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WEB PAPER

Cultural dimensions in the transition of overseas medical graduates to the UK workplace

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Abstract

Background: Historically, overseas-qualified doctors have been essential for meeting service needs in the UK National Health Service (NHS). However, these doctors encounter many cultural differences, in relation to training, the healthcare system and the doctor-patient relationship and training.

Aim: To examine whether Hofstede's cultural model may help us understand the changes doctors from other countries experience on coming to work in the UK, and to identify implications for supervisors and clinical teams.

Method: Telephone interviews were conducted with overseas medical graduates before starting work as a Foundation Year One (F1) doctor, followed up after four months and 12 months; and with educational supervisors. Data were analysed using a confirmatory thematic approach.

Results: Sixty-four initial interviews were conducted with overseas doctors, 56 after four months, and 32 after 12 months. Twelve interviews were conducted with educational supervisors. The changes doctors experienced related particularly to Hofstede's dimensions of power distance (e.g. in relation to workplace hierarchies and inter-professional relationships), uncertainty avoidance (e.g. regarding ways of interacting) and individualism-collectivism (e.g., regarding doctor-patient/family relationship; assertiveness of individuals).

Conclusion: Hofstede's cultural dimensions may help us understand the adaptations some doctors have to make in adjusting to working in the UK NHS. This may promote awareness and understanding and greater 'cultural competence' amongst those working with them or supervising them in their training.

Introduction

Historically, overseas-qualified doctors have been essential for meeting a shortfall in the number of UK-qualified doctors required to meet National Health Service (NHS) needs. Currently, a greater proportion of UK-registered doctors have qualified abroad than had 10 years ago, although the proportion has reduced from a peak of just under 40% in 2005 to 37% in 2011 (GMC 2011, 2012).

Slowther et al. (2009, 2012) identified that doctors who qualified outside the UK can face difficulties when they start to practise in this country, such as unfamiliarity with UK legal and ethical standards. The UK General Medical Council (GMC) has recognised that overseas-qualified doctors need better support and need to be properly inducted into UK practice (GMC 2011).

Preparedness for practice relates to complex cultural issues, including the doctor-patient relationship and the culture and structure of the healthcare system, as well as clinical issues. The patient-centred approach emphasised in the UK can be at odds with the focus of regulators in many countries (Rand 2009), with doctors' own cultural values and experience (Manderson & Allotey 2003; Hall et al. 2004; Jaffrey & Faroqui 2005; Hamilton 2009; Slowther et al. 2009; Chen et al. 2011; Dahm 2011; Slowther et al. 2012) and with patients' expectations of consultations or the physician-patient power dynamic (Dorgan et al. 2009; Hamilton 2009). Communicating emotional support for patients can be a challenge for doctors who have graduated overseas (Fiscella et al. 1997; Hawken 2005).

Practice points

- It has previously been identified that doctors who qualified outside the UK can face difficulties when they start to practise in the UK NHS.
- Preparedness for practice relates to cultural as well as clinical issues. Cultural differences can relate to the doctor–patient relationship, the culture and structure of the healthcare system and the training culture.
- Hofstede's cultural dimensions of power distance, individualism-collectivism, uncertainty avoidance and masculinity provide a framework for understanding these differences.
- Awareness and understanding of national differences may promote greater cultural competence amongst those working with or supervising overseas-qualified doctors and contribute to the support they receive on starting work and ongoing into their practice.

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Furthermore, doctors from outside the UK often have a different way of dealing with end-of-life decisions (Miccinesi et al. 2005).

The UK healthcare system is less hierarchical than many others, and overseas doctors can feel uncomfortable with challenging their supervisors (Hall et al. 2004). Working within a multi-disciplinary team, an important feature in the NHS, is also a new way of working for many overseas doctors and can be a challenge to those from more hierarchical cultures (Kramer 2005; Mahajan & Stark 2007).

