Comparison of the British and Nigerian Medical Councils’ Codes of Practice: Implications for Postgraduate Medical Training

Foluke Odeyale[2], Itoro Udo[3], Zeid Mohammed[4], Iniobong Udo[5]

Abstract

Recruitment into psychiatry training has benefitted from the willingness of International medical graduates opting to go into psychiatry training. However, in the process of acculturation, international medical graduates face numerous challenges. One of these is the adaptation of medical professionalism from home country to new training environment. Comparison of Medical Codes of Practice of Great Britain and Nigeria showed differences in emphasis in areas such as medical record keeping, risk management, multidisciplinary collaboration, communication needs, relationships with patients & colleagues and financial affairs. It is predictable that on moving medical practice from one medical jurisdiction to another, international medical graduates encounter unique challenges. There is a need for proper attention to the assimilation of international medical graduates into newer practice settings with targeted interventions.

Keywords: Postgraduate, Professionalism, International Medical Graduates and Acculturation

Introduction

Recruitment into specialist and subspecialty training can be challenging (Henry, 2015). The National Health Service in the United Kingdom (UK) has benefitted from influx of International medical graduates (IMGs) over the years. However, in the process of acculturation, international medical graduates face unique challenges. One of these is the adaptation of medical professionalism from their country of primary medical qualification to their new training environment. This, amongst several factors, has been identified as playing a causal role in the higher rates of international doctors losing their registration, i.e. being suspended or struck off the medical register (Slowther et al,
International medical graduates (IMGs) represent 36% of registered doctors in the UK (General Medical Council, 2017). These are doctors who had received their primary medical qualification from outside the UK. As at 2016, Nigeria represented the 5th largest group of IMGs (General Medical Council, 2017). IMGs were noted to have higher numbers of doctors who had been suspended or removed from the UK medical register in 2011 (General Medical Council, 2017; Tonkin, 2016).

Medical training in different countries of the world is guided by relevant codes of professional behaviours and attributes which are embodied by respective medical governing body's code of conduct (Barr, 1996; Bernat, 2012; Medical & Dental Council of Nigeria, 2004). The principles governing proper professional conduct are generated from wider societal (Bernat, 2012; Collier, 2012) and cultural values (Barr, 1996; Ho et al, 2012; Chandratilake et al, 2012; Al-Eraky & Chandratilake, 2012), influenced by history (Pellegrino, 2012; Sugand et al, 2013) and legal processes (Hilton, 2004; Irvine, 2005). They are embedded beginning from medical school (Pellegrino, 2012; Hays et al, 2013; General Medical Council, 2017). There seems to be a general expectation from the wider public that standards and ethics of medical training are similar worldwide, hence patient expectations in UK in regards to doctor-patient encounters (General Medical Council, 2013; Bensing, 2013).

In order to understand the possible wider influences on medical professionalism, the professional codes of conduct in Great Britain is compared with those of Nigeria to identify areas of concordance and dissonance and implications of these on training. This article compares the code of medical ethics of Medical and Dental Council of Nigeria (MDCN; the body responsible for preparing and reviewing the code of conduct for the practice of the profession in Nigeria) with the Good Medical Practice, a publication of the GMC. All doctors who work in the UK are required to be registered with the GMC and to comply with the standards of good practice set out in the core GMC guidance ‘Good Medical Practice’ (GMP). These professional standards are the benchmark against which decisions about a doctor’s fitness to practice are taken. A lack of awareness or due regard to these standards on the part of a doctor may have dire consequences including withdrawal of registration with the relevant regulating body (Slowther et al, 2009; Pellegrino, 2012).

Method

A comparison is made of the official codes of practice of the GMC and the Medical and Dental Council of Nigeria (MDCN) noting areas of similarity or otherwise. Implications for medical training and professionalism are discussed. The MDCN code of medical ethics was issued in Lagos on January 2004 (Medical & Dental Council of Nigeria, 2004). The latest edition of the "Good Medical Practice" was published in March 2013 and came into use from 22nd April 2013 (General Medical Council, 2013).

Results

- Areas of Concordance/Similarity

In both jurisdictions, medical professionals are expected to be knowledgeable, competent and up to date. They also agree on the importance of recognition of one’s professional limitations. Both agree that patients are to be regarded positively and treated fairly. Both emphasize the professional nature of doctor-patient relationship and emphasize necessary social boundaries existent in such relationships.
Both councils expect physicians to be fit for practice and agree that the health of the physician is important. The GMC is silent on the types of illnesses that may constitute impairment, the MDCN states that professionals need to be in the "right frame of mind" (Medical & Dental Council of Nigeria, 2004) and gives examples of situations where this may not occur such as impairment through use of alcohol or substances; senile dementia, etc. Both councils are clear on the professional's duty to maintain confidentiality even after a patient has died except in circumstances whether life and public security is threatened.

