The 'grey literature' including non-refereed publications, conference proceedings, statistical and department reports were also searched for inclusion in the review. As most of the research in this type of subject is based on qualitative studies, surveys and reports, the results are discussed after meta-synthesis of all relevant studies included in the review.

## Results

### Reasons for Migration by IMGs to Other Countries

Migration of doctors revolves around the reasons of better structure of medical education, desire for better income, general security and improved prospects for the family (Astor et al. 2005). Feedback from recruited IMGs in the UK shows that they value the opportunity to work in a different health system, acquire new skills, get wider work experience, pursue research interests and develop their teaching skills (Gadit 2008).

A review from the USA (Singhal and Ramakrishnan 2004) suggested that IMGs could take a few months to build up their interpersonal skills in the office and hospital settings, which will help them acclimatize in the new environment when they arrive in a foreign country. Despite having good knowledge of written and spoken English, IMGs face difficulty in understanding local words, colloquial terms and different accents; this makes communication with patients and families difficult leading to problems in working with the teams and multidisciplinary work atmosphere. Owing to different socio-cultural background, IMGs are faced with difficulty in judging the social and educational background of families and in asking parents and patients about their family structure, paternity and sexual history (Mahajan and Stark 2007).

### Training of IMGs in Their Country of Origin

The World Federation for Medical Education (WFME) conducted the Edinburgh Declaration in 1998 to implement 'International Collaborative Program for the Reorientation of Medical Education'. According to this declaration (The Edinburgh Declaration 1988), the aim of medical education is to produce doctors who will promote the health of all people. The declaration specifies that a doctor should acquire the skills to be 'an attentive listener, a careful observer, a sensitive communicator and an effective clinician'.

The training in most of the medical schools in Asia and Africa has been traditional hospital-based, didactic, pedagogic and teacher-centered with only a few exceptions: the teacher is the main source of information resulting in passive learning from students. Compared to other parts of the world, in India, teaching is less evidence-based with fewer experiments and educational innovation (Majumder et al. 2004). In comparison with graduates from medical schools in the UK, USA, and some European countries such as the Netherlands, the graduates from the Institutions of Gulf

Cooperation Council countries (Bahrain, Kuwait, Oman, Qatar, Yemen, United Arab Emirates and Saudi Arabia) are seen to be having less satisfactory standards because the curriculum is based on the traditional lecture method, which is a less effective method of teaching (Abdulrahman 2008).

The problems identified with traditional medical education as compared to the problem-based learning (PBL) model are that many medical students try to memorize the learning material and the learning process will be more passive, boring and resists further learning (Camp 1996). The medical education in some middle Eastern countries is noted to have less integration between the basic science course and the clinical learning. It is also noted that the curricula is more inclined towards passive learning, and this coupled with overcrowding and poor facilities in colleges and medical schools has resulted in a less effective learning environment (Tavakol et al. 2006).

The acronym SPICES refers to six main concepts in medical education—student-centered teaching, PBL, an integrated curriculum, community-based teaching, electives with a core, and the use of systematic methods (Harden et al. 1984). It helps in assessing the status of current undergraduate curricula between innovative and traditional curriculum and also encourages self-directed learning from a rigid to a more systematic approach in designing and planning the curriculum (Harden et al. 1984).

In most Indian medical schools, the recruitment is based on performance in premedical entrance examination. Minority groups (ethnic and social), which are underrepresented, are recruited with lower cutoff scores in competitive entrance examinations. The rotating internship year after completing the final medical exams, usually the fifth year, is most of the time used to study and prepare for postgraduate medical entrance examination (Supe and Burdick 2006) which undermines the experience and usefulness of the internship year.

## Psychosocial, Legal, Ethical and Cultural Issues Faced Post-migration

It has been difficult for IMGs to achieve a professional registration, being shortlisted for a job, facing employment regulations and having a smooth career progression (Stewart 2003), which will impact on psychosocial functioning of IMGs. The registration system to the UK for all IMGs who are from non-European Economic Area (EEA) countries depends on the pass or fail in Professional and Linguistic Assessments Board (PLAB) examination. The candidates who appeared for part 1 of the PLAB test raised concerns as the results dropped to a low of 22 % in March 2011 (Jaques 2011). According to the results of PLAB surveys conducted by the General Medical Council (GMC), which polled doctors having passed the PLAB examination, about 60 % could not find any job even after 1 year in 2005; this figure came down to 28 % in 2007 (General Medical Council) probably due to changes in the medical training system brought upon by Modernising Medical Careers (MMC). When IMGs eventually find a medical job, the psychological stress mounts further due to lack of awareness of the ethical, legal and cultural system of a new country. It has been reported that non-UK doctors lack relevant information about legal, ethical and professional standards and guidance prior to registration; the training and support available especially in the area of communication and ethical decision-making is variable and isolation in non-training posts further complicates the situation (Slowther et al. 2009). Data from hearings conducted by GMC found that doctors who qualified outside Britain were twice as likely to face a disciplinary hearing compared to doctors trained in Britain (Humphrey et al. 2011).