Overseas-qualified doctors may have experienced a different training culture from that of the UK, for example, with greater emphasis on formal didactic teaching and individual learning from books, less use of feedback and less questioning of teachers (Cross & Smalldridge 2011). In some countries the relationship between teacher and student is more rigidly hierarchical, and there are cultural variations in rules about eye contact, interruptions and body posture (Cole-Kelly 1994); deference to authority is the norm and criticism is not offered directly (Bates & Andrew 2001).

The current article draws on findings from a larger study on the experiences of UK, European Union (EU) (non-UK) and non-EU medical graduates making the transition into the UK workplace (Illing et al. 2009). Cultural issues were a significant element in the adaptation of overseas medical graduates, from both within and beyond the EU, to working in the UK NHS system. The study highlighted the need for awareness and understanding of doctors' cultural norms in relation to training and practice, and for initial and on-going support. It is also important to recognise that doctors who have graduated from a non-UK medical school are not a homogeneous group and face diverse challenges.

Hofstede devised a model to measure aspects of culture so that countries can be compared (Hofstede 2001; Hofstede et al. 2010b). He employs a meaning of culture derived from social anthropology that refers to the way people think, feel, and act, and defines it as "the collective programming of the mind that distinguishes the members of one group or category of people from another".

The model consisted originally of four dimensions or constructs: power distance (PDI), individualism (IDV), masculinity (MAS) and uncertainty avoidance (UAI) (Hofstede 2001; Hofstede et al. 2010b, p.344). These dimensions were developed from Hofstede's research in one multinational company in 40 countries (Hofstede 2001) and have since been replicated in other cross-national studies (e.g., with consumers and airline pilots). Some studies have been carried out in the healthcare context using one or more of the dimensions as a framework. These include studies in relation to cross-national differences in antibiotic use (Deschepper et al. 2008), blood transfusion practices (de Kort et al. 2010), medical communication between general practitioners (GPs) and patients (Meeuwesen et al. 2009), and attitudes of medical practitioners towards medical professionalism (Chandratilake et al. 2012).

Power distance relates to the extent to which power is distributed, from relatively equally (small power distance) to extremely unequally (large power distance). In large power distance societies hierarchy is important, and employees are more reluctant to express disagreement or question those in charge. Students give teachers respect and teachers are "gurus" who take the initiative in class. In medicine, patients will treat doctors as superiors, and consultations are shorter and controlled by the doctor. In contrast, in small power distance societies patients treat doctors as equals and actively supply information. Superiors and subordinates consider each other to be colleagues, employees are seldom afraid to disagree and expect to be consulted before decisions are made and teachers expect initiatives from students in class (Hofstede et al. 2010b). Latin, Asian, and African countries have high power distance scores and Anglo and Germanic countries have smaller scores (www.geerthofstede.nl/dimensions-of-national-cultures).

Individualism relates to the encouragement of the individual over collective behaviour. It indicates the extent to which the ties between individuals are loose, with everyone expected to only look after him/herself and immediate family, the opposite being collectivism – the extent to which people in a society, from birth onwards, are integrated into strong, cohesive in-groups, often extended families. Educational differences include differences in expectations regarding speaking up in class, and more of an emphasis on "learning how to do" in collectivist societies rather than "learning how to learn" in individualistic societies. Doctors from countries where collectivism prevails may appear less assertive. Individualism prevails in the UK and other developed and Western countries; collectivism prevails in less developed and Eastern countries, with Japan in a middle position (www.geerthofstede.nl/dimensions-of-national-cultures).

Masculinity relates to ambition as a driving force and to values along a dimension from very assertive and competitive to modest and caring. A feminine culture is focused more on quality of life and process versus task or results orientation. In feminine cultures, teachers praise weaker students to encourage them, rather than openly praising good students. Students in masculine societies are reported by Hofstede to try and make themselves visible in class, compete openly with each other and over-rate their own performance (ego-boosting vs. ego-effacement) (Hofstede et al. 2010b). Masculinity is high in Japan, some European countries (e.g., Germany, Austria, Switzerland) and moderately high in Anglo countries. It is low in Nordic countries and the Netherlands, and moderately low in some Latin and Asian countries (e.g., France, Spain, Thailand) (www.geerthofstede.nl/dimensions-of-national-cultures).