- **Areas of Dissonance**

There are no areas of dissonance. However there are areas where emphases are different; record keeping, communication, working with colleagues, working with others and teaching responsibilities.

**Record keeping:**

Both jurisdictions expect doctors to keep records, however while the MDCN emphasises records as proof of adequacy of treatment, the GMC’s emphasis is on the content of what has been documented (See Table 1). Generally, in the latter, medical records are legal documents and information not written may be considered as not having been shared with patients or acted upon.

Table 1. Record keeping-MDCN Vs GMC.

| MDCN | GMC |
|------|-----|
| Maintain medical records that can prove adequacy of methods of treatment. "The medical records… are not for the consumption of any person who is not a member of the profession". | Records should be "clear, accurate and legible". Records should include ”clinical findings, information given to patients, decisions agreed and made any medications prescribed, person making decision and time". |

**Communication:**

Communication is one of the 3 commonest reasons, for referrals to the GMC (Bazian, 2012). Communication is more than language; it includes the nuances, subtleties of the language, non-verbal communications, and tone of voice, mannerisms, body posture and written formats. The GMC emphasizes the need to communicate appropriately with vulnerable persons such as persons with learning disability while the MDCN looks at the mechanics of communication laying emphasis on verbal fluency and clarity of content as well as clarity around monetary arrangements. It omits nonverbal communicational skills as well as the importance of listening (See Table 2). A standard consent form is included in MDCN code (General Medical Council, 2013; Medical & Dental Council of Nigeria, 2004).

Table 2. Communication MDCN Vs GMC.

| MDCN | GMC |
|------|-----|
Communicate fluently and in a language that the patient understands and if necessary use a competent interpreter.

Listen to patients, give them information, and consider the information needs of persons with learning disabilities, hearing and sight impairment.

**Relationship with colleagues:**

While both jurisdictions expect doctors to work collaboratively with colleagues, the GMC promotes a horizontal type of relationship in which individuals relate as equals with different responsibilities and have a duty to work together (General Medical Council, 2013). The MDCN promotes a vertical type of relationship in which the profession is promoted as "noble" (Medical & Dental Council of Nigeria, 2004) with members having a duty to respect seniors and help colleagues while not supporting unethical behaviours including smoking in clinical areas (See table 3). Relationships with colleagues in the MDCN is presented in a way that promotes teamwork in a way that is different from how teamwork may be conceptualised in western societies in which care is increasingly being delivered by multi-disciplinary teams; portraying doctors as authoritarian (and wholly responsible) professionals who operate and work closely with other doctors.

Table 3. Relationship with Colleagues MDCN Vs GMC.

| MDCN | GMC |
|------|-----|
| Accord senior members respect. Acknowledge their seniority in professional or social circumstances. Older members should consider "junior ones as their brothers" and set good examples. "In all such relationships (with non-medical colleagues), the practitioner shall retain the absolute authority and responsibility for the patient and should not delegate any exclusive professional medical or dental responsibility to any non-medical or non-dental person". | Treat colleagues with respect. Be aware of how your behaviour impacts on others |

**Relationship with others:**

The MDCN emphasises professional self-protection. The 2 councils differ in emphasis as regards responding to risks to safety; the GMC is outward looking, emphasizing the need to protect vulnerable persons in one's care (General Medical Council, 2013). The MDCN focuses on the needs of the physician, suggesting to doctors the need to be watchful for any ulterior motives, manipulations and be mindful of their safety. However the means to accomplish this is not stated (Medical & Dental Council of Nigeria, 2004).

