Overseas Registration Examination Stakeholder Consultation

Final Report
September 2016

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1. Executive Summary

1. The purpose of this piece of research is to provide credible evidence of stakeholders' perceptions of the effectiveness of the Overseas Registration Examination (ORE) and its role in assessing fitness for UK dental practice. This study aims to provide information that will add to the evidence that is already in existence through QA processes, to aid the ORE Advisory Group in making a judgement about the fitness for purpose of the examination.

2. In conducting this research, and interpreting the findings, it is important to acknowledge that as the focus of the research was in relation to ORE qualified dentists it is not possible to identify whether UK qualified dentists have similar or different weaknesses/areas for development from their ORE qualified peers. Although respondents were asked to consider performance of ORE qualified dentists in relation to UK qualified dentists, systematic data that enables comparisons to be made is not available. As such, great care needs to be taken in interpreting any findings in relation to the performance of ORE qualified dentists when there is no comparative data from UK qualified dentists available.

3. A mixed methodology approach was employed, applying both a rapid literature review, drawing upon evidence from dentistry and other healthcare professions, and stakeholder interviews. A total of 21 stakeholders participated in the research. They came from a range of roles and backgrounds. Interviews lasted for approximately 45 minutes and were structured around the four domains identified in the GDC documentation 'Preparing for Practice' that cover the skills and attitudes required of a UK qualified graduate.

4. Thematic content analysis was used to analyse the data. Using the structure of the four Preparing for Practice domains, the data was coded, trends and patterns identified, and then themes summarised and presented alongside qualitative comments. Evidence was also drawn from the literature review to help validate the findings.

5. Areas of both strength and development need were identified by respondents in all four areas. Under the **Clinical** area, it was generally agreed that it was not the clinical skills that are problematic or an area of weakness and that ORE qualified dentists are experienced, knowledgeable and skilled in this area. The greatest area of development need for some ORE qualified dentists appeared to be **Communication**. When ORE qualified dentists are having difficulties, communication was perceived to be at the centre of these problems with language and culture being the underlying influencing factors. It was concluded from the analysis that overarching perceptions of ORE qualified dentists' **professionalism** was generally high with a clear theme emerging that ORE graduates are generally very motivated, diligent and organised in relation to learning and on-going development. However, there was some mixed evidence, with a few areas that were unanimously highlighted as requiring attention. Finally, the pattern of responses indicated that ORE qualified dentists' **management and leadership** skills were generally mixed although there were no areas that were unanimously highlighted as being problematic. However, increasing an awareness of UK dental team structures as well as wider UK social structures (i.e. absence of hierarchies) may be a potential area to be further considered as part of the ORE.

6. In summary, some common patterns and trends were identified through the research that have provided valuable insight into the working practices of ORE qualified dentists. A number of the

areas highlighted by respondents would be challenging to fully address through the examination itself (e.g. nuances of English language, cultural norms and beliefs), and indeed may be viewed as more developmental in nature, and would best (and are in many cases) be addressed through the post-registration training period. Many of these findings also align with findings from both within and outside of dentistry, as outlined in the literature review indicating that these are not unique issues and are broader in scope rather than being attributable to the ORE itself.

7. There were a small number of practice issues deriving from the evidence identified that could possibly be considered for potential emphasis/inclusion in the ORE. Decisions relating to this approach should also take into consideration the range of other information that may be available on the content and construct validity of the ORE, as this piece of research can only provide one source of information. These practice issues are outlined below and summarised in Figure 1:

8. *Clinical*:

    - Taking radiographs, assessing their diagnostic quality and interpreting the findings
    - Choice of dental materials and types of available clinical instruments

9. *Communication*:
    - Communication skills focussing on empathy and building rapport
    - Patient consultations where the dynamic of the communication is changed by the presence of a husband or male relative
    - Consultations where nuances of language are explored
    - Consultations where the subtleties of body language have to be interpreted
    - Consultations involving anxious patients
    - Obtaining consent and the principles surrounding this

10. *Professionalism*:
    - Emphasis on record and note keeping in UK practice in order to prepare ORE graduates for the standards expected in the NHS
    - Approaches to, and awareness surrounding, seeking advice/admitting mistakes

11. *Management and Leadership*:
    - Approaches to referrals patterns so that ORE qualified dentists are able to approach UK practice with a full understanding of standards regarding referrals.
    - Increasing an awareness of UK dental team structures (i.e. the roles of other members of the dental and other healthcare teams) as well as wider UK social structures (i.e. absence of hierarchies) to support multi-professional working.

Figure 1: Summary of Findings and Issues Identified

12.   A number of potential next steps are provided and a summary of these are outlined below:

- **Alignment with other Findings**. This research has provided some valuable information, however it is prudent to consider the findings in relation to broader evidence that is available to help support and validate. For example, a review could be undertaken to investigate how these results correlate with both Preparing for Practice domains and assessment data.

- **Candidate Perceptions**. An understanding of candidates' reactions to the process is essential, particularly in relation to perceptions of relevance and fairness (i.e. face validity). Candidate perceptions of an assessment process can also be used to make continued improvements to the process. This can be gathered following each sitting of the examination if required.

- **Assessor Feedback Process**. Given the valuable insight that stakeholders can provide, it is recommended that an effective mechanism for gaining feedback from stakeholders on a regular basis is considered.

- **Post Assessment Evaluation**. Establishing the validity of an assessment process is especially important to ensure that the test is assessing what it is intended to assess. Within an assessment context, *predictive validity* is the 'gold standard' in terms of the primary evaluation criterion. Predictive validity examines the relationship between test performance and in-role performance. Outcomes can also be used to identify areas for further improvement and development as well as informing policy to optimise effectiveness and efficiency of the assessment system in future.

- **Evaluation of Implementation**. If any changes are made to the ORE then it is important that this is done in accordance with best practice principles. This includes seeking further

evaluation evidence as to the impact of these changes on the reliability, validity and perceptions of the examination.

- ***Broader Dissemination***. A number of issues or factors have been elicited from the research (e.g. aspects relating to nuances of English Language, cultural norms and beliefs, levels of support received) that would be difficult to fully addressed by the ORE. To maximise the outputs of this research it is important to share this rich data with the GDC and other bodies such that this information could be used to help inform work plans and further training.

13. In conclusion, this qualitative piece of research has added valuable insight into the performance of ORE qualified dentists, and thus perceptions in relation to the effectiveness of the ORE. Although no clear conclusions can be drawn about the validity or effectiveness of the ORE itself, given that ORE-registrant performance cannot be solely directly attributable to the exam, this nevertheless provides an important part of the jigsaw in terms of further understanding of the ORE's fitness for purpose.

2. Overview

Background and Context

2.1   The Overseas Registration Examination (ORE) is a means by which dentists whose primary dental qualification was obtained outside of the European Economic Area may gain entry to the UK Dentists Register maintained by the General Dental Council. Such registration allows dentists to practice dentistry unsupervised in the UK. The ORE is based on the GDC requirements for registration and has two parts. These consist of a written examination (Part 1) and a simulated clinical examination (Part 2).

2.2   The GDC 2014 annual report states that 6.9% of dentists and dental care professionals on the register were ORE qualified, and 10% of new registrants in 2014 were ORE qualified. Thus there is a significant proportion of dental professionals within the UK that are entering through this route.

Evaluation Aims

2.3   The purpose of this piece of research is to provide credible evidence of stakeholders' perceptions of the effectiveness of the Overseas Registration Examination (ORE) and its role in assessing fitness for UK dental practice. This study aims to provide information that will add to the evidence that is already in existence through QA processes, to aid the ORE Advisory Group in making a judgement about the fitness for purpose of the examination.

2.4   Evidence is predominantly collected from stakeholders, who have had experience of employing, training or working with ORE qualified dentists. These individuals are able to provide valuable insight into the performance and quality of work of these dentists. Where appropriate, attempts were made to explore differences or similarities between ORE qualified dentists and their UK counterpart, however this was not the primary aim of the research and the methodology applied did not fully allow for robust direct comparisons to be made.

2.5   This research cannot in itself fully inform stakeholders about the face validity, construct validity or predictive validity of the exam. It does however have the potential to help all stakeholders further understand some characteristics of the performance of ORE qualified dentists in their first few years of practice in the UK. It may therefore provide additional information that can contribute to the quality assurance of the examination.

2.6   This research forms one part of a wider evaluation strategy aimed at gathering views on the perceptions of the ORE. This includes an ORE registrant survey, carried out in November 2015, which explored these dentists' career paths and experiences in gaining employment in the UK. The outputs of this research will be considered alongside the outputs of the registrant survey.

Outcomes of the Research

2.7   The outcome of the research is a framework of themes relating to the performance of ORE qualified dentists. This is supported by qualitative comments to aid understanding and interpretation. Together, these outputs will help support understanding of how the ORE functions and aid further discussion and reflection.

2.8   This document consists of three sections, as follows:

- Methodology

- Results

- Summary, Conclusions and Next Steps

3. Methodology

3.1 Research Design

3.1.1 This research utilises a qualitative research design, consisting of individual interviews. Whilst individual interviews have fewer opportunities for shared discussion, debate and spontaneity than focus groups for example[1], participants may be more candid expressing their views and perceptions concerning the potentially sensitive and personal issues relating to quality of work and differential attainment in practice.

3.1.2 During the interviews, a critical events approach[2] in order to elicit examples or specific narrative incidents that are characteristic of participants' experience was used. This sought to help identify the key issues and how these are different or similar across groups. This approach allows the exploration of significant events which have occurred for the interviewee, and enables the exploration of interviewees' direct experiences, beyond simply discussing their opinions or views about a particular subject. Also employing narrative interviewing[3] techniques (where interviewees are encouraged to provide an account of the event or situation in their own words, at their own pace) encourages participants to articulate personal or general incident narratives relating to their work with ORE qualified dentists.

3.1.3 In analysing the data gathered, thematic content analysis[4] was used, employing both a deductive and inductive approach. Template analysis is a method for systematically identifying, organising and offering insight into patterns of meaning across a dataset thus allowing the researcher to see and make sense of collective or shared meanings and experiences.