Uncertainty-avoidance (strong vs. weak) refers to the way in which a culture deals with flexibility, change and uncertainty. It indicates the extent to which the members of a culture feel threatened by uncertain, unknown or unstructured situations. In strong uncertainty-avoiding nations, people are more expressive, and in weak uncertainty-avoiding nations the expression of feelings is inhibited and people are more tolerant of different opinions (Hofstede et al. 2010b). In strong uncertainty-avoidance societies less attention is given to rapport building (e.g., less eye contact) with patients (Meeuwesen et al. 2009), doctors may avoid ambiguity in diagnosis (Deschepper et al. 2008), and more money tends to be spent on doctors than nurses, thus more tasks are performed by doctors themselves (Hofstede et al. 2010b).

A culture of strong uncertainty avoidance can result in a more structured learning environment which is more teacher-centred (Eldridge & Cranston 2009); teachers are supposed to have all the answers, and students are concerned with the right answers (Hofstede et al. 2010b). Uncertainty-avoidance scores are higher in Latin countries, Japan and German-speaking countries, and lower in Anglo, Nordic, and Chinese culture countries (www.geerthofstede.nl/dimensions-of-national-cultures).

The data discussed in this article were collected for the main study on the transition of UK, EU, and non-EU medical graduates to the UK workplace (Illing et al. 2009), which took a constructivist grounded theory approach (Strauss & Corbin 1998; Charmaz 2006). As such, typically "a researcher does not begin a project with a preconceived theory in mind" (Strauss & Corbin 1998); however, a theory may emerge from the data and other pre-existing theory may be found to be relevant to the findings. The data highlighted the relevance of cultural issues to the transition (e.g., differences regarding workplace hierarchies, inter-professional working and patient-centeredness) and the potential relevance of Hofstede's work. This article presents an additional analysis undertaken to further explore the relevance of Hofstede's model in explaining the data. The aim of the article is to use Hofstede's original four dimensions as a theoretical framework to assess the hypothesis that this cultural model may help us understand the cultural changes doctors from other countries experience in coming to work in the UK NHS system. A further objective was to identify implications for clinical team members working with overseas graduates and those undertaking their educational or clinical supervision, or induction.

Methods

Participants

Overseas doctors entering the first year of the Foundation Programme were recruited from five deaneries with the largest populations of the target group. (The Foundation Programme is a two-year training programme that all UK medical school graduates are required to undertake to practise medicine in the UK. Deaneries are organisations responsible for postgraduate medical and dental education at regional level.) Participants were recruited by email distributed via deaneries. An information sheet about the research was sent as an email attachment, with contact details for the research team in case of queries. Replies were sent direct to the researchers.

Procedure

Participants were interviewed by telephone three times: before starting Foundation Year One (FY1), at the end of their first four-month placement, and again at the end of FY1. In the second and third interviews the researcher referred back to issues discussed in the previous interview to aid continuity of discussion and to serve as a form of member checking. Verbal consent was taken at the start of the telephone interviews, which were conducted by four researchers who had no role in the education, training or support of participants. At the end of the first and second interviews verbal consent was taken for a follow-up interview, and confirmed at the start of those interviews. Interviews were between 30 minutes and 1 hour in length.

Pilot interviews were carried out with five overseas-trained doctors already undertaking the Foundation Programme in one of the deaneries, to identify issues to be explored in subsequent data collection. Analysis by the four researchers, as well as a review of the literature, informed the semi-structured interview schedule for the initial interviews. The schedule covered broad themes but the precise structure and questioning were adaptable to each individual interview depending on responses. The follow-up interviews were developed by reviewing analysis of the initial interviews. Questions covered, for example, reasons for coming to the UK, differences between the UK and country of origin and/or training, and factors that helped or hindered the transition to the UK workplace.