Berry (1997) describes diversity in society as one of the spices of life, in addition to providing competitive advantages in international diplomacy and trade. The most important aspect from a social systems perspective is that the cultural diversity enhances society's adaptability: alternative ways of living are available in the social system when attempting to meet changing circumstances, due to changes in a society's ecological, or political, context. IMGs experience discrimination, prejudice and cultural differences (Singh 1994) within the medical profession which has also been reported by the British Medical Association (BMA) in 2003; they suggested that these racial factors hinder progress at all levels of profession (Cooke et al. 2003; Esmail and Everington 1993; Mian 1994).

## Training Issues of IMGs in National Health Service (NHS)

After the changes to training brought upon by the introduction of MMC, subsequent to completing undergraduate training, trainees complete 2 years of foundation training and after that they are eligible to apply for core speciality training which is for 3 years in psychiatry. After attaining Membership of Royal College of Psychiatrists (MRCPsych) by passing exams, trainees progress for advanced psychiatric training to get to Certificate of Completion of Specialist Training (CCT) (General Medical Council 2011; The Royal College of Psychiatrists 2011). In the training process, IMGs have used clinical attachment as an essential step to secure training posts (Malik et al. 2007). The British Medical Association (BMA) defines a clinical attachment as 'a period of time when a doctor is attached to a clinical unit with a named supervisor with the broad aims of gaining an appreciation of the nature of clinical practice in the UK and observing the role of doctors in the NHS (British Medical Association). Recently, it has been much harder for IMGs to secure an approved clinical attachment post as many hospitals and consultants are levying a charge for granting attachments. Moreover, as there will be no accommodation provided by the hospitals, it is more expensive to find a private accommodation whilst working without a pay (Ghanaian Doctors and Dentists Association). Doctors require good communication skills to develop a doctor-patient therapeutic relationship and the point has been reiterated by GMC (2011a, b) that IMGs from outside (EEA) seeking licence to practice must satisfy GMC of their knowledge of English. This is to identify appropriate communication skills and tested by the International English Language Testing System (IELTS) with respect to their speaking, listening, reading and writing abilities. It was highlighted in a survey published in 2009 that trainers perceived the need for additional training for trainees if their language skills were deficient (Hashmi 2009).

Cooke et al. (2003) highlighted in a survey that there is a widely held view within the profession that the problems encountered by trainees from an ethnic minority are due to 'not understanding English culture' (Cooke et al. 2003). A work by Esmail and Everington (1993) found that applications for the same job using Asian and English names, Asian names were significantly less likely to be shortlisted than identical applications with an English name.

A study undertaken in Canada by Wong and Lohfeld (2008) came up with four possible reasons for challenges in training faced by the IMGs; they argued that training entry barriers exist at all levels in the process of application and the most frustrating part was that the authorities would not describe the

methods of selecting somebody. The second theme in the study was the loss of personal identity, belonging, financial autonomy and the ability to fulfill a familial role. The third theme was of confusion over the roles and responsibilities and on how to behave around peers and staff supervisors. Adaptation was the fourth theme and the IMGs would describe it as 'blending with Canadian peers', 'staying out of trouble' and 'staying focused on long term goals' (Wong and Lohfeld 2008).