3.1.4 Template analysis is flexible to enable both a deductive and inductive approach; an inductive approach to data coding and analysis is a bottom-up approach and is driven by what is in the data. In contrast, a deductive approach to data coding and analysis is a top-down approach, where the researcher using a structure or predetermined framework to code and interpret the data. A combined approach is often adopted by researchers as it is almost impossible to be purely one or the other[5].

3.1.5 The key stages when undertaking thematic analysis include; familiarising self with the data, generating initial codes, identifying emerging themes, verifying, confirming and qualifying the themes, defining and naming the themes and producing a report.

3.2 Research Stages

3.2.1 *Stage 1: Rapid Literature Review.* A rapid review of the literature was undertaken to provide some initial insight into the potential factors that can impact overseas qualified dentists (and other healthcare professions) working in the UK. The purpose of this review was to both help inform the design of the framework, but also provide context during the interviews. By

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[1] Stringer, E. (2004) Action Research in Education. Pearson/Merritt/Prentice Hall.

[2] Flanagan, J. C. (1954) The critical incident technique. Psychological Bulletin, 51, 327-358

[3] Powell, M., Fisher, R., & Wright, R. (2005). Investigative interviewing. In N. Brewer & K. Williams (Eds.), Psychology and law: An empirical perspective (pp. 11–42). New York: Guilford.

[4] Guest, G., MacQueen, K.M. & Namey, E.E. (2012). Applied thematic analysis. Thousand Oaks, CA: Sage.

[5] Braun, V. & Clarke, V. (2012). Thematic analysis. In H. Cooper (Ed.) The APA handbook of research methods in psychology: Vol 2. Research designs (pp.57–91). Washington, DC: American Psychological Association.

understanding the potential issues that ORE qualified dentists could face, this enables the interviewer to be able to explore the responses in more depth, be vigilant to any interaction effects or underlying reasons for behaviours and help to separate issues relating to the ORE (i.e. clinical competence, knowledge, possession of professional attributes) and those relating to other influencing factors (i.e. first language, ethnicity).

3.2.2 Literature in relation to the dentistry profession was reviewed, however literature from other healthcare sectors was also drawn upon. Given WPG's previous work in this area, evidence in relation to struggling trainees and professionals in healthcare was able to be rapidly drawn upon. In relation to dentistry specific evidence, a review was carried out across databases including: PubMed, ResearchGate and Google Scholar with search terms including 'dentists', 'dentistry', 'overseas', 'performance', 'struggling' and 'difficulty'. Recent research in relation to difficulties that dental practitioners face and the reasons why was found to be scare, with more recent research originating from Australia and New Zealand. It should be noted that this has not been, and nor has intended to be, a systematic review of the difficulties facing dentists or healthcare professionals, but rather is to be used as a starting point for the ORE stakeholder evaluation.

3.2.3 The research found that overseas healthcare professionals tend to perform less well in both academic assessments (e.g. Patterson et al 2013) and clinical practice (e.g. Harik et al, 2006) than their UK or home-trained counterparts. For overseas healthcare professionals in particular, **differences in academic backgrounds** (e.g. curriculum, standards) and **cultural backgrounds** (e.g. team working, the role of seniors) have been proposed as potential reasons for why these individuals may face difficulty in UK practice. In addition, the level and **quality of preparation to work in the UK** for overseas graduates (e.g. knowledge of the UK healthcare and legal system, induction processes etc.), is another theme emerging in the literature as a reason why these individuals may go on to encounter difficulty (Bhat et al, 2014; Slowther et al, 2009). **Language** has also been found to impact subsequent performance, with bilingual international graduates being more likely to struggle in practice and during examinations (Patterson et al, 2013; Harik et al, 2006). This links to general levels of **clinical skills/knowledge** as seen in examination performance, with international graduates tending to perform less well than their home-trained counterparts (Patterson et al, 2013; Holtzman et al, 2014), which in turn, has been linked to future performance in practice (Norcini et al, 2014; Wenghofer et al, 2009).

3.2.4 Research has found that specific **physical and mental health** problems can have an impact on health professionals' performance in practice (Pitkanen et al, 2008; Firth-Cozen, 1999), with some research suggesting that the individual's behaviour in relation to these complaints e.g. reluctance to take sick leave etc. can further exacerbate some of these difficulties (Cox et al, 2006; Baldwin et al, 1997). **Behavioural and personality factors** are also highlighted as contributors as to why health professionals struggle, with research suggesting that health professionals who are rigid and lack insight may experience difficulty in practice (Cox et al, 2006), and health professionals who demonstrate low levels of conscientiousness and high levels of neuroticism may also go on to struggle (Paice, 2009; Firth-Cozens et al, 1999).

3.2.5 **Work context** is another salient theme emerging from the literature, with research indicating that health professionals who feel isolated at work, have experienced bullying in the workplace

and who are dealing with supervisory issues or contractual changes are more likely to go on to encounter difficulty in practice (Southgate et al, 2001; Paice, 2009). **Significant life events** e.g. death, breakdown of relationships, major transitions, money worries have also been identified as reasons why healthcare professionals both in general and overseas may go on to struggle in practice (Cox et al, 2006; Bhat et al 2014).

3.2.6 A summary of the key themes emerging can be found in Figure 1 below. The full literature review can be found in Appendix A.
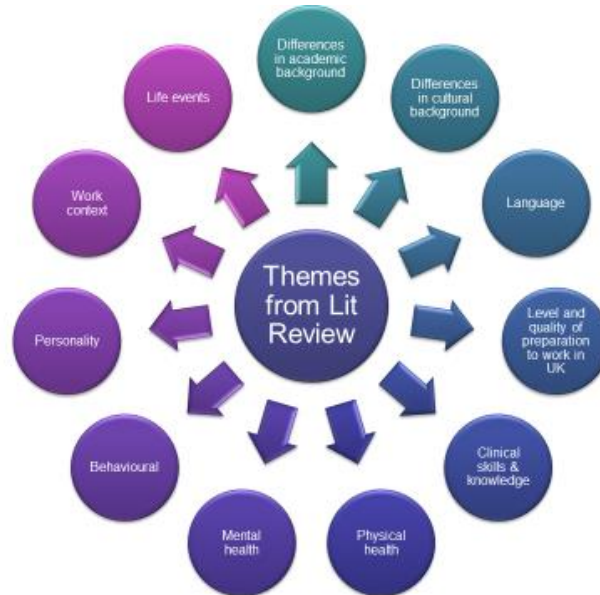
3.2.7 *Stage 2: Development of Interview Framework.* In order to develop a framework to inform the research content and the interview design, relevant dental experts took part in a workshop. The workshop lasted for two hours and n=5 experts attended. Here issues relating to defining performance was explored, and detailed discussions were held in relation to the proposed structure of the interviews.

3.2.8 Following this workshop, the information was collated and reviewed, and then triangulated with the findings from the rapid review to create an initial interview framework. The framework was designed to ensure that the questions were able to effectively draw out the relevant information from the interviewees. The framework was primarily the four domains identified in the GDC documentation 'Preparing for Practice' that cover the skills and attitudes required of a UK qualified graduate (Clinical practice, Communication, Professionalism, Leadership & Management), and included a series of prompts around these areas. There were amendments to wording depending on the type of participant. A draft version of the framework was shared with the steering group and a final framework confirmed. The full framework can be found in Appendix B.

3.2.9 The framework was reviewed after four interviews (conducted by two researchers) but no further amendments were made to the framework.

3.2.10 *Stage 3: Semi-structured Interviews*. Telephone interviews were conducted to maximise convenience for participants, and minimise travel costs. The interviews typically lasted for 45-60 minutes and were audio recorded (consent was sought at the commencement of the

interview). Interviewees were provided with a briefing prior to the interview and assured anonymity in terms of their interview responses.

3.2.11 Three researchers undertook the interviews. Following the first five interviews a debrief was held to review the evidence coming out of the interviews and calibrate the style and structure of the interviews. This preliminary analysis and discussion helped to direct further interviews (although not alter questions), drawing upon grounded theory[6].

3.2.12 **Stage 4: Data Analysis.** In the analysis of the data, thematic content analysis was employed. Predefined structure codes (in the form of the four Preparing for Practice domains) had already been identified, and these were used as a basis for the analysis (deductive approach). Additional layers of coding within each of these themes then took place, with patterns relating to consistent themes across the structure codes also identified (inductive approach).

3.2.13 The revision to the initial coding framework took place iteratively throughout the capturing and review of data, to the point at which the research team was confident that the coding structure was saturated (i.e. when all aspects of the data can be readily classified). Themes and patterns in relation to performance were identified and triangulated between respondents, and influencing or underlying factors explored.

3.2.14 Throughout the review, researchers remained vigilant for situations in which additional factors such as period of training, academic attainment, and other factors (such as family remaining in home country) are having any bearing on relative success in practice, and whether there are any identifiable interactions between these different factors, drawing upon the findings from the literature review.

3.2.15 Following the data analysis, the outputs were critically discussed, triangulated and compared to the existing research i.e. the literature review, to validate the findings.

3.2.16 As a final validation of the outputs from the analysis, a panel of researchers trained in qualitative analysis reviewed the content and the constructs within the output to confirm the themes derived were accurately represented.

3.3   Sampling Approach

3.3.1   *Sampling of Individuals:* A range of individuals were targeted to gain a breadth of perspectives. These included practising dentists (including those who employ ORE qualified dentists in their practice), trainers (for those who are overseas qualified but still eligible for training posts), practice managers, dental nurses, dental hygienists and dental technicians.

3.3.2   When sampling individuals, a representative cross section of demographics was sought, particularly in relation to gender and ethnicity. This is particularly important given topic under research. Consideration was also given to sampling from experienced overseas qualified dentists (i.e. <15 years working in the UK) to ensure a representative view was sought.

3.3.3   *Sampling of Sectors:* ORE qualified dentists may work in primary care in general practices (NHS, private or mixed), or in secondary/tertiary care where more specialised care is provided by NHS hospitals/foundation or acute trusts. Here there are a number of specialties they may work in,

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[6] Strauss, A. and Corbin, J. (1998) Basics of qualitative research: grounded theory procedures and techniques. Sage: London.

including oral surgery, endodontics and orthodontics. Some of these specialties may also be practiced in specialist practices. Universities also employ dentists to teach undergraduate and postgraduate students. Sampling attempted to take place across these sectors in a representative manner.