Interviews were also conducted with educational supervisors recruited from those known to work with Foundation Year One doctors (F1s) in one deanery, to gain their perspective on any cultural issues in the adaptation of non-UK medical graduates to the UK workplace.

Analysis

Interviews were recorded, with participants' consent, and transcribed verbatim. A confirmatory (hypothesis-driven) approach was taken to the analysis used for this paper (Guest et al. 2012), with codes predetermined by the theoretical framework of Hofstede's cultural dimensions. The transcripts were coded by the four researchers, using NVivo 8 software (QSR International Pty Ltd, Doncaster, Victoria, 2008), with joint coding of the first transcripts. Further regular meetings took place to discuss and interpret the data in relation to the four dimensions to mitigate any potential bias.

Table 1 shows how the four cultural dimensions were operationalized for data analysis.

Results

Sixty-six doctors were recruited to the study. Sixty-four initial interviews were conducted; 56 were conducted at four months follow-up, including two with new participants, and 32 at 12-month follow-up. The participants had been in the UK for between one day and eight years when initially interviewed – the majority for about two years. Some doctors were newly qualified, while the longest time since qualification was 10 years (mode of 12 months). Twenty-nine of the participants were female, 37 male.

Participants had graduated in countries both within the EU (6 countries) and outside the EU (14 countries). Table 2 shows a profile of participants' countries of graduation, displayed in relation to Hofstede's original four dimensions. For the purpose of this study, Great Britain has been treated as a baseline, and the relative scores of the other countries calculated (where these data are available). Overall, the countries represented in our sample have relatively high power distance and uncertainty avoidance scores, and

Table 1. Operationalization of dimensions.

Dimension	Working definition
Power distance	References to hierarchy (inter- and intra-professional; teacher/student), expertise, social status
Individualism	References to groups, e.g., family unit and patient or staff members; assertiveness
Masculinity	References to ambition, task vs. process, nurturing or rewarding educational relationships, emotional gender roles
Uncertainty avoidance	References to rapport (including body language), pedagogy, learning environment

Table 2. Countries represented and their scores on four dimensions relative to Great Britain. (Source: http://www.geerthofstede.nl/research–vsm).

Great Britain	0	0	0	0
Africa West[1] (Sierra Leone, Nigeria only)	42	−69	−20	19
Arab-speaking countries[2] (Egypt, Iraq, United Arab Emirates only)	45	−51	−13	33
Austria	−24	−34	13	35
Bangladesh	45	−69	−11	25
India	42	−41	−10	5
Italy	15	−13	4	40
Lithuania	7	−29	−47	30
Malta	21	−30	−19	61
Pakistan	20	−75	−16	35
Poland	33	−29	−2	58
Romania	55	−59	−24	55
Russia	58	−50	−30	60
Afghanistan	No data	No data	No data	No data
Cuba	No data	No data	No data	No data
Jordan	No data	No data	No data	No data
Sudan	No data	No data	No data	No data
Syria	No data	No data	No data	No data

[1]Overall scores for Africa Western region, where scores for these four dimensions are listed (Ghana, Sierra Leone, and Nigeria).
[2]Overall scores for the Arab-speaking countries for which scores for these four dimensions are listed (Egypt, Iraq, Kuwait, Lebanon, Libya, Saudi Arabia, and Emirates).

lower individualism and masculinity scores compared to Great Britain.

Twelve interviews were conducted with educational supervisors. Whilst they did not refer to overseas doctors by their country of graduation, their observations do indicate experience of cultural differences that may be seen to relate to one or more of the dimensions.

Findings are presented under the four original dimensions described by Hofstede (2001). Overseas-qualified participants were given a unique identifying number to protect anonymity and quotations in the text below have an identification suffix 'a', 'b', or 'c' to denote whether they are drawn from the first, second or third interviews. Educational supervisor interviews are identified as ES.

Power distance

Power distance was the dimension that appeared to have the greatest relevance to overseas doctors when describing the cultural differences they experienced. Some participants commented on the high status of doctors in their country, and reported that there was a different approach to dealing with error.