## Psychiatry as a Career Option in the UK and Elsewhere

A study undertaken in the USA among medical graduates by Feifel et al. (1999) found that psychiatry was a less attractive specialty. New medical students rated psychiatry significantly lower than other specialties with reference to some factors like job satisfaction, financially rewarding, enjoyable work, prestigious, helpful to patients, dealing with an interesting subject matter, intellectually challenging, drawing on all aspects of medical training, based on a reliable scientific foundation, expected to have a bright and interesting future and a rapidly advancing field of understanding and treatment (Feifel et al. 1999). A study by Galeazzi et al. (2003) suggested that efforts should be made to challenge factors that can frustrate and discourage the strong curiosity of medical students like cynicism, prejudice, intellectual stereotypes, early burnout and dehumanizing defensive attitudes, thus allowing the transformation of the intellectual challenge into a direct and hopeful engagement (Galeazzi et al. 2003). Recruiting into psychiatry in the UK has been difficult; Brockington and Mumford (2002) reported that intake into psychiatry had been consistently low at 3.6 %. They discussed about improving the admission criteria in psychiatry, more exposure of medical students to psychiatry and tackling social status and stigma associated with mental disorders. In 2008, psychiatry was the sixth preferred specialty among UK graduate specialty trainees compared to fourth among IMGs (Fazel and Ebmeier 2009). They also reported that psychiatry received the lowest number of applications by UK graduates at 1.1 % compared to surgery, which received the highest numbers at 9.4 %. Brown et al. (2009) suggested that engaging positively with medical students and the medical schools in the recruiting process and also in taking part in shared learning and assessment activities with other specialties will help in recruiting to psychiatry.

## Changing Specialties by IMGs—Opportunity and Struggle

The choice of speciality by IMGs is markedly different compared to that of UK medical graduates; Goodyear et al. (2007) found that medicine was the most popular (45 %) specialty among IMGs of non-European Union (EU) origin compared to UK medical graduates (15 %). General practice was most popular among UK medical graduates (26 %) compared to IMGs (15 %) and a similar trend among UK medical graduates was found in London for general practice (Stern 2005).

IMGs have contributed to the NHS for a long time, but the problem of choosing specialties and available specialties to work in still exists. A study undertaken by the Open University among retired geriatricians who were IMGs in the UK found that between the 1950s and early 1980s, geriatric medicine was known as a 'Cinderella specialty' as it was not highly regarded by UK-trained doctors, and thus, geriatric

medicine offered opportunities for career progression to both the early geriatricians and the South Asian doctors (Bornat et al. 2009).

Although NHS relies considerably on the services of overseas doctors, the vast majority among this group are forced to make difficult career choices in order to achieve security and stability in their professional and personal lives. It was observed by Decker (2001) that of the staff grade and associate specialist (SAS) doctors, two thirds are overseas qualified and nearly all of them have been unsuccessful in obtaining a structured training leading to a consultant post in the UK. The inability to obtain specialist registrar or consultant posts, the desire for permanent post and family situations are some of the reasons for opting an SAS grade (SCOMPE 1994; SCPMDE 1996).

The consultant appointment process is effectively governed by a patronage system, as opposed to one based on competency, and thereby works to the disadvantage of ethnic minority doctors and those who had qualified outside UK (IMGs) (BMA (2005) policy paper). Majority of Pakistani doctors who come to the UK for a specialist postgraduate training end up with SAS grade or return to their country with a sense of failure (Shiwani 2006). However, many IMGs have also chosen to change their faculty rather than compromise their grade that several IMGs with postgraduate qualifications from India have changed their specialty interests just to be able to secure a job and earn a living in the UK. In comparison to their UK qualified counterparts, IMGs operate with greater workload, lesser autonomy and lower levels of morale (Oikelome and Healy 2007). It has been indicated that ethnicity should take into account the country of qualification and not just the ethnic origin because those with overseas qualifications may suffer disproportionately the effects of institutional racism (Oikelome and Healy 2007).

## Adapting to Different Learning Styles by IMGs

One of the important roles of a doctor is educator and this would need constant effort in learning and adapting to the upcoming challenges in the medical fraternity, training, learning cycle and attempting to provide a role model for junior doctors who learn best from their seniors. In the traditional IMG teaching, the teacher is expected to provide students with all the material and information required (Arthur et al. 1979) which would be in contrast to what happens in countries like the UK, USA, Canada and Australia.

IMG's learning styles are primarily teacher-centered and the position of the teacher is held in great esteem; the student is not encouraged to question or challenge the teacher (Sharif 2003; Lassers and Nordan 1975). In Western-style teaching sessions, feedback is often presented through group discussion, but IMGs may find this situation very uncomfortable (Sharif 2003). When IMGs are the target of negative criticism, it can often be perceived as personal and result in 'loss of face' and 'lowered self-esteem' (Bates and Andrew 2001).

It is important for the educational supervisors/trainers to understand the IMG's undergraduate and postgraduate experiences and clearly articulate the expectations for participation, feedback, work ethic and commitment (Bates and Andrew 2001). Differences in perceptions of the role of the teacher and learner need to be explored by discussion about effective ways to learn, including the delivery of feedback (Pilotto et al. 2007).