This section of the MDCN guidance even when it is read in an open and understanding way seems to reflect a sense of caution and possibly paranoia in respect of a doctor's vulnerabilities, whereas the GMC does flag up the importance of doctors advocating for patients and our duties to protect them rather than to protect ourselves from them.
Table 4. Relationship with Others.

| MDCN                                                                 | GMC                                                                 |
|----------------------------------------------------------------------|----------------------------------------------------------------------|
| "prompt steps to protect themselves from unscrupulous and dubious    | Allow staff to raise concerns openly and safely; speak up if a      |
| patients who may be out to deceive or manipulate them"              | patient is not receiving basic care; tell on colleagues; offer help  |
|                                                                    | in emergencies; protect vulnerable persons.                         |

**Teaching Responsibilities:**

Both the MDCN and GMC expect doctors to be involved in teaching, assessments and appraisal. The MDCN code requires doctors to appropriately supervise and train other doctors while the GMC widens the beneficiaries of supervision to include other members of the multidisciplinary team. (General Medical Council, 2013; Medical & Dental Council of Nigeria, 2004)

Table 5. Teaching Responsibilities

| MDCN                                      | GMC                                                                 |
|-------------------------------------------|----------------------------------------------------------------------|
| Appropriately supervise other doctors.    | Contribute to teaching doctors and students, make sure that all      |
|                                           | staff (including other professionals) have appropriate supervision,  |
|                                           | honesty in writing references, be willing to mentor "more junior    |
|                                           | doctors," support colleagues who have problems but put patient first.|

**Discussion**

The MDCN code of medical ethics and the GMC’s Good Medical Practice are both comparable pieces of guidance with some areas of differing emphases related to record keeping, communication, working with colleagues, working with others and teaching responsibilities. Doctors coming into the UK from the Nigerian jurisdiction to take up training opportunities may occasionally encounter difficulties in adapting their practices to the expectation of their new roles, to reflect these areas of differing emphases. For example, they may not commit to the teaching of other members of the multidisciplinary team as in the jurisdiction of their training, their responsibility is to teach other medics only. They may not also understand why the wishes of persons with learning disability cannot be assumed. They may be less likely to question the practice of older doctors and discuss their training challenges.

The substance of emphasis by the GMC has evolved over time to reflect societal norms, values and expectations of the British people (Slowther et al, 2009) and would possibly keep evolving. We do accept that the MDCN code also reflects the cultural and social norms in Nigeria, especially its unique history of medicine (Scott-Emuakpor, 2010) but there may be a case for whether this code of practice ought to be reviewed to bring it into line with practice as promoted in other countries like the UK.

Patient's autonomy in doctor-patient relationship in the UK, allows patients to be more involved in decision making processes regarding their care (Slowther et al, 2009), except in situations where patients lack capacity to make such decisions. Where that arises, there is complex legislation to protect these patients (British Medical Association,
Medical practitioners are expected to have working knowledge of these legislation, acting in best interests of patients, giving due regard to patients' and carers’ perspectives and/or advance directives (British Medical Association, 2007). It is expected that the details of clinical encounters, examination findings, decision making processes regarding care and agreed actions are recorded for medico-legal reasons. Within MDCN jurisdiction records are also expected to be kept, however doctors appear to be more paternal in their roles and are expected to make decisions for their patients, hence the emphasis on keeping adequate records with additional expectation that such records are reserved for professionals (Medical & Dental Council of Nigeria, 2004).

When it comes to professionalism, IMGs, in our opinion are unfairly expected to develop this competency and quickly at that, without taking into account the fact that this attribute is shaped by the training environments and period of primary medical qualification (Wilkinson, 2012). Ojuka et al in a study of perception of medical professionalism in Kenya, found that their study cohort predominantly conceptualized professionalism as relating to respect between colleagues and towards patients; Respect, being a cultural norm, which may be expected to be an important part of the core curriculum of professionalism in the African cultural context (Ojuka et al, 2016). This is comparable to our findings where MDCN and GMC expect doctors to respect colleagues with the MDCN emphasizing respect for senior members of the profession in professional and social circumstances. Senior colleagues are seen as custodians of knowledge and wisdom in the profession and as such are highly placed.

Even where there may be wider variations in different jurisdictions’ codes of practice, we recognise that these documents are written with good intentions and with requisite recommendations appropriate for their geographical contexts. However, the social context of medical practice potentially influences what behaviours are considered unprofessional in any environment (Jha et al, 2014). An example is the habit of smoking which may be accepted amongst doctors in western social circumstances which in the Nigerian context is likely to be met with public disapproval.

It is recognised that a complex interplay of systemic, organisational, training specific and individual factors are crucial to increased chances of success in adapting to new practice environments (Woolf et al, 2016a; Woolf, 2016b). The above comparison of codes of practice broadens our understanding of some of the systemic differences that crystallise difficulties for IMGs. By addressing these areas of differing emphases, through targeted interventions, the chances of IMGs succeeding in their training may be improved (Kehoe et al, 2016; Dahm & Cartmill, 2016).