3.3.4 *Sampling of Geographical Location*: Interviews were sought with individuals across the UK including ensuring representation from London and other large urban centres, as well as more rural locations.

3.4   Limitations

3.4.1 The project initially aimed to secure approximately 32 participants in the research; 21 individuals participated overall. Along with the Steering Group, every effort was made to recruit volunteers. In some instances, potential participants were reluctant to get involved due to the nature of the study and a belief that they would not be able to provide accurate information about the cohort due to the limited numbers of individuals with whom they have come into contact. However, despite not meeting the original aims for participant numbers, the researchers did identify a level of saturation towards the end of the data gathering stage (i.e. the collection of new data was not shedding any further light on the themes and patterns emerging) thus indicating that the number of participants involved was satisfactory. With any qualitative analysis, there is a point of diminishing return to a qualitative sample; as the study goes on more data does not necessarily lead to more information (Mason, 2010)[7]. Whilst there is no clear guidance on this, Green and Thorogood (2009, p.120)[8] state that "*the experience of most qualitative researchers is that in interview studies little that is 'new' comes out of transcripts after you have interviewed 20 or so people*".

3.4.2 Stakeholder perception research enables views to be sought in relation to a particular topic area (i.e. the performance of ORE qualified dentists); how far this can be attributed back to the ORE itself is not a straightforward question as the underpinning reasons for this behaviour are likely to be multi-faceted and may not be related to aspects that the ORE is able to address. Thus, by the nature of this type of research, any conclusions or attributions made to the ORE itself by the researchers require further triangulation and review.

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[7] Mason, M. (2010) Sample size and saturation in PhD studies using qualitative interviews. Qualitative Social Research, 11 (3)
[8] Green & Thorogood (2009) Qualitative Methods for Health Research. Sage

4. Results

4.1 Overview

4.1.1 This section presents the results of the qualitative analysis and triangulation. Given the framework that had been used to guide the interviews, the findings are presented by overall theme (i.e. four Preparing for Practice domains). Underlying concepts or influencing factors that help interpret the findings are also drawn upon across the four themes, with a summary of these provided in section 4.4 and Figure 2. Triangulation with evidence collated from the literature review is incorporated into the presentation of results. Finally practice issues arising from the evidence are summarised in section 4.5.

4.2 Participant Sample

4.2.1 A total of 21 interviews were undertaken over a period of three months. Appendix C provides a breakdown of the gender, age and ethnicity of the sample.

4.2.2 Table 1 below provides an overview of the role of the participants. Some participants had multiple roles, as well as previous experience/background (i.e. a trainer with a nursing background). Primary role is presented here.

Role	N
Dental Trainer/Advisor/Tutor	13
Clinical Director	4
Practice Manager	3
Postgraduate Teacher	1

Table 1: Role

4.3 Findings from Qualitative Analysis

4.3.1 Within each overall theme, subthemes are examined with illustrative qualitative comments to accompany the narrative and provide context and clarity.

4.3.2 Clinical

4.3.2.1 17 of the 21 respondents were able to comment in this area; with five of the respondents identifying no developmental areas at all in this area, with the remaining providing mixed evidence.

4.3.2.2 The majority view was that ORE qualified dentists are **experienced, knowledgeable and skilled** in this area;

> "They tend to have experience and there is no substitute for this in the clinical dental field, as with this comes confidence. In general terms I don't have any that come onto my radar as being poor in terms of clinical performance"

however as with any group, there is variability within this cohort just as there is with the UK counterpart cohort.

4.3.2.3 A relatively large proportion of respondents cited the **experience they have had in their own country is beneficial.**

> "*the majority of ORE dentists have got several years' experience so clinically they tend to know what they're doing*".

and that often they have **specialised in particular areas** (e.g. periodontal, oral surgery, emergency patients), and thus these are areas of particular skill. However, this higher likelihood of specialism may mean that they not have worked in general dental practice for a number of years; therefore, they may have **skills in one particular area but not across the board.**

> "*[ORE qualified dentists are] experienced in different areas of clinical dentistry, some hadn't done anything doing oral surgery before whereas other had more attention on their crowns and routine dentistry.*"

4.3.2.4 However, having experience in another country outside the UK was also deemed to be a potential weakness. Aspects such as **lack of clinical knowledge/experience or understanding of materials used, or particular procedures** were mentioned; some of this likely to be attributable to how things are done differently in different countries (for example other team members responsible for radiographs)

> "*probably mainly to do with the radiography, where they're used to somebody else doing that for them…it's just something that they don't do so if there's nobody else available to do that, that's kind of when we have the issues around it*"

or where certain procedures are not common (e.g. restorative work). In addition, there was general agreement that the focus on dentistry in some counties is **more treatment focussed than preventative** as it is in the UK. This concept of 'experience' or exposure to UK specific systems or ways of doing things was also drawn out across the communication theme in relation to consent in particular, and professionalism in relation to note taking.

4.3.2.5 This theme relating to experience aligns with the findings from the literature review with regards to '*differences in academic background*'. Here the research mainly focussed on the curriculum but the same principles apply to practice. The review found that dentists graduating from countries with different curriculums to the UK (and thus experience) possess varying levels of clinical skills and knowledge which may thus cause them to demonstrate different working patterns and exhibit different levels of performance to UK trained dentists (NCAS, 2011).

4.3.2.6 Another cited important consideration was that ORE qualified trainees may have been **out of practice for some time** which may mean that their clinical skills and clinical knowledge are not current; this is also an underlying consideration across the communication theme.

> "*They become a bit deskilled in the clinical aspects, so unless they are working in the private sector in either primary or secondary care in the UK…the need some time to get their skills back [due to] not having done clinical work for some time*".

4.3.2.7 Only one respondent could recollect any clinical incidents (in relation to radiographs) and no one was aware of any complaints in relation to clinical skills

4.3.2.8 However, it was generally agreed that it was not the clinical skills that are problematic or an area of weakness for the majority of ORE qualified dentists.

4.3.3 Communication

4.3.3.1 All 21 respondents felt able to comment on the communication skills of ORE qualified dentists. The **response here was more mixed**; two respondents indicated that they had never experienced any issues in the area of communication and their experience was overly positive. Five respondents provided an overall less positive picture, indicating that this was a real area of concern. The remaining respondents felt the evidence was mixed, with some areas being of strength and other areas being opportunities for development, and in other cases where no particular pattern for this cohort could be identified.

4.3.3.2 An overarching theme that was identified is that ORE dentists tend to be **respectful and professional** and this can be observed through their communication both with peers and patients;

> "*[they have] very good communication skills…and their professionalism and their work ethic is second to none*".

However, a **lack of confidence**, and traits such as being more quiet and **reserved** were cited in some cases as impacting upon communication both with members of the team and patients. A small number of respondents used the phrase 'eager to please'. Whilst positive in some respects, this trait does have the potential to negatively impact the patient interaction i.e. trying to please the patient at the expense of doing what is clinically necessary, or simply saying what they think the patient wants to hear.

4.3.3.3 A number of respondents indicated that ORE qualified dentists as a whole are readily able to demonstrate **empathy** towards patients,

> "*In terms of wanting to make people feel at ease and communicate from that point of view [empathy], I've never come across anybody on the ORE scheme who's had issues with that*".

However, others felt that this was not an area of strength or that they had observed both cases of positive and negative examples of this, in some cases with gender also playing a role.

> "*I have found that often there's a gender difference with the ORE qualified dentists that I've dealt with in the fact that female ORE dentists seem to……empathise with patients better and build up a rapport and a lot of that is based around the body language, whereas in some cultures, particularly from a male point of view…these individuals, unknowingly can come across quite cold and quite hard and firm.*"

4.3.3.4 The terms 'short', 'blunt' and 'abrupt' were used by a small number of respondents (n=7) when describing the interactions that ORE qualified dentists may have with patients or peers.

> "*we've had some cases where parents have said they've been abrupt with child patients*"

4.3.3.5 The literature review found evidence that overseas trainees may struggle that GP trainers reported non-UK trained GPs as struggling with levels of empathy (and a tendency to respond

to patients in an abrupt, brisk and authoritative manner) as well as the general structure of patient consultations.

4.3.3.6 Similarly, **mixed views** were obtained in relation to being able to **adapt their style of communication** with some indicating that they generally had seen no issues with this, whilst others had observed that this was an area of difficulty, for example not using less complex language with a child or not getting down to their eye level**.** The ability to **build rapport with patients** again engendered contrary views, as did the **listening skills** of ORE qualified dentists where some respondents indicated that ORE qualified dentists can sometimes struggle to "deep listen" whereby a dentist listens to a patient's concerns before coming back to them, summarising and clarifying**.** Some respondents indicated that ORE qualified dentists were competent in dealing with **anxious patients,** whilst others indicated that this was area where they struggled, with a potential lack of experience of this in their home country cited as one contributory factor and thus lack of knowledge in how to handle such situations.

> "*some struggle a bit more and again it comes back to a lack of experience in terms of being able to manage those anxious patients*"

One respondent noted that ORE qualified dentists tend to discharge responsibility in this area, often referring anxious/phobic patients to another dentist.

4.3.3.7 **Challenges in gaining consent** was identified as a key factor by a number of respondents (n=10) and is an example of how the three underlying influences can interact to impact upon performance. Here it was identified that i) a lack of understanding of the UK requirements in relation to gaining consent, ii) challenges in presenting complex information in a way that the patient understands, and iii) the ability to 'read' the patient to know if they had fully understood i.e. interpreting the subtleties and patients' feelings and understandings were all contributing factors.

> "*It's the ability to explain and inform to patients what they're doing and what concerns me is the level of consent they're getting from the patients…Their ability to convey to a patient what can be a complex treatment plan and all our students, because they're doing postgraduate dentistry, the treatment is essentially complex. It's their ability to get this across to the patient and the associated risks and that's where I see the problems coming and they don't surface probably until they've completed the ORE, got into practice somewhere in the UK and then they struggle*".

4.3.3.5 Given the variety of experience in relation to these areas, it is important to further try and understand <u>why</u> these differences exist and whether once identified, these can be highlighted as potential areas for addressing/emphasising to a greater extent as part of the ORE. Reasons for the challenges identified in these areas tended to be related to a number of factors which interweave throughout this research. These are explored below.