Different countries utilize diverse teaching methods in schools and universities depending upon the available resources and culturally popular method of teaching. Problem-based learning (PBL) is quite a new phenomenon in India and had been introduced in some medical colleges; a study done by Abraham et al. (2008) suggests that deep and strategic learning was significantly high in medical students studying physiology with partial PBL model compared to non-PBL approach. McParland et al. (2004) studied the effectiveness of PBL compared to traditional learning among medical students and found that the PBL curriculum was more successful than traditional learning. In the same study, it was found that students did not change their preferred learning styles, i.e. surface, deep and strategic learning even though people who received PBL did well in examinations. Students on a PBL curriculum scored better in examination than students on a traditional course, and they suggested a change of traditional to PBL curriculum in psychiatry (McParland et al. 2004).

A systematic review by Koh et al. (2008) highlighted that social and cognitive competencies such as coping with uncertainties and communication skills improve with PBL in medical graduates, and adaptation of this reflects progress of IMGs in the UK. There is another issue to teacher-centered or learning-centered education system, and in many countries of the Indian subcontinent, the teacher-centered approach to education is common. In a study done by Allan et al. (2009) among UK students at the University of Wolverhampton, it was concluded that students regarded learning in a supportive environment in which teachers scaffold learning (provision of sufficient support to promote learning when concept and skills are first introduced to students), as a requisite for effective learning (Allan et al. 2009).

Brookfield (1987, 1993) describes another method of adult education and that is critical reflection; Brookfield comments that a number of constructs like embedded logic, dialectical thinking, working intelligence, reflective judgments, post-formal reasoning and epistemic cognition describe how adults can think contextually and critically. Brookfield (1987) in addition to discussing constructs of critical thinking also talks about ethnic/cultural differences in methods of learning and education and suggests that the ethnocentric theories and assumptions regarding adult learning styles underscore the need for mainstream adult educators to research their own practice with native and aboriginal peoples.

Numerous problems are encountered by IMGs in communications, competencies and passing examinations. A recent meta-analysis on IMGs has shown that doctors and medical students of non-White ethnicity underperform academically compared with their White counterparts, and ethnic differences are unlikely to be primarily caused by examiner bias or candidate communication skills because similar effects are reported when examined by a machine or marked by the examiner (Woolf et al. 2011). The difficulties faced by IMGs in completing their postgraduate medical training in the UK and passing Royal College exams depend on various factors such as gender, ethnicity, postgraduate medical training, country of origin and medical schooling (Ayres et al. 1996; Tyrer et al. 2002). It has been shown that in the year 2000, 67 % of UK graduates passed the final Practical Assessment of Clinical Examination Skills (PACES) exams compared to 26 % of non-UK graduates (Bessant et al. 2006). In the Membership exam of Royal College of General Practice (MRCGP) in May 2010, the overall pass rate for IMGs was lower than UK graduates: the pass percentage of UK graduates was 93.8 % and that of non-UK graduates was 52 % (MRCGP Statistics 2010).

The Royal College of General Practitioners (2010) reported that in September 2010, a substantial minority of candidates failing on their first attempt appeared to be at the very start of their specialist training (ST) of 3 years and that a high failure rate from this group is not entirely unexpected and would distort the statistics, and secondly, a substantial number of candidates taking the examination in September were taking it for the second or third time and, therefore, likely to be weaker candidates. In spite of the overall pass rate of 75 % in MRCGP exams in March 2011, the performance was poor among non-UK graduates especially male candidates (Royal College of General Practitioners 2010).

The primary qualification of a medical degree also has an impact on exam results due to different types and quality of medical education. The exams in the UK are structured on the syllabus, which includes only a few topics that the IMGs have in their own syllabus in their countries of origin, and this appears to be a disadvantage to foreign graduates (Oyebode and Furlong 2007; McManus et al. 1996).

International medical graduates face several difficulties in the UK, which affect their performance in exams and career progression. A study (Mahajan and Stark 2007) carried out in South Yorkshire among IMGs in paediatrics department found problems in communication skills due to different accents, use of colloquialisms and dealing with sensitive issues compounded with tremendous stress due to visa restrictions and job searching. Trainee's cultural aspects of communication appear to be affecting the final outcome of the examinations (Oyebode and Furlong 2007).