Strategies necessary to support IMGs to successfully adapt and acculturate to new jurisdictions may be at individual, training hospital/programme and country levels. Individual doctors need to be proactive in learning about their new locations and associated cultures. They need to be willing to adapt or make adjustments for their new surroundings, for example, this may be through revisiting their communication skills. They need to be enthusiastic and willing to engage in support programmes and schemes.

More could be done by employing hospitals to address some of the issues highlighted in this review, to facilitate smooth transition into new jurisdictions. Kehoe et al (2016), suggests that information about work, culture and general issues should be sent to IMGs at the earliest opportunity, before commencement of work. Comprehensive and mandatory induction should be provided as early as possible before IMGs begin practice; IMGs would benefit from an individualised needs assessment and their supervisors should be aware of these individual needs and provide on-going feedback. Kehoe et al (2016) also suggest the assignment of buddies to IMGs. Mentorship programmes, hosted by the receiving hospitals or training programmes could also be useful in pairing new IMG trainee doctors with more experienced doctors who share similar cultural background or social experiences. Human resource departments need to be able to easily identify IMGs entering organisations and put in place requisite support.

At a country level, induction courses for doctors new to the GMC register, organised by the GMC in the past
received positive feedback from doctors about its usefulness in introducing new doctors to the UK’s complex health service (Slowther et al, 2009; Wakeford, 2011, with doctors having opportunities to share first-hand experiences of more experienced colleagues. Policy needs to be clear that those in non-training posts should be entitled to the same induction and level of support accorded to trainees. This is important because IMGs, from our practical experience, tend to begin their overseas medical careers from non-training positions. Policies can also guarantee that diversity in postgraduate medical education is taken more seriously, with better understanding and appreciation of differing learning styles and cultural experiences. Experiential learning opportunities for IMGs are needed to ensure that new practices are adopted and transferred into practice (Kehoe et al, 2016).

In terms of research priorities, there is paucity of research examining the implications for patient care of differences in medical codes of practice. A further comparison of the GMC code of practice with the codes of practice of countries with higher numbers of IMGs practising in the UK would be necessary to understand these differences in wider context. There are limited studies on medical professionalism in Africa and the Middle East.

Conclusions

Patients may expect to receive good standard of medical care in both jurisdictions. However, medical councils differ in areas of emphases such as pertaining to medical record keeping, multidisciplinary collaboration, communication skills and relationships with patients and colleagues. It is predictable that IMGs moving to train or work in other jurisdictions may struggle with multi-disciplinary (team) work, advanced communication skills, record keeping, delegation and changes in professional duties, roles and responsibilities. These differences underscore the need for proper attention to the assimilation of IMGs into newer professional councils. Both IMG doctors and employing bodies need to be aware of these difficulties, and target them for specific supportive interventions. Creating an accommodating, supportive and enabling environment which takes into account these known potential challenges is perhaps the most essential ingredient for successful transition. It is possible to address the highlighted issues proactively.

Take Home Messages

- International Medical Graduates face unique challenges in transitioning to new health systems of their host countries.
- One of the reasons may be challenges in acculturation of medical professionalism from one jurisdiction to another.
- Host countries may play a role in supporting new doctors by becoming aware of their unique difficulties, and target them for specific supportive interventions.
- Creating an accommodating, supportive and enabling environment which takes into account known potential challenges is essential for successful transitioning.
- Host hospitals and countries can work proactively with international medical graduates to address the highlighted issues.

Notes On Contributors

Dr. Foluke Odeyale is a Specialty Registrar, ST6 in Older Person’s Mental Health, Langstone Centre, St James
Hospital, Portsmouth, Solent NHS Trust.

Dr. Itoro Udo is a Consultant Psychiatrist (Locum), Haleacre Unit, Amersham General Hospital, Amersham, Oxford Health NHS Foundation Trust. He holds an MSc (Medical Education) with distinction from Durham University.

Dr. Zeid Mohammed is a Consultant Psychiatrist, Lanchester Road Hospital, Durham, Tees, Esk, Wear Valleys NHS Foundation Trust. He is postgraduate tutor at Tees, Esk, Wear Valleys NHS Foundation Trust.

Dr. Iniobong Udo is a Consultant Physician (Locum) at Queen Alexandra Hospital, Portsmouth, Portsmouth Hospitals NHS Trust.

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Appendices

Declarations

The author has declared that there are no conflicts of interest.

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