> *"You're a small God and everyone respects everything you say"* (35a, Nigeria)
>
> *"Back home, they perceive doctors should know everything"* (23b, Jordan)
>
> *"Some of the doctors in our country… they can make some mistakes, they might not be challenged, sometimes, but here in the UK is very different"* (30a, Syria)

Power distance was apparent in contact with other doctors, with other professions, and with patients.

The main reported difference was the approachability and friendliness of senior doctors in the UK, and several reported that they were often "terrified" and "feared" their senior doctor in their own country. Several reported that more hierarchical aspects of culture, such as respecting elders, often erected barriers and meant that seniors could not be treated as colleagues.

> *"This is a huge barrier in my country when you talk to any doctors, you need to give first [their] title and you say, 'Oh Dr Brown' or whatever… you don't feel like he is really… one of your team colleagues"* (64a, Poland)
>
> *"It was quite difficult for me… maybe because of where I used to study, or where we come from the consultants are usually assertive and authoritative and you can't speak to them really…"* (56b, Pakistan)

Junior doctors often felt unable to approach seniors and ask for help in their own countries compared to in the UK. Some reported feeling 'shy' about asking for help in their own country, and some reported that asking for help at night was not encouraged.

> *"You don't ask questions when you are on call at night and you have a problem during the night, it is not advisable to wake up the senior, I mean you don't call and wake the senior. And I mean here you can call the senior if it is a real problem, nobody will say anything"* (42a, Romania)

Power distance was also apparent in inter-professional relationships. F1s work with a range of colleagues in different professions, and UK graduates are taught extensively about multi-disciplinary teams. Both EU and non-EU doctors noted differences in the types of teams and the nature of working together as a team. In some cases, doctors and nurses were reported to work as separate teams with separate responsibilities. The health system in which some had worked was also reported to be hierarchical in that nurses were not regarded as

colleagues, in contrast to the UK where nurses were seen to be part of the team and doctors could ask nurses for help or for their opinion on a patient's care.

> *"I mean most of the Asian countries, let's say the doctors are seen as a higher level compared to the nurses, but in this country everything is equal basically. I mean you need to be aware of that aspect basically"* (45a, Iraq)
>
> *"I think it probably is coming from a very hierarchical society... whereas British graduates that have worked on the wards, they've got some idea, much more idea of how people interact and stuff and maybe are far more likely to ask a nurse"* (ES5)

This cultural difference was sometimes considered to impact on communication within the team.

> *"I think there have been misunderstandings about how you communicate with different members of the team, more of a dictatorial role – 'this is what I say so you do it'. It's not a negotiation... I've seen it a few times and I think it's a cultural difference"* (ES3)
>
> *"In Romania, it's a more autocratic society, you know. So the doctor is the boss, which here [in the UK] is not the case – you're part of a huge team, and you have to take your role and your place in the team and try to negotiate all the time with all the other"* (27c, Romania)

However, participants reported becoming more accustomed to team working during the year after an initial adjustment.

> *"It [multi-disciplinary team working] was quite a novel thing. I haven't seen that sort of system before or that sort of an approach towards the healthcare before... initially it takes a bit of time [to get used to], like a couple of weeks or so... Now I know how important it is and how integral a part of that is for the healthcare and the health system"* (20c, Pakistan)

Power distance in the doctor-patient relationship was implicit in references to patients' expectations of doctors, and this was the area where the largest difference was reported by doctors who had graduated overseas. Several doctors commented on the differences in power relations between doctors and patients in their own country. Some commented that the open friendly approach with patients in the UK was very different to their own country.

> *"We are servants of patients [in the UK] not the other way round. In Syria sometimes... doctors are the masters, we should be doing anything without any questions... I would say the culture of the society has given the doctors this amount of respect..."* (30a, Syria)

Doctors in the UK are expected to explain and inform the patients at every stage of the procedure, for example, what they are going to do and how it will feel. Doctors also have to explain the diagnosis, the management plan and the possible risks involved. For the majority of participants, this was a new way of working. Patients in their own country often did not want to know what was wrong with them, and were told what was going to be done to them rather than included in the decision making. This illustrates that power distance is not just a consequence of power being exerted by those who hold it, but something embedded in a culture, and expected by those who ostensibly do not have the power.

