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# International medical graduate doctor to doctor telephone communication: A genre perspective

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ABSTRACT

Few English for Medical Purposes studies focus on the spoken communication between doctors in the professional setting. This study examined the effectiveness of telephone calls from International Medical Graduate (IMG) doctors to a more senior doctor as part of simulation training to increase patient safety and well-being.

We adopted genre analysis to examine 12 telephone consultations about a critically ill patient made by junior IMG doctors to a senior doctor. With the assistance of the senior doctor informant, two successful calls were identified and analysed functionally for their generic structure and linguistic features. Feedback comments from the senior doctor on all the calls were transcribed and analysed thematically. The findings from the genre analysis of the successful calls as well as from the senior doctor feedback informed the development of an analytical tool to examine the less effective calls.

Insights from the senior doctor highlight the institutional, professional, and situational variables contributing to the effective calls. A generic structure of nine stages was identified for the effective calls. In the less effective calls, the findings show difficulties with sequencing, realisation of stages, and interactional management with shifts from workplace discourse to apprenticeship discourse features.

Implications of the findings for EMP course design are discussed.



## 1. Introduction

### 1.1. English for Medical Purposes: beyond doctor patient communication

International Medical Graduates (IMGs), that is, doctors who have undertaken their medical training overseas, play an important role in filling health workforce shortages in developed countries such as the UK, the US, Canada, Australia and New Zealand (Gorman & Brooks, 2009; Wette, 2011). For example, in Australia about 39% of the total medical workforce are IMGs, with the percentage increasing to 46% in some rural and remote areas (House of Representatives Standing Committee on Health, 2012). Many IMGs come from lower income, less well resourced countries such as India, Bangladesh, Pakistan and the Philippines, where English is a minority language (Hawthorne, 2012; Lockyer, Fidler, de Gara, & Keefe, 2010; Mullan, 2005). In Australia, there are ongoing concerns about IMGs' communication skills reported by clinicians (for example McDonnell & Usherwood, 2008) and other institutional bodies addressing regulatory requirements (House of Representatives Standing Committee on Health & Ageing, 2012). Language proficiency, particularly conversational English, medical

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discourse, and different cultural expectations have all been identified as issues for IMGs practising medicine in their new host country (Hoekje & Tipton, 2011; Pilotto, Duncan, & Anderson-Wurf, 2007).

English for Medical Purposes (EMP) programs play a crucial role in providing opportunities for non-English speaking background IMG doctors to develop the communication skills needed to meet the demands of the new healthcare context. To date, the focus of much research that has informed EMP is IMG doctor to patient communication, including appropriate use of medical language with patients (Dahm, 2011), empathy (Cordella & Musgrave, 2009; O'Grady, 2011), language difficulties (Wette & Basturkmen, 2006), and pronunciation and questioning (Ibrahim, 2001). There has been little focus in EMP on doctor to doctor communication, such as handovers or telephone communication. Doctor to doctor telephone consultations are common (Wadhwa & Lingard, 2006) and are used to communicate about a wide variety of patient care issues (Car & Sheikh, 2003). They can be a source of risk for patient safety (Barenfanger et al., 2004; Rabøl et al., 2011).

Studies of intercultural professional telephone communication suggest that there can be significant linguistic and cultural barriers to effective communication via the phone (see for example Bowles, 2006; Forey & Lockwood, 2007); research into this aspect of medical communication is warranted for EMP.

### *1.2. The SBAR communication protocol*

To manage the potential for miscommunication between health professionals about patient care, structured communication frameworks play a role in medical training. One communication protocol is SBAR: SBAR stands for 'Situation', 'Background', 'Assessment' and 'Recommendation' (Haig, Sutton, & Whittington, 2006) where the elements indicate the content and the order of the information to be exchanged. Versions of SBAR have wide currency in Australia and the UK (Aldrich, Duggan, Lane, Nair, & Hill, 2010; Marshall, Harrison, & Flanagan, 2011; Veljii et al., 2008); in Australia alone at least seven formats are in use (Marshall et al., 2011). One adapted version of the SBAR protocol, ISBAR, which incorporates an additional category 'I' referring to Identification, was perceived by junior doctors to be useful, particularly during telephone communication (McGregor, Lee, Slade, & Dunston, 2011). However, despite the high face validity of the SBAR model as a method of ideal communication, it is unclear how the model relates to real-world instances of effective clinical communication. The widespread use of communication protocols and the significance of doctor to doctor communication are important course design considerations for EMP practitioners addressing medical communication.

### *1.3. Expert and learner professional discourse in medical education*

Interactional and communicative norms are markers of professional discourses (Sarangi & Roberts, 1999). Learner professionals, such as junior doctors, need to gain expertise in clinical knowledge and practice but also proficiency in the communicative practices and genres of various clinical settings and specialties. Socialisation into professional practices and discourses has been traditionally viewed as taking place in the relationship between an apprentice or novice and a master or expert practitioner (in the medical context see for example, Paltridge, 2006). In teaching hospitals, more experienced clinicians play an integral role in junior doctor training. For example, Atkinson's description of case presentations in a haematology department exemplifies a microcosm of a community of practice whereby novice medical students learn not only from the expert consultant but through observation and interaction with more experienced but not yet fully expert registrars (1999). Erickson (1999) describes the indirect correction strategies of consultants supervising intern case presentations so that in spite of errors, the novice intern is still treated as a member of the community of practice. How IMG doctors, who are medically trained yet who may lack discursive and cultural expertise in the new clinical setting, are inducted into the discursive practices of their new setting is yet to be examined. For this reason our article focuses on one important discursive practice, doctor–doctor communication via the telephone.

## 2. Theoretical framework and methods

### *2.1. Study setting and patient safety training*

The broad aim of this study was to examine a key intra-professional medical genre for all junior doctors, including IMG junior doctors. We examined telephone calls initiated by non-English speaking background IMG junior doctors to a more senior doctor (SD): we focused on how the IMG doctors achieved the goal of the interaction, namely to seek clinical advice on a deteriorating patient. The study was carried out at one metropolitan teaching hospital in Melbourne, Australia. It was conducted in a training setting as part of an existing patient safety training and transition program for International Medical Graduates (IMGs) at the hospital. The program was run at the simulation centre and was modelled on an undergraduate medical student patient safety program. The aim of the program was to ensure that IMGs working in the hospital network had the same level of skills in basic patient safety as domestically trained medical graduates. Between five and 12 IMGs and four to five instructors were involved in each training session. The program consisted of five one-day training sessions run on a monthly basis. The study was conducted over a 10 month period and encompassed two main intakes into the program. The training incorporated lectures, workshops covering clinical skills such as inserting an intra-venous line, as well as immersive simulated clinical scenarios. As part of the simulation training, participants received instruction in the use of ISBAR, a