Since the introduction of the new Clinical Assessment of Skills and Competence (CASC) exam in 2008 in psychiatry, the pass rate has significantly dropped from 60 % in the first edition in 2008 to around 33 % in the very next edition and has consistently remained around 33 % (Hussain and Husni 2010). The Royal College of Psychiatrist's annual report (2008–2009) stated that the pass rate for UK graduates was 87.5 % compared to 48.5 % for non-UK graduates in Autumn 2008, and in Spring 2009, it was 76 % success rate for UK graduates and 47.7 % for non-UK graduates. Regular mock exams as part of a postgraduate course could help the overseas graduates to gain necessary clinical knowledge and skills (Oyebode and Furlong 2007; Vassilas et al. 2007).

Roberts et al. (2000) investigated the reason for lower success rate among Asian doctors passing oral exams of MRCGP using sociolinguistic analysis. This study identified three different types of 'talk' that existed between candidates and examiners which determined the success in the oral exams. The first type was 'personal experience discourse' which was based on one's own experiences of dealing with similar cases, the other type was 'professional discourse' which is the conversation that takes place in their clinics with patients or doctor-doctor interactions and the third and most important type was 'institutional discourse' which is the type of conversation and talking style that is used in quality assessments of institutions and organizational settings. IMGs often find it difficult to give a response that could meet the examiner's expectations as the examiners expect an answer of 'institutional discourse' from candidates even if their question is based on other types of discourses. This study recommended that examination boards should publish standard examples of answers to oral questions followed by opinions made by the examiners and also the need for educating the examiners about these difficulties faced by the IMGs.

Training in communication competencies during medical school has been found to improve student's skills with reference to core competencies in building patient relationship, organization and time management, patient assessment, negotiation and shared decision-making (Yedidia et al. 2003). It has also been shown that Asian and Black students who speak a non-English language in their childhood have poorer communication skills in US medical schools (Fernandez et al. 2007).

## Discussion

Many doctors from different countries migrate to the UK, USA, Canada and Australia to prosper in the field of medicine and also to better their future economically, but the psychosocial impact on them when they migrate has sparsely been studied. In the UK, recruitment into some specialties like psychiatry, paediatrics and public health has been a problem for many years (Goodyear 2009; Goodyear et al. 2007; Turner et al. 2007; Brockington and Mumford 2002; Fazel and Ebmeier 2009) and this is not just confined to the UK but also in the USA (Feifel 1999). These recent and past trends have prompted the NHS to recruit doctors from other countries and this in turn encouraged many IMGs to explore better training and research options, opportunity to acquire new skills, boost life style, improve economical stability and enjoy decent family prospects (Astor et al. 2005; Gadit 2008). But at times, it has been found that post-migration IMGs face a number of psychosocial issues like loss of personal identity and belonging, confusion of roles and responsibilities and interaction with peers and loss of financial autonomy (Wong and Lohfeld 2008).

A study (Kilpatrick et al. 2011) examined the characteristics and attributes of mobile skilled workers from six different Australian rural communities and one Canadian rural community. The dwellings in the community and to some extent national policies make a difference to the mobile skilled worker integration and community participation. The cultural aspects of a community, interactional infrastructure and leadership influence the process of integration for mobile skilled workers. The mobile skilled workers provide a range of skill mix, which can be cashed by the local rural communities if the integration process is strengthened. The study (Kilpatrick et al. 2011) also found that this integration can increase resilience, community capacity, identification and uptake of opportunities such as new enterprises, good practice in natural resource management and enhanced social and leisure opportunities.

The communication problems have always been an issue with research on IMGs, and in the USA, it is also suggested that IMGs must incorporate a short program of language/speech techniques to build up their accent and communication skills with patients (Singhal and Ramakrishnan 2004). An assessment procedure to gain entry and get registration from a professional body like GMC in itself is a long and demanding process; although it is necessary for the receiving country to be sure of the capabilities of IMGs and their suitability to work, it is hard for IMGs to get the registration process sorted, get shortlisted for a job and have smooth career progression (Stewart 2003). Disciplinary actions and GMC hearings are twice as high for IMGs compared to UK doctors and it has been implicated that this is because of the lack of knowledge and guidance about legal and ethical issues among IMGs (Slowther et al. 2009; Humphrey et al. 2011). Training issues have been a difficult for IMGs and they have used clinical

attachments as a method of gaining entry into the training schemes but there have been problems getting the funding to support the professionals who are willing to support these candidates during their clinical attachments (Malik et al. 2007). IMG's contribution to a number of specialties has been recognized and the Royal College of Psychiatrists reported that the specialty has always benefitted enormously from the contributions made by IMGs both at the consultant and trainee levels (The Royal College of Psychiatrists 2008a).