> *"In my country we don't give the patients too much choice, we decide everything for them. Here the patients are deciding everything"* (7a, Syria)

An educational supervisor also commented on this difference.

> *"Some of them are undoubtedly more used to patients being told what is right for them rather than being given options of treatment and leaving them to discuss with family and so on. That is again a patient centred approach to medicine that we would sort of take for granted"* (ES 9)

The comments of some doctors regarding a difference in relation to obtaining patient consent could perhaps also be linked to power distance, with their reporting that either there was no standard procedure for obtaining consent in their own country, or it is taken once at the beginning of the consultation rather than at every stage.

> *"I know it's a lot different here [UK], and they focus more on that [informed consent] over here than they do back home because a patient deserves the right to know, you know, exactly what's going on and should be told everything but, I don't know, it's not done much back home..."* (11a, India)

Individualism

In some cases, a family orientation was evident in the involvement of the family in getting information about, and treatment of, the patient. Some doctors reported that in their own countries they often told the patients' relatives of their disease and let them decide whether to tell the patient and, if so, how much to tell them.

> *"When a patient has got cancer first of all we inform the parents before informing the patient, then it's them to tell the patient or not"* (40a, Syria)
>
> *"There is a tendency to make the patient aware of what is going on [in the UK], when in Italy often the family ask the doctors not to tell... if they [the family] tell [the doctor] not to tell [the patient] then you don't, because their opinion is more important for this than yours"* (65a, Italy)

Educational supervisors noted that overseas-qualified doctors tended to be more subservient and reticent with senior doctors, which could appear to be a lack of confidence. They were also less likely to speak up or talk about their problems.

> *"I think often you find that the IMGs are more reticent in general... lacking confidence to perhaps*

say things... I think that the UK graduates are more vocal if there's something that they don't like or if they're having problems" (ES17)

The individualism dimension may also be related to team working, as suggested by this participant:

"I was born in a communist country and the whole idea about communities and team working; there are no problems at all" (50a, Russia)

Masculinity

In terms of the transition, there was a feeling that while the core clinical science remains the same, there are differences in the approach, which could perhaps be interpreted in relation to "process orientation" as against "task orientation".

"It's the same sickness, it's the same patient, perhaps the approach is a little bit different here, but the basic idea stays the same, you know... there's a lot more emphasis on communication and how you speak to your patient" (11a, United Arab Emirates)

The reticence of some overseas graduates referred to earlier under individualism may also reflect a more feminine society, where there is less emphasis on competition and more ego-effacement, with students under-rating their own performance.

Uncertainty avoidance

In several cases doctors could be seen to be adjusting to differences in non-verbal communication and rapport building during patient interactions. This included looking directly into people's eyes when talking to them, touching a person on the arm (to show affection or sympathy) or holding their hand (as a sign of comforting).

"Back home when you talk to people you don't actually look directly into their eyes, especially older people, now I have to make an effort to do it here because it is quite different... you actually turn your eyes away... it's a sign of disrespect... they find it insulting and you can be reprimanded" (59a, Pakistan)

Whilst training programmes were not examined, some participants did report that their undergraduate degree had more of a theoretical focus than those in the UK. Educational supervisors commented that doctors who had graduated overseas often had good theoretical knowledge, which they attributed to the often didactic approach to teaching in their own countries.

"They are used to learning that is prescriptive... which areas you need to develop, they find that difficult and I think it is reflected in when they are writing out their personal development plan, they find that difficult because they are not used to it..." (ES 6)

It was also evident from the data that the training culture in the UK differed from that experienced by many doctors in how far trainees felt able to question their seniors.