4.3.3.6 *English Language Proficiency*; an overarching theme raised was that it is the **subtlety and nuances of the English language** that some ORE qualified dentists tend to find so difficult;

> "*one of the problems that we've had with our ORE colleagues and other dental colleagues is picking up the nuances of regional accents and expressions…some ORE colleagues will miss out on this and that has a massive impact on communication with a patient.*"

For example, words with more than one meaning (e.g. the word 'smart' in relation to pain), the nuances of expressions (e.g. the word 'pop' as in 'pop open your mouth') and regional terminology/colloquialisms. This latter aspect may be particularly problematic as it can be difficult to pinpoint in standard language assessments or indeed through the ORE itself.

> *"There is a huge variation in the ability of these ORE qualified dentists to communicate either with professional colleagues or patients and I think this is borne out by a variation in their English language skills. One of the things that we have experienced is that they may have scored well in IELTS however their actual practical communication sometimes doesn't match the score that they've got."*

4.3.3.8 Lack of language proficiency can cause difficulties in **explaining complex patient treatment plans** and the associated risks, potential misinterpretations, as well as being a barrier to enabling a **two-way dialogue**, with patients not always being able to effectively convey their expectations or queries to the dentist. This can then result in patients having a lack of confidence in their dentist.

4.3.3.9 This underlying theme aligns with previous research as identified in the literature review. Difficulties arising due to language barriers was a common theme that Patterson et al (2013) found as being a contributing factor towards why non-UK trained GPs are perceived to struggle in UK practice. The research found that although GP trainees who had English as a second language showed good comprehension and accurate diagnoses, they often struggled with the nuances and phraseology that are specific to the UK context, which was in turn, found to impact on the quality of their patient consultations. A study by Balasubramanian et al (2015) found that overseas qualified dentists in Australia struggled most with language and communication, including understanding 'slang' as well as differences with people, religion or lifestyle.

4.3.3.10 *Cultural differences:*

- *In the UK NHS values & UK culture* i.e. placing the patient at the centre of care. Some ORE qualified dentists may expect patients to simply do what they say given the difference in hierarchy afforded in some countries, where **healthcare professionals have more of a 'status' associated with them**. This can cause them to overlook the patient's wishes and result in them *telling* people what they need rather than *discussing* what they need.

  > *"I've seen some cases where I think maybe in countries where dentists, doctors are held in high esteem and they just expect people to do what they say. But here they have to adjust the way they work so that they have to accept the fact that there's a patient there who has their own thoughts and ideas and we have to work with that".*

  This relates to a rigidity of thinking and a tendency to form their own opinions of a patient's condition before listening to what the patient has to say. Research suggests that often the key elements behind poorly performing doctors are behavioural traits including rigidity and poor insight (Cox et al, 2006; Paice & Orton, 2004).

  It was also cited that in the UK, we may have different (and often higher) expectations and standards around how we expect to be treated and communicated to compared

to in their home countries. One example cited was that UK patients may expect to be given local anaesthetic more readily than in some countries.

Patterson et al (2013) found cultural background to be a salient theme contributing towards overseas doctors struggling when practising in the UK, particularly in relation to consultation behaviour; thus this does not seem to be a unique issue to ORE qualified dentists.

- *In relation to cultural norms and beliefs*; in some cultures, **men, woman and children are given different status,** which can influence communication style. For example, males are viewed as dominant and females as subservient;

  "There are definitely cultures where some of our ORE colleagues come from that the man is spoken to and the lady is not. I have first-hand seen that where a husband and wife have come into a surgery and even though the wife was the patient, the dentist is very much communicating with the husband."

  However, this was observed as less pronounced in female ORE qualified dentists. This may also include not making eye contact with women and children as they are not perceived as being on the same level and therefore deserving of eye contact. As addressed specifically under the Leadership and Management area, this behaviour can also be apparent in peer relationships with some ORE qualified dentists sometimes treating their dental nurses, for example, as a "lower class" rather than a professional colleague.

- *In how we express ourselves*; some ORE qualified dentists can have difficulty in reading what the patient is trying to say, non-verbally and **how patients express themselves**.

  "I think it's very difficult when English is not your first language, to pick up on the nuances of variety of dialects and accents and non-verbal cues that patients give you. I have seen misinterpretation of non-verbal and in some cases, verbal information in these individuals."

  The example of dialects and accents is an important aspect that has been highlighted by respondents, but not one that could easily be directly addressed through the ORE itself (i.e. it would not be possible to have one simulation with a 'difficult' accent to understand). In addition, this is also something that UK trained dentists will encounter, and could be considered as a training, rather than an assessment issue.

  A further example given was that they may not always identify when a patient is unhappy based on tone, mannerisms or non-verbal cues and thus this can result in complaints or issues being escalated, or not identifying when a patient is becoming anxious.

  "They don't tend to pick up on the vibe, the mannerisms of the patient; it's like this is what has to be delivered, this is what you have to know, so this is what I am going to tell you"

4.3.3.11   *Differences in UK requirements;* the need for following the correct steps in relation to recording information and gaining consent can differ between the UK and the country the ORE qualified dentist trained in.

4.3.3.12   A clear theme that emerged is that communication skills are influenced by the environment in which the ORE qualified dentists are working and the skills and support from their trainer;

> "*If they've not had much contact with kids, or elderly, or in some cases if they're maybe quite reserved around men, especially for the female candidates, that's when sometimes these issues can occur to the extent that it then depends on the skills of the trainer and the support in the training practice in terms of getting them to see how it could be in this country and how they could work differently*".

However, **with the right support, in the majority of cases, it is deemed that these can be overcome**. The role of the dental nurse was identified as being instrumental in development and feedback around ORE qualified dentists' English language and communication skills. This influencing factor of trainer or practice support was also raised within the Professionalism theme as an important contributing factor to a trainees continued professional development. As such, many of the issues identified could be viewed as developmental in nature that can (and perhaps should) be addressed through the training period.

4.3.3.13   It was also cited that following mandatory training courses, there tend to be few issues and they are 'on par' with their UK counterparts in their ability to interact with patients (of all ages and genders), gathering the necessary information via active listening and enabling informed consent. However, **they may still struggle with the potentially more difficult skills to learn in a training environment such as empathy and building rapport**.

4.3.3.14   Finally, it was noted that although these issues tend to be more prominent in ORE qualified dentists they are not unique to this population, and particularly these issues are found in EEA graduates as well.

4.3.3.15   In conclusion, when some ORE qualified dentists are having difficulties, **communication does tend to be at the centre of these problems with language and culture being the underlying influencing factors**. In addition, communication underpins all other competencies and any issues arising from communication is likely to impact on the other competencies.

4.3.4   Professionalism

4.3.4.1 All 21 respondents were able to comment in this area, with 14 respondents providing mixed evidence, six providing exclusively positive evidence (or highlighting no issues) and one providing exclusively negative evidence – thus suggesting that professionalism is not an area of great concern in relation to the performance of ORE qualified dentists but that there may still be room for improvement.

4.3.4.2 A clear theme that emerged was that ORE graduates are generally very **motivated, diligent and organised in relation to learning and on-going development**, and demonstrate a keenness to attend a number of training courses.

> "*My general observation is that they are very diligent in terms of committing themselves to study and furthering their knowledge base and their education, they are very proactive in finding courses, good at filling in the paper work and making sure they are fully compliant.*"

Indeed, many respondents indicated that this commitment amongst ORE qualified dentists is **often over and above that of their UK counterparts** and is one of the main differentiators.

> "*I think there is an increased commitment [over UK graduates] …they realise that they have large black holes in their knowledge in terms of UK dentistry and what it means to be fully compliant so they realise that they have to be pretty compliant and pretty proactive in terms of seeking out these courses and improving their knowledge.*"

4.3.4.3 Potential reasons for this included that it is an immense commitment to apply and pass the ORE, and thus once provided with the opportunity, they are keen to make the most of it. In addition, many have struggled (or are struggling) to gain a training place in the UK which may therefore increase their motivation for furthering their knowledge and learning. Another suggested that this motivation may stem from the fact that ORE qualified dentists are "starting afresh" in a new country and are therefore keen to keep themselves up to date.

4.3.4.4 However, this intensity that surrounds passing the ORE and gaining a training place was noted to also have the opposite effect by a few respondents. As ORE qualified dentists can have multiple new things to learn and gain competence in when they move to the UK, this can cause some ORE graduates to feel overwhelmed which can in turn, result in a **reduction in drive to participate in CPD** compared to their UK counterparts. In addition, a number stated that although ORE qualified dentists do attend courses, there is sometimes **poor transfer of training** in that they are less likely than their UK counterparts to implement their new skills in practice, instead seeing the course as just a tick box exercise.

4.3.4.5 Evidence related to other areas under the professionalism domain provided more mixed respondents, with no clear themes or patterns emerging. These included:

4.3.4.6 The likelihood of ORE qualified dentists **seeking advice** when needed; a number of respondents stated that ORE qualified dentists are good ask recognising when they are out of their levels of competence and more likely than their UK trained counterparts to seek help when needed and recognise their own limitations.

> "*[ORE qualified dentists are] more happy to ask for advice than their UK counterparts; if they struggle they'll happily come and say 'can you help me with this?'*".

However, others stated that some ORE qualified dentists can be reluctant to ask for advice and indeed their UK counterparts were viewed as more likely to seek advice when struggling.

> "*[I have] found some [ORE qualified dentists] have been reluctant to ask for advice and that can be because maybe they have some issues around relating to their trainer and getting used to how the trainer might work in this country and knowing that there's a portal for advice open to them and I think for others…maybe again it's down to their previous experience…and feeling like they've just got to get on and get it done and maybe haven't had the previous support network*".

Some of this was also attributed to having less of an awareness of the importance of peer review and input from others.

4.3.4.7 Levels of **personal accountability and the likelihood of them admitting any mistakes**; whilst a number of respondents stated that they had never encountered any problems with ORE qualified dentists failing to admit mistakes, others stated that some trainees can struggle with

personal accountability and that some are less likely to admit mistakes than their UK trained counterparts although this could be due to lack of insight that a mistake has been made.