Culture-related issues have been highlighted a problem that needs tackling among IMG's training and there is evidence that race can be a barrier to advancement. During the transition period of post-migration, IMGs will have to deal with the more prudent phenomenon of acculturation and assimilation which will have implications on their cultural, ethnic and deep-rooted concepts. There is significant dearth in literature regarding the acculturation aspect of the families of IMGs living with them, their quality of life, social needs of IMGs and their families. In more rural societies, the impact of acculturation and settlement process is quite significant and intense. A study conducted in Australia concluded that there are significant gaps that exist in the standard of living, quality of life and social milieu of IMGs and their families, which has been overlooked for a considerable amount of time. In some of the rural societies like in Tasmania, which are culturally less diverse, the factors like rural acculturation and retention of IMGs, their health and well-being are pertinent (Terry et al. 2011). Another study looking specifically at the cultural issues and adjustment of the IMGs in Australia found that IMGs face some issues related to security, cross-cultural adjustment, social expectations of gender roles, isolation and medical work practice influence in the process of integration to the new society but the spouses face more difficulty in adjusting (Durey 2005).

The major element of this transition in training will be on the learning and teaching styles in the country of origin; this issue has been highlighted by a number of studies (Sharif 2003; Lassers and Nordan 1975; Bates and Andrews 2001; Pilotto et al. 2007). The way forward might not be easy but it is important to adapt to a new learning and teaching style and be successful. A few tools to help teaching is to make it interactive by getting feedback, having clear objectives, using appropriate technology and using knowledge of the learner to make it a worthwhile exercise (Selzer and Ellen 2010). Learning and teaching is a lifelong process, the value of which cannot be emphasized enough and it is especially relevant in today's changing NHS.

IMGs come from a variety of cultural and educational backgrounds and are at different levels of training with varying needs and goals ahead of them. They have been exposed to learning, which is subject-oriented, teacher-centered, discipline-based, lecture-focused and hospital-based (Majumder et al. 2004). Allan et al. (2009) found that teachers had high expectations of their students, but in contrast, the students did not have academic achievement as their priority and favored actions that lead directly to the enhancement of their own learning and teaching strategies. This change in teaching culture from a teacher-centered approach in the Indian subcontinent to a learner-centered approach in the UK puts an immense amount of pressure on IMGs when they migrate.

IMGs face an uphill task in training and examination in different specialties, and the Royal College of Psychiatrists reported that 94 % of the trainees who appeared for psychiatry exam in June 2008 were IMGs (The Royal College of Psychiatrists 2008b).

A number of studies have reported that over the board IMGs perform poorly in Royal College and other examinations and a number of factors are discussed like communication skills, methods of education, country of primary medical qualification, cultural differences and speaking non-English language in childhood (Ayres et al. 1996; Tyrer et al. 2002; MRCGP Statistics 2010; Oyebode and Furlong 2007; McManus et al. 1996; Roberts et al. 2000). The traditional methods of teaching, which are teacher-centered and lecture-dominated, are prevalent in many countries, which pose a challenge to the IMGs when they are faced with more PBL pattern of learning in the education system in host countries (Majumder et al. 2004; Abdulrahman 2008; Camp 1996; Tavakol et al. 2006).

## Conclusions

Some specialties like psychiatry, paediatrics and public health had faced under-recruitment for a long time in countries like the UK and the USA; IMGs contributed significantly not only filling this space of under-recruitment but also serving comprehensively in a variety of specialties and constitute about 30–48 % of the medical workforce in the UK. There has been a consistent decline in preferring psychiatry as career option among UK medical graduates and medical students. IMGs migrate to foreign countries in pursuit of better medical education, desire for better income, general security and improved prospects for the family, but in doing so, they are confronted with psychosocial problems, cultural differences, hurdles in career progression and passing exams. IMGs lack awareness of the ethical, legal and cultural system and also lack knowledge of professional standards and guidance prior to registration. The overall pass rate for IMGs in Royal College exams has been consistently low and more so in PACES, GP and psychiatry exams. There is a serious need to take significant steps to improve IMG's employability and productivity in the UK that would be beneficial to the NHS, UK patients and the concerned doctors.

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