Discussion

The findings of this study may enable us to relate the cultural differences in healthcare and training experienced by doctors moving to the UK to the cultural dimensions of their country as identified by Hofstede (2001). The culture of the countries in our study for which data were available differed from Great Britain in several ways, with relatively higher power distance in all countries except Austria, and relatively lower prevalence of individualism and stronger uncertainty avoidance in all countries, although there was variation between these countries on all dimensions.

The changes doctors in our study experienced related particularly to Hofstede's dimension of power distance, but differences in uncertainty avoidance and individualism-collectivism were also identified. The masculinity dimension appears to offer less information to help us understand the cultural distance, in that clearly these doctors are highly motivated, and have made effort and sacrifice to move to the UK.

Hofstede reports that in large power distance countries there is more reluctance to disagree with, or question, those in charge. Patients treat doctors as superiors; consultations are shorter and are controlled by the doctor. Meeuwesen et al.'s (2009) cross-national study of communication between GPs and patients found that the larger the nation's power distance, the less room there was for unexpected information exchange. Roles of physician and patient were clearly fixed. In countries where power distance scores highly there tends to be an attitude of "doctor knows best", patients are less inclined to question the doctor and may be embarrassed to be asked for their opinion of treatment options, and physicians expressing diagnostic uncertainty may not inspire patient confidence (Deschepper et al. 2008). Countries with low power distance show a preference for a more patient-centred approach whereby the patient is involved in their treatment and diagnosis, and is able to ask questions. However, Meeuwesen et al. (2009) found that, contrary to their expectations, the more feminine a country was, the more instrumental communication there was between GPs and patients, with a lot of question-asking by both doctor and patient, and much biomedical information exchange; in masculine countries, there was more affective than instrumental communication. In individualist countries, there was high exchange of psychosocial information.

In large power distance countries, teachers are seen as 'gurus'; similarly, students from strong uncertainty-avoidance countries expect their educators to be experts with all the answers and students will tend not to express intellectual disagreement, which can be seen as personal disloyalty, whilst in weak uncertainty-avoidance societies students are comfortable with open-ended learning situations and discussions (Hofstede et al. 2010b). Eldridge and Cranston (2009) reported that a culture of high uncertainty avoidance can result in a more structured learning environment which is more

teacher-centred as in Thai culture. They also reported that Thai university students are reluctant to engage in classroom critical debates due to their collectivist nature and culture of high femininity where competition is not encouraged. Students in masculine societies are reported by Hofstede to over-rate their own performance.

There are a number of factors to consider in relation to the use of Hofstede's cultural dimensions. For example, it is important to recognise that culture is a richer phenomenon than a reduction into this small number of dimensions (Deschepper et al. 2008), to be aware that there can be a complex relationship between cultural dimensions and a country's wealth (Deschepper et al. 2008), and to note that there can be different regional cultures within a country (Meeuwesen et al. 2009; Slowther et al. 2009; Hofstede et al. 2010a). In addition, national culture is not the only culture that will impact on some of the issues identified, such as questioning or challenging seniors, which may also be influenced by organisational and professional culture (Kobayashi et al. 2006).

Hofstede's dimensions apply at a national level and are group-level constructs; they are not about individual differences between members of society and are thus not meaningful as descriptors of individuals or predictors of individual differences (Minkov & Hofstede 2011). As noted by Meeuwesen et al. (2009) in relation to their study on medical communication, the current study does not permit us to draw conclusions regarding the behaviour of individual doctors. Furthermore, the dimensions do not allow for behavioural adaptations of individuals interacting with people not from their own nationality (Eldridge & Cranston 2009).

Nevertheless, the work of Hofstede may help us to identify adaptations doctors are making in the transition from their training culture to the culture of the NHS. A key point is not to overstate or over generalise difference, as not all of overseas graduates' experience is different from UK graduates', but also not to ignore it. Equality and diversity and cultural competency initiatives may already be laying the groundwork for this (Cowan & Norman 2006; Chavez & Weisinger 2008; Egan & Bendick 2008).