4.3.4.8 **Practical professional skills**; a number of respondents stated that ORE qualified dentists tend to have excellent timekeeping and punctuality skills, and that their performance in these general professionalism areas is largely on par with their UK trained counterparts. However, other respondents asserted that some ORE graduates can often struggle with a number of general professionalism behaviours such as timekeeping and understanding the knock-on effect of poor timekeeping on patients, surgery management, and timely responding to lecturer/supervisor communications.

4.3.4.9 **Record keeping** in terms of ensuring that this is of the required standard and written in a comprehensible manner; many respondents (n=7) indicated that ORE qualified dentists **tend to require more support in this area of practice than UK graduates,** but once further training has been received there is normally no further issues in this area**.**

4.3.4.10 The underlying reasons for instances where it was considered that ORE qualified dentists struggle in these above areas again align with similar themes emerging from the other themes and include:

- **Level of support** that the ORE qualified dentists receive in their practices, with less supportive environments being more likely to engender record keeping that is not of a good standard, impact upon the likelihood and extent to which an ORE qualified dentist will seek advice and the likelihood of ORE graduates admitting mistakes, with highly supportive working environments more likely to engender high levels of personal accountability and openness.

    "*Depends on…the support in the training practice in terms of getting them to see how it could be in this country and how they could work differently…If they're working in a strong, supportive environment, I think hopefully we usually see a trend [of improvement]*".

- Understanding of the **requirements in the UK healthcare system** is likely to be an influencing factor, particular in the case of record keeping and not having an adequate understanding of the standards expected in UK practice. This was also seen to apply in relation to maintaining a safe environment and cleaning instruments, which was cited as a development area by a small number of respondents.

- A perceived **sense of status**. This was cited as a potential underlying reason for unwillingness to seek advice as they do not believe that they require assistance/advice, with this "*inflated belief*" in their own abilities also making it less likely that they would choose to own up to an error because "*in their mind they are a dentist so they must be right*". However, one respondent indicated that ORE qualified dentists may not ask for advice because that this would cause their colleagues to think less of them which therefore causes them embarrassment.

- Also linked to **cultural norms and beliefs** it was identified by some that as ORE qualified dentists may have undergone training in very hierarchical societies, this can result in some ORE qualified dentists perceiving that those that are higher than them

in the hierarchy are always right and **they may not challenge these individuals** because this is seen by them as being impolite.

- **Lack of experience in relation to UK culture**; respondents reflected that differences in relation to timekeeping/punctuality may be that these attributes are not perceived as a priority in some ORE countries and therefore some ORE qualified dentists are often not aware of these social norms upon arrival to the UK.

4.3.4.11   Overall, it can be concluded that overarching perceptions of ORE qualified dentists' professionalism is generally high and although there is some mixed evidence, there are no areas that have been unanimously highlighted as requiring attention. The only exception to this may be ORE graduates' performance in record keeping, with many interviewees highlighting this particular area as something that some ORE qualified dentists can struggle with.

4.3.5   Management and Leadership

4.3.5.1 20 out of 21 respondents were able to comment on this area, culminating in generally mixed evidence. Overall, five respondents provided exclusively positive evidence (or highlighting no issues), eight provided exclusively negative evidence and seven provided mixed evidence – thus suggesting that management and leadership, may be an area that warrants further attention moving forwards. However, it was acknowledged by a number of respondents that management and leadership skills tend not to be skills that are explicitly taught

> "*I think the ones from overseas have not had any exposure to this at all and in reality it's not tested in the exam, therefore if it's not tested, they don't learn it and therefore their ability to manage or lead within the NHS is very poor*".

and this is the same for their UK counterparts;

> "*In reality, dentists in general are not very good leaders…very few [UIK graduates coming out of dental school] show any aptitude or any leadership skills like resilience or self-awareness or the sort of things that you expect of people in the profession.*"

4.3.5.2 Therefore, skills in relation to leading and managing a practice, or understand leadership and the need for change and improvement can be dependent on the skills that they have had exposure to.

> "*Those who have experience in lecturing are more likely to have management and leadership skills, and there are some who have experience in running peer review and others who have skills in leading teams.*"

4.3.5.3 One area for further scrutiny is in the area of **multi-professional working**. Here there were clear views that this is an area of particular development for some ORE qualified dentists, which does align with the growing recognition within UK healthcare of the importance of multi-professional working for everyone. A number of respondents' perceptions centred on a **lack of understanding as to the different roles within teams** and how to optimise different skills sets. It was asserted that much of this was down to **experience** and differences in how teamwork is perceived in different countries. Many ORE qualified dentists will be used to working independently in their home countries and not alongside a dental nurse/hygienist, as

is the case in the UK, which may help to explain why some ORE qualified dentists can experience issues relating to interactions with the wider team.

> "*I would say that they are not great team players because a lot of them have worked independently; does depend where they come from, so they are used to being both the dentist and the nurse, so can have conflict when used to doing everything and now there is a nurse standing with them*"

4.3.5.4   According to NCAS (2011), cultural variations across countries in the structure of the dental team and the role of its members may result in non-UK trained dentists reacting differently to other members of the team when compared to UK trained dentists, thus providing some validation for the current research findings.

4.3.5.5   A number of the respondents reflected that some ORE qualified dentists can **treat members of the team differently** depending on their perceived level of seniority within the hierarchy and do not afford all team members the same respect. In addition, differences in the treatment of male vs female colleagues by some ORE qualified dentists was also reflected upon.

> "*they [ORE qualified dentists] can be dismissive and very patronising but this is not everybody…the female dentists aren't but the males tend to see the female nurses as beneath then…is perhaps a cultural thing*"

4.3.5.6   This area of teamwork also ties in closely with communication, with some comments that a lack of politeness; understanding of the UK value of 'please' and 'thank you' and a tendency to 'tell' rather than 'ask', all potentially causing underlying difficulties for the team as a whole. The explanations for these differences were unanimously attributed to **differences in cultural norms** and how team members are perceived in their own countries.

4.3.5.7   Conversely, a number of respondents stated that some ORE qualified dentists are able to work well with a multi-disciplinary team, treat all team members equally and some respondents asserted that there were no or minimal difference between ORE qualified dentists' level and quality of interaction with the dental team, and that of their UK counterparts.

> "*As a general rule my ORE colleagues have interacted well with me; some have found my position of authority a threat but I would not say that that behaviour is any different to some UK graduate*s"

4.3.5.8   Differences in cultural norms here could be playing a role, with an individuals' performance or behaviour being dependent on which culture they are from, rather than assuming that all ORE qualified dentists are from a 'different' culture to the UK.

4.3.5.9   There were some comments focusing on **general administration skills** of some ORE qualified dentists with evidence in this area being generally mixed;

> "*They are very meticulous [in their note taking] …to the point of being very controlling and wanting to do everything themselves. [In contrast] UK graduates will dictate [their notes] …and they are always there for a nurse to re-read, but the minute you try and go back [to an ORE qualified dentist] they are not happy for you do so*".

although it was stated that this does not necessarily set them apart from their UK counterparts who can also struggle with administration.

> *"They do struggle with that to begin with because there is a lot to take on board...but in fairness our foundation dentists have the same issues; those that are stronger are those that have had general practice experience as an undergraduate, anyone who hasn't had that does find it difficult so no different from the OREs".*

4.3.5.10   Mixed evidence was also apparent as to their overall levels of contribution to practice policies with some ORE qualified dentists being able and willing to further their knowledge of policies as well as showing an eagerness to be involved in general practice tasks.

4.3.5.11   A specific behaviour that was mentioned in the research, centred around some ORE qualified dentists' **referral patterns**, again with respondents providing mixed evidence. Some asserted that they had not witnessed any issues pertaining to referral habits of ORE graduates whilst others stated that some ORE qualified dentists can sometimes experience difficulties in relation to referrals

> *"I have had situations in the past where because of a lack of experience they have had to rely quite heavily on their trainer...where they have struggled to do it themselves, but in terms of referrals outside of the practice, that's not something I have been as aware of."*

which was largely attributed to a **lack of experience of how this process works in UK practice.**

4.3.5.12   Overall, it can be concluded that overarching perceptions of ORE qualified dentists' management and leadership skills are generally mixed although there are no areas that have been unanimously highlighted as being problematic. However, there are areas which evidence suggests are areas to further reflect upon including increasing an awareness of UK dental team structures as well as wider UK social structures (i.e. absence of hierarchies) , which have been suggested as stemming from differences in experience of dental teams in their home countries as well as inherent cultural beliefs regarding hierarchy. In terms of more practical skills, a lack of competence in referral patterns (also stemming from a lack of experience and lower standards/expectations in their home countries) is again, something that could potentially be looking into further.

4.4   Influencing Factors

4.4.1   As outlined in the previous sections; respondents were able to articulate the underlying potential reasons for any particular areas of strength or development, or for differing behaviours compared to their UK counterparts. Understanding these influencing factors is important as it can help to unpick what potentially can and cannot be addressed or reviewed in relation to the ORE. A summary is provided below and in Figure 2:

4.4.2   *Lack of 'experience' or exposure to UK specific systems* or ways of doing things e.g. lack of clinical knowledge/experience or understanding of materials, requirements in relation to recording information, gaining consent and referrals.

4.4.3   Some ORE qualified trainees may have been *out of practice for some time* which may mean that their clinical skills and clinical knowledge are not current.

4.4.4   *English Language Proficiency* e.g. subtlety and nuances of the English language can cause challenges with communication.

4.4.5   ***Differences in the NHS values & UK culture*** i.e. placing the patient at the centre of care, differences in hierarchy, differences in how we express ourselves, different values place on timekeeping/punctuality, differences in team roles.

4.4.6   ***Differences in cultural norms and beliefs***; i.e. different status' awarded which can influence communication style and teamwork, or perceived sense of status may influence areas in professionalism.

4.4.7   ***Level of support*** that the ORE qualified dentists receive in their practices and from their educational supervisor can influence both the themes independently but also interplay with these factors, particularly differences in culture.

Figure 2: Influencing Factors

14.   Practice Issues Identified from the Evidence

5.14.1   Providing tangible and practical outputs for the ORE Advisory Group is an important element of the process, and as such, attempts have been made to draw out the salient themes and patterns that could be used to aid further discussion as to areas of particular focus of the ORE in the future. These are outlined in detail below and summarised in Figure 3.