The findings suggest implications for the induction, education and training of overseas qualified doctors who come to undertake further training in the UK NHS, and implications for their communication with doctors, other staff and patients both during training and on-going into practice.

Implications for communication with doctors and other staff

Power distance may help to explain the finding that doctors from some overseas countries reported a distant relationship with seniors in their own country and hence some may be less likely to treat senior doctors in the UK as colleagues, to ask for help from seniors or to express disagreement with them. It could have implications for working in a team and go some way towards explaining the differences that many of the overseas doctors reported in communicating and working with nurses and doctors. The masculinity dimension may have implications for perceptions of roles and functions in healthcare teams.

Implications for communication with patients

The power distance, individualism and uncertainty avoidance dimensions, in particular, may have implications for the type and extent of communication doctors have with patients, and hence for their colleagues' understanding of potential differences. Many of the doctors in our study highlighted a difference in the way they communicated with patients, for example avoiding eye contact, and not including them in treatment plans or offering options, which are now the norm in the UK. Several doctors reported that patients in their own country would not want to know about what was wrong with them, or that it was not common practice to inform patients of their illness. The uncertainty avoidance dimension may also have implications for doctors' attitudes towards making mistakes and approach to decision-making and management plans.

Implications for education

In terms of education and training, the implications of the findings are important both for content and for pedagogy. The cultural differences highlighted in relation to, for example, hierarchies, team working, patient centeredness and informed consent, may be important areas of focus to increase overseas doctors' knowledge and understanding of the way things may be done differently in the UK.

In relation to pedagogy, overseas doctors and educational supervisors commented on previous experience of a more theoretical and prescriptive approach to teaching and learning, which may be related to uncertainty avoidance. Power distance may have implications for teaching and the trainee-supervisor relationship, such as learner-centred teaching, group dynamics during teaching sessions, asking questions and accepting feedback. Doctors from countries where collectivism prevails may appear less assertive than UK graduates in the classroom and on the ward, and more reluctant to offer an answer or engage in classroom critical debate. Masculinity may have implications for competition and self-assessment of performance and for supervisory relationships. As well as awareness of variations in individual learning styles, educators may therefore need to be aware of, and accommodate, potential cultural variations in learners' responsiveness to different educational strategies.

Conclusion

Hofstede's framework and cultural dimensions may help us understand nations' cultural norms and values in relation to important aspects of practice such as the doctor–patient relationship and communicating and working within a team, as well as to their training culture, and hence the adaptations some doctors have to make in adjusting to working in the UK. This may in turn promote awareness and understanding and greater 'cultural competence' amongst those working with

them or supervising them in their training. It may also be of benefit to the GMC and others in developing an induction programme for overseas-qualified doctors (GMC 2011; Carter 2012), not only regarding the content of the programme but also the way in which it is delivered.

It is important to note that, not only were there overall differences in scores between Great Britain and the countries represented in this study, but also differences between those countries (Table 2). This highlights that incoming doctors are not all facing the same cultural changes, and that knowing in which 'direction' and to what extent they are experiencing cultural change in relation to Hofstede's dimensions may be useful in supporting their transition and on-going practice.

The relevance of this study extends beyond doctors in training. There are other overseas-qualified doctors who come into non-training posts in the UK, who have similar cultural issues, but do not have the benefits of close supervision and a training programme to bring and support them into the UK workplace.

Limitations

Few doctors from the EU could be recruited due to a lack of EU doctors coming to the UK to start FY1 in the year of the study.

As this study followed doctors only up to their first 12 months into the UK workplace, we cannot comment on the long-term impact of training overseas.

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Glossary of terms

Culture: The collective programming of the mind that distinguishes the members of one group or category of people from another.
Reference: Hofstede G. 2001. Culture's Consequences: Comparing Values, Behaviours, Institutions and Organizations across Nations (2nd edition). Thousand Oaks Ca: Sage Publications.

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Ethical approval

The study was approved by the NHS National Research Ethics Service (Cambridgeshire 1 Research Ethics Committee).

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