5.14.2   ***Clinical***:

- Taking radiographs, assessing their diagnostic quality and interpreting the findings
- Choice of dental materials and types of available clinical instruments

5.14.3 *Communication*:

- Communication skills focussing on empathy and building rapport

- Patient consultations where the dynamic of the communication is changed by the presence of a husband or male relative

- Consultations where nuances of language are explored

- Consultations where the subtleties of body language have to be interpreted

- Consultations involving anxious patients

- Obtaining consent and the principles surrounding this

5.14.4 *Professionalism*:

- Emphasis on record and note keeping in UK practice in order to prepare ORE graduates for the standards expected in the NHS.

- Approaches to, and awareness surrounding, seeking advice/admitting mistakes

5.14.5 *Management and Leadership*:

- Approaches to referrals patterns so that ORE qualified dentists are able to approach UK practice with a full understanding of standards regarding referrals.

- Increasing an awareness of UK dental team structures (i.e. the roles of other members of the dental and other healthcare teams) as well as wider UK social structures (i.e. absence of hierarchies) to support multi-professional working.
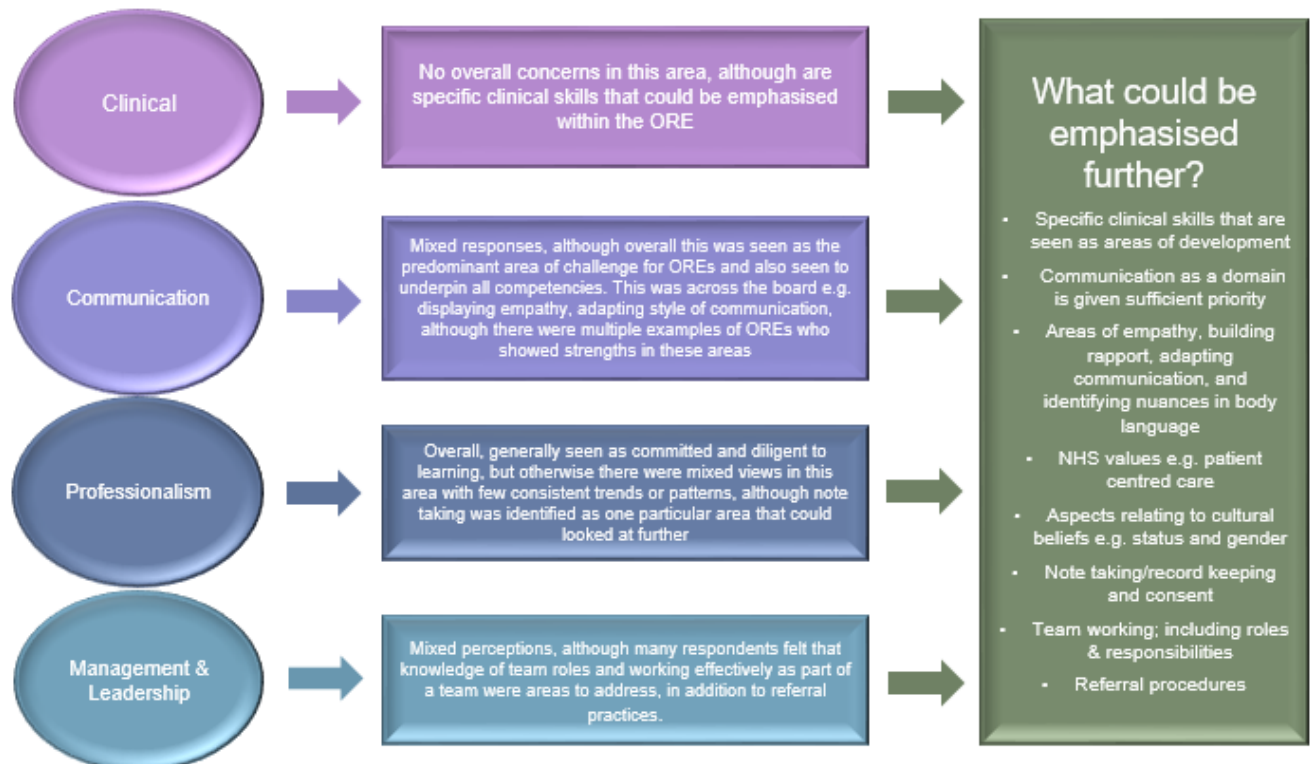

Figure 3: Summary of Findings and Issues Identified

4.6 Wider Findings and Considerations

4.6.1 Finally, as part of this process, broader questions in relation to the ORE itself were presented to respondents, as well as about other challenges or issues that ORE qualified dentists may face. A summary of the key themes emerging from the data are summarised below.

4.6.2 **Availability of Jobs:** The main barrier outlined for individuals who have passed the ORE is obtaining a job. As there is no financial incentive to provide placements, there are few jobs available. It was stated by a number of respondents that some OREs are not fully aware of the difficulties they may face once they have passed the ORE, and perhaps more could be done to communicate this to them, prior to the examination. Difficulties in finding a job can lead to dentists becoming de-skilled, which in turn can impact on their performance, as identified in the analysis.

4.6.3 **The Training Programme**: A number of respondents provided feedback on the training programme i.e. once the dentists have passed the ORE. It was identified that the structure and level of support they receive can be variable and that a more uniform training programme would enable consistent monitoring and the identification of ORE graduates who are struggling. It was also suggested that perhaps a more consistent method of selecting trainers may help here so that values are aligned across the country and from the very top. Engaging ORE qualified dentists to become educational supervisors for other OREs could be beneficial as they can apply their own learning and give assistance to the next raft of people coming through.

4.6.4 **Alternative Methods of Assessment**: A number of respondents suggested that the inclusion of a portfolio station may be beneficial which would provide a longitudinal record of their achievements and clinical practice which can help establish authenticity. Here candidates could present a series of cases that they have treated, and explain how each of the competencies were demonstrated throughout the treatment (could even be verified by patient feedback). This approach could also be useful outside of clinical practice e.g. how they have developed leadership skills, what they have contributed to meetings, whether they're part of peer review, whether spoken to the college, part of local BDA meetings etc.

4.6.5 Two respondents suggested that a situational judgement test to measure skills such as empathy and team working could also be beneficial.

4.6.6 One respondent suggested reviewing and learning from the Dental Foundation Training selection process and another respondent suggested reviewing the Membership of the Faculty of Dental Surgery (MFDS) and Membership of the Joint Dental Faculties (MJDF) as these both cover the UK system and thus there may be scope to include some of those elements in the ORE.

4.6.7 **ORE Training Courses:** One respondent raised some concerns about the existence of numerous training courses that candidates can attend before the exam. The respondents view was that these teach a candidate how to pass the exam rather than how to be a good dentist and behave in UK dental practice. Therefore, people learn how to pass the exam but when they enter real-life practice they can struggle.

4.6.8 **Developmental Feedback:** One respondent suggested that the introduction of developmental feedback, based on performance at the ORE could be beneficial. This could broadly outline

the candidate's strengths and weaknesses from a developmental point of view. Currently, when NHS England/dental practice advisors see the dentists they have to 'start from scratch' and purely rely on what they dentist says they can or cannot do.

4.6.9 **Costs of the ORE:** One respondent indicated that costs for individuals to sit the ORE and to undergo further training once they have passed the ORE should be reviewed. The costs can often discourage some ORE qualified dentists from furthering their learning and may be unrealistic expectations in light of the fact that some ORE qualified dentists are not paid during training. These costs are further exacerbated by the fact that if you fail the ORE, you still have to pay the same amount to re-sit.

4.6.10 **ORE Content:** Respondents were asked 'If you ran the ORE, is there anything in particular you would focus on?' The majority of respondents provided some insight into their views of potential content for the ORE. These are summarised below:

- Encompass more role play exercises; viewed as more realistic

- Specifics in relation to dental teams, the hierarchy in relation to this and optimal ways of working together as a team e.g. being more open and collaborative, utilisation of staff and distributive leadership

- Cultural adaptation; differences and challenges in terms of treating patients

- Communication assessment as a priority whereby communication in practice is assessed as well as competence in English language. Could be through a role play where assessors would be able to examine ORE qualified dentists' levels of empathy and how they behave more generally in face-to-face interactions.

- Compulsory rules and regulations of the NHS and their knowledge of the UK dental industry and system

- Ability to manage and lead i.e. present candidates with scenarios involving issues such as patient complaints, staff members being late etc. in order to test these skills and how they would deal with these situations

- Competence in consent rather than the principles of consent

- Greater emphasis on patient-focus; not just about giving options and providing information, but around putting the needs of the patient first, listening and showing empathy

5. Summary, Conclusions & Next Steps

5.1 Summary & Conclusions

5.1.1 This piece of research aimed to provide credible evidence of stakeholders' perceptions of the effectiveness of the ORE and its role in assessing fitness for UK dental practice. A mixed methodology approach was employed, applying both a literature review and stakeholder interviews.

5.1.2 In conducting this research, and interpreting the findings, it is important to acknowledge that as the focus of the research was in relation to ORE qualified dentists it is not possible to identify whether UK qualified dentists have similar or different weaknesses/areas for development from their ORE qualified peers. Although respondents were asked to consider performance of ORE qualified dentists in relation to UK qualified dentists, systematic data that enables comparisons to be made is not available. As such, great care needs to be taken in interpreting any findings in relation to the performance of ORE qualified dentists when there is no comparative data from UK qualified dentists available.

5.1.3 Areas of both strength and development need were identified by respondents in all four areas. Under the **Clinical** area, it was generally agreed that it was not the clinical skills that are problematic or an area of weakness and that ORE qualified dentists are experienced, knowledgeable and skilled in this area. The greatest area of development need for some ORE qualified dentists appeared to be **Communication**. When ORE qualified dentists are having difficulties, communication was perceived to be at the centre of these problems with language and culture being the underlying influencing factors. It was concluded from the analysis that overarching perceptions of ORE qualified dentists' **professionalism** was generally high with a clear theme emerging that ORE graduates are generally very motivated, diligent and organised in relation to learning and on-going development. However, there was some mixed evidence, with a few areas that were unanimously highlighted as requiring attention. Finally, the pattern of responses indicated that ORE qualified dentists' **management and leadership** skills were generally mixed although there were no areas that were unanimously highlighted as being problematic. However, increasing an awareness of UK dental team structures as well as wider UK social structures (i.e. absence of hierarchies) may be a potential area to be further considered as part of the ORE.

5.1.4 In summary, some common patterns and trends were identified through the research that have provided valuable insight into the working practices of ORE qualified dentists. A number of the areas highlighted by respondents would be challenging to fully address through the examination itself (e.g. nuances of English language, cultural norms and beliefs), and indeed may be viewed as more developmental in nature, and would best (and are in many cases) be addressed through the post-ORE training period. Many of these findings also align with findings from both within and outside of dentistry, as outlined in the literature review indicating that these are not unique issues and are broader in scope rather than being attributable to the ORE itself. However, there were a small number of practice issues deriving from the evidence identified that may be useful to review for potential emphasis/inclusion in the ORE.

5.1.5   In conclusion, this qualitative piece of research has added valuable insight into the performance of ORE qualified dentists, and thus perceptions in relation to the effectiveness of the ORE. Although no clear conclusions can be drawn about the validity or effectiveness of the ORE itself, given that ORE-registrant performance cannot be solely directly attributable to the exam, this nevertheless provides an important part of the jigsaw in terms of further understanding of the ORE's fitness for purpose.

5.2   Next Steps

5.2.1   Research has demonstrated that best practice assessment is an iterative process. The results from studies aiming to evaluate assessment processes should be used to continually review the criteria and content of the assessment, and the choice of assessment methods to enhance future processes. A number of considerations for review are presented within this report (section 4.5) in relation to the examination, based on evidence derived from the research and it is recommended that these are carefully considered by the ORE Advisory Group. These are wholly achievable and feasible over a relatively short time period and should not interrupt business as usual activity. WPG would be happy to advise further in relation to any assessment specific areas that were identified by respondents e.g. role play development, or Situational Judgement Tests.

5.2.2   *Alignment with other Findings*. This research has provided some valuable information, however it is prudent to consider the findings in relation to broader evidence that is available to help support and validate. For example, a review could be undertaken to investigate how these results correlate with both Preparing for Practice domains and assessment data. The former could likely take the format of a qualitative review. The latter would require a quantitative analysis of specific aspects of the examination that are viewed to correlate with the key findings from this research to identify any trends or patterns.

5.2.3   *Candidate Perceptions*. An understanding of candidates' reactions to the process is essential, particularly in relation to perceptions of relevance and fairness (i.e. face validity). The survey of ORE qualified dentists was carried out in November 2015, explored these dentists' career paths and experiences in gaining employment in the UK, but there was limited focus on the ORE itself. Candidate perceptions of an assessment process can also be used to make continued improvements to the process. This can be gathered following each sitting of the examination if required.

5.2.4   *Assessor Feedback Process*. Given the valuable insight that stakeholders can provide, it is recommended that an effective mechanism for gaining feedback from stakeholders on a regular basis is considered. ORE assessors are likely to have great insight into the different aspects of the ORE and could provide further useful feedback which could be gathered and analysed on a regular basis.

5.2.5   *Post Assessment Evaluation*. Establishing the validity of an assessment process is especially important to ensure that the test is assessing what it is intended to assess. There are various types of validity, including face validity (e.g. the degree to which a method appears appropriate or relevant), construct validity (e.g. the degree to which a method measures what it claims to be measuring) and content validity (e.g. the extent to which a measure represents all facets of a given construct). Within an assessment context, *predictive validity* is the 'gold

standard' in terms of the primary evaluation criterion. Predictive validity examines the relationship between test performance and in-role performance. Outcomes can also be used to identify areas for further improvement and development as well as informing policy to optimise effectiveness and efficiency of the assessment system in future.

5.2.6   *Evaluation of Implementation*. If any changes are made to the ORE then it is important that this is done in accordance with best practice principles. This includes seeking further evaluation evidence as to the impact of these changes on the reliability, validity and perceptions of the examination. This may be in a number of forms, including stakeholder perceptions, psychometric evaluation or assessor and candidate perceptions.

5.2.7   *Broader Dissemination*. A number of issues or factors have been elicited from the research (e.g. aspects relating to nuances of English Language, cultural norms and beliefs, levels of support received) that would be difficult to fully addressed by the ORE. To maximise the outputs of this research it is important to share this rich data with the GDC and other bodies such that this information could be used to help inform work plans and further training.

Appendix A: GDC Rapid Literature Review

What are the difficulties that overseas qualified dentists may face once working in the UK?

Overview

By drawing on research from both within and outside of dentistry, this literature review attempts to draw out common themes in relation to the potential difficulties that qualified professionals from outside the UK may face once in practice or training. This review aims to help inform the broad interview themes and questions that will be used in the interview stage, alongside the ORE Advisory Group workshop. This review will also support with benchmarking against similar professions (i.e. medicine) when both deriving the framework and interpreting the outputs of the stakeholder consultation.

Literature in relation to the dentistry profession was reviewed, however we have also drawn upon the literature from other healthcare sectors. Given WPG's previous work in this area, we were able to rapidly draw upon existing research and evidence available to us in relation to struggling trainees and professionals in healthcare more generally, with the majority of evidence available from medicine where doctors in difficulty has been a well-researched topic for some years. In relation to dentistry specific evidence, a review was carried out across databases including: PubMed, ResearchGate and Google Scholar with search terms including 'dentists', 'dentistry', 'overseas', 'performance', 'struggling' and 'difficulty'. Recent research in relation to difficulties that dental practitioners face and the reasons why was found to be scare, with more recent research originating from Australia and New Zealand. It should be noted that this has not been, and nor has intended to be, a systematic review of the difficulties facing dentists or healthcare professionals, but rather is to be used as a starting point for the ORE stakeholder evaluation.

The current rapid literature review summarises 11 salient themes and supporting evidence, emerging from the academic literature, including:

- The factors that have been found to impact more generally on the performance of health professionals

- The factors that appear to influence the performance of overseas qualified health professionals in particular

Summary of Review

There has been much research into differing performance levels of overseas healthcare professionals in comparison with their UK or home-trained counterparts. Such research often concludes that overseas healthcare professionals tend to perform less well in both academic assessments (e.g. Patterson et al 2013) and clinical practice (e.g. Harik et al, 2006) than their UK or home-trained counterparts. Increasing research is also being undertaken in examining the factors that impact on the performance of health professionals in practice as well as more specifically, the reasons behind why non-UK trained health professionals may be more likely to struggle in UK practice.

For overseas healthcare professionals in particular, **differences in academic backgrounds** (e.g. curriculum, standards) and **cultural backgrounds** (e.g. team working, the role of seniors) have been

proposed as potential reasons for why these individuals may face difficulty in UK practice. In addition, the level and **quality of preparation to work in the UK** for overseas graduates (e.g. knowledge of the UK healthcare and legal system, induction processes etc.), is another theme emerging in the literature as a reason why these individuals may go on to encounter difficulty (Bhat et al, 2014; Slowther et al, 2009). **Language** has also been found to impact subsequent performance, with bilingual international graduates being more likely to struggle in practice and during examinations (Patterson et al, 2013; Harik et al, 2006). This links to general levels of **clinical skills/knowledge** as seen in examination performance, with international graduates tending to perform less well than their home-trained counterparts (Patterson et al, 2013; Harik et al, 2006; Holtzman et al, 2014), which in turn, has been linked to future performance in practice (Patterson et al, 2015; Norcini et al, 2014; Tamblyn et al, 2007; Wenghofer et al, 2009).

Research has found that specific **physical and mental health** problems can have an impact on health professionals' performance in practice (Pitkanen et al, 2008; Firth-Cozen, 1999), with some research suggesting that the individual's behaviour in relation to these complaints e.g. reluctance to take sick leave etc. can further exacerbate some of these difficulties (Cox et al, 2006; Baldwin et al, 1997). **Behavioural and personality factors** are also highlighted as contributors as to why health professionals struggle, with research suggesting that health professionals who are rigid and lack insight may experience difficulty in practice (Cox et al, 2006), and health professionals who demonstrate low levels of conscientiousness and high levels of neuroticism may also go on to struggle (Paice, 2009; Firth-Cozens et al, 1999).

Work context is another salient theme emerging from the literature, with research indicating that health professionals who feel isolated at work, have experienced bullying in the workplace and who are dealing with supervisory issues or contractual changes are more likely to go on to encounter difficulty in practice (Southgate et al, 2001; Paice, 2009; Hoosen & Callaghan, 2004; Paice et al, 2004; Steadman et al., 2009; Willet & Palmer, 2009). **Significant life events** e.g. death, breakdown of relationships, major transitions, money worries have also been identified as reasons why healthcare professionals both in general and overseas may go on to struggle in practice (Cox et al, 2006; Turner & Lloyd, 2004; NACT UK, 2008; NCAS, 2011; Bhat et al 2014).

Table 1 overleaf provides more detailed information on the 11 salient themes emerging from the literature review; a commentary comprised of evidence and source for each theme as well as the type of research that each finding pertains to (healthcare professionals in general or overseas health professionals in particular).

Table 1. Rapid Literature Review Summary (dentistry relevant articles in bold)

Salient Themes	Evidence and Source	Research Type
Differences in Academic Background	• **Research suggests that the content, standards and outcomes of dental curriculums differ widely from one country to another and this lack of uniformity in the curriculum across countries may mean that dentists graduating from these countries possess varying levels of clinical skills and knowledge which may thus cause them to demonstrate different working patterns and exhibit different levels of performance to UK trained dentists (NCAS, 2011).** • According to Bucur (2004), these differences in academic backgrounds may be due to cultural, social and political differences e.g. socio-political determinants, the national educational system, and the prevalence of disease in the country of qualification.	**Overseas**
Differences in Cultural Background	• Patterson et al (2013) found cultural background to be a salient theme contributing towards overseas doctors struggling when practising in the UK, particularly in relation to consultation behaviour. The authors also found that GP trainers reported non-UK trained GPs as struggling with levels of empathy (and a tendency to respond to patients in an abrupt, brisk and authoritative manner) as well as the general structure of patient consultations. • **According to NCAS (2011), cultural variations across countries in the structure of the dental team and the role of its members may also result in non-UK trained dentists reacting differently to other members of the team when compared to UK trained dentists, which again may have an impact on their levels of performance.**	**Overseas**
Language	• Difficulties arising due to language barriers was another common theme that Patterson et al (2013) found as being a contributing factor towards why non-UK trained GPs are perceived to struggle in UK practice. The research found that although GP trainees who had English as a second language showed good comprehension and accurate diagnoses, they often struggled with the nuances and phraseology that are specific to the UK context, which was in turn, found to impact on the quality of their patient consultations. • Harik et al (2006) also found that performance on a clinical skills examination set in a 'standardised patient' format, used to assess interpersonal and communication skills, was moderated by English language proficiency. That is, candidates with English language proficiency below a certain level were found to struggle with the "ability to gather data, share information and establish rapport". In addition, failure rates on this examination were higher for International Medical Graduates (IMGs) and that this was partially attributable to poorer proficiency in spoken English. • **A study by Balasubramanian et al (2015) found that overseas qualified dentists in Australia struggled most with language and communication, including understanding 'slang' as well as differences with people, religion or lifestyle. Although not UK specific, it is likely that similar difficulties would be faced by overseas qualified dentists practising in the UK.**	**Overseas**
Level and Quality of Preparation to work in the UK	• Bhat et al (2014) found that IMGs who reported unpreparedness in a number of different practical aspects of medicine including GMC's Good Medical Practice, UK ethical standards and legal framework for practising medicine, were more likely to be rated as experiencing problems in these areas by their supervisors. According to Slowther et al (2009): "a lack of awareness or understanding of these standards on the part of a doctor may have adverse consequences for the doctor (he or she may lose their registration) but it may also mean that patients receive care that is below the standard that they can and should expect". • Bhat et al (2014) also found that IMGs reported obtaining limited benefit from UK induction processes which were described as generic, not tailored to support their specific needs and conducted with an underlying assumption that doctors were already familiar with the UK healthcare system.	**Overseas**

Clinical Skills/Knowledge	• Patterson et al (2013) highlighted that a lack of clinical knowledge, insufficient revision, taking exams early and lack of reflection/insight into their own knowledge, were all potential causes of difficulty amongst healthcare professionals. In addition, research suggests that IMGs tend to perform less well in clinical exams than their UK-trained counterparts, which may be a reflection on their clinical skills/knowledge (e.g. Esmail & Roberts, 2013, McManus & Wakeford, 2014). • Patterson et al (2013) found that 1) failure in the Applied Knowledge Test (AKT) component of the Membership of the Royal College of General Practitioner (MRCGP) exams was most commonly attributed to insufficient knowledge due to lack of wide or deep reading into subject areas and 2) candidates who had trained outside the UK had the lowest pass rates on the Clinical Skills Assessment (CSA) when compared to those who trained in the UK, with this discrepancy being primarily attributed to deficiencies in language skills and lack of cultural understanding regarding levels of empathy and the structure of consultations. • Harik et al (2006) also found that there were higher failure rates for IMGs than for home graduates on the clinical skills component of the United States Medical Licensing Examinations (USMLE), which again, could be partially attributed to poorer proficiency in spoken English. • Holtzman et al (2014) replicated Harik et al's (2006) findings in that they also observed higher failure rates for IMGs over home graduates on the clinical skills element of the USMLE. According to Holltzman et al (2014), these differences in performance can be attributable to differences in curricula, clinical experiences, the patient populations encountered by the trainees, cultural differences, differential effects of English as a second language, structure and quality of educational programmes and differences in how medical schools prepare students for examinations. • Performance on exams has been positively linked to future performance in practice (e.g. Patterson et al, 2015; Norcini et al, 2014; Tamblyn et al, 2007; Wenghofer et al, 2009).	General and Overseas
Physical Health	• There is much evidence to suggest that doctors are reluctant to see other doctors about their health. This results in more doctors becoming ill which, in turn, can lead to fatigue and impaired performance (Cox et al, 2006). • Doctors take less than average sick leave, developing maladaptive patterns such as working when unfit, self-prescribing and informal rather than formal consultations, which again, can result in impaired performance (Baldwin et al, 1997). • **More specific serious physical illnesses and their impact on doctors and dentists have been discussed in the literature including diabetes (linked to impaired performance when operating), epileptic seizures (disruptive to the delivery of care; cause health professionals to become unresponsive to questions or instructions), multiple sclerosis (linked to problems with eyesight, mobility, coordination as well as general cognitive decline) and musculoskeletal disorders (linked to impaired movement) (Pitkanen et al, 2008; Cox et al, 2006; Kay & Scarrott, 1997).**	General
Mental Health (inc. substance abuse)	• Depression and high levels of stress amongst doctors have been found to cause memory, concentration, attention loss and difficulty in making decisions (Cox et al, 2006). • Doctors have been found to suffer from elevated levels of stress, depression and substance abuse compared to the general population (Firth-Cozen et al, 1999; Wall et al, 1997) and those with competency concerns are at a higher risk of undiagnosed cognitive problems (Hanna et al, 2000). • There seems to be a larger problem with psychiatric/psychological ill health amongst doctors, with GMC records demonstrating that 199 out of 201 doctors under supervision at the end of 2001 had mental health problems (Harrison, 2008). • **Studies have suggested that dentistry generates more stress than any other occupation (Moore and Brodsgaard 2001) and research by Myers & Myers (2004), found that a large proportion of dentists out of a 2,441 sample size reported high levels of psychological stress symptoms.**	General

	• **Dentists are also at risk of developing burnout according to Osborne & Croucher (1994) and Gorter et al (1998), which in turn, has been linked to gradual changes in one's emotional, cognitive or behavioural patterns (Te Brake et al, 2008a) and depression (Humphris, 1998).** • **Research by The Department of Health (2001) also concluded that drug and alcohol misuse in doctors and dentists can have a detrimental impact on performance at work, reducing the quality of service provided to patients and the individual's ability to work safely.**	
Behavioural	• There is increasing evidence that complaints about doctors largely revolve around non-clinical attributes such as team working, leadership and communication (Sanger, 2000). • Research suggests that often the key elements behind poorly performing doctors are behavioural traits including rigidity and poor insight (Cox et al, 2006; Paice & Orton, 2004).	**General**
Personality	• Certain personality traits/patterns have been linked to poor performance in doctors e.g. low conscientiousness, high neuroticism (Paice, 2009; Firth-Cozens et al, 1999), a 'risky personality' consisting of sensation seeking behaviours and a low threshold for boredom (Firth-Cozens, 2006; Rabaud et al, 2000), high/low levels of self-criticism (Firth-Cozens, 1995) and high levels of perfectionism (Firth-Cozens, 2006). • **Research by Chamberlain et al (2005) also found that conscientiousness and neuroticism are major factors influencing dentists' professional performance in that dentists who scored highly on conscientiousness were more likely to perform better in their clinical and academic courses and receive higher scores on professionalism whilst the same was found for those demonstrating a lack of neuroticism. Rada & Johnson-Leong (2004) also conclude the personality traits common to those who choose to practise dentistry may also play a role**	**General**
Work Context	• **Croucher et al (1998) in their cross-sectional investigation of burnout amongst general dental practitioners found that respondents were more likely to report high levels of emotional exhaustion and low levels of personal accomplishment if they worked in practices with few other dentists.** Research also indicates that poor performance has been observed amongst doctors who report feeling isolated in their workplace and as such, appeared to be unaware of their poor performance and any gaps in their knowledge/skills (Southgate et al, 2001). • Supervisory issues have also been identified as factors contributing to why doctors struggle. Paice (2009) found that serious problems occurred when supervisor criticism was not constructive or accepted and Kroll et al (2008) identified supervisory issues such as inappropriate role modelling or "conspiracy of tolerance" in relation to mistakes made, as being key factors in preventing adequate learning and development. • **Further research has identified bullying as a factor contributing to why doctors and dentists may struggle (Hoosen & Callaghan, 2004; Paice et al, 2004; Steadman et al. 2009).** • **Contractual changes to NHS dentistry (Willet & Palmer, 2009) and times of organisational change (Cooper & Humphris, 1998) have also been identified as work context factors that can impact on the performance of healthcare professionals in their roles.**	**General**
Life Events	• Numerous significant life events have been identified as potential contributors to doctors' performance including the breakdown of relationships, marriage, children, death of parents and money worries which have all been linked to the formation of maladaptive coping strategies and mental health issues (Cox et al, 2006; Turner & Lloyd, 2004).	**General and Overseas**

	- Lake & Ryan (2005) offer a colloquial mnemonic for identifying the life events that may cause some doctors to perform poorly: 'the six Bs' (blues, birds/blokes, banks, babies, booze, bilingual background) and argue that poor performance may result from one or more of these factors. - **In addition, periods of transition such as changing jobs and moving regions (which links especially to overseas health professionals) have again, been linked to deterioration in clinical performance both in doctors (NACT UK, 2008) and dentists (NCAS, 2011).** - Examples of such transitional issues for overseas health professionals are outlined by Bhat et al (2014) who found that non-UK trained doctors reported a number of transitional issues during their move to the UK e.g. registering with the General Medical Council and a medical indemnity organisation, finding a place to live, opening a bank account, information on childcare and schooling, obtaining a National Insurance number and qualifying for a driving license.	

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Appendix B: ORE Stakeholder Consultation: Interview Framework

Background Information

The aim of this research study is to understand better the careers of ORE qualified dentists and in particular learn more about the quality of their work. Evidence will mainly be collected from stakeholders, who have had experience of employing, training or working with ORE qualified dentists. It is hoped that by learning more about the performance of ORE qualified dentists working in the UK, and the type of employment that they go into, the GDC will generate useful further data about the role of the ORE in the provision of dental services in the UK.

Notes for the interviewer

- This framework draws upon the four Preparing for Practice domains required of all UK practicing dentists (Clinical skills, Communication skills, Professionalism, and Management & Leadership; see Appendix A). However, given how qualified dentists work, it may be that some groups of interviewees will have more experience or insight into some aspects that others; this is detailed in the framework. As such, not all questions will be relevant to all interviewees and/or greater time may be spent on some areas compared to other areas. It may be useful prior to questioning in each theme that you establish their perceived level of contribution that they can make to that area to help guide questions/timing.

- Each theme will start with a broad question, and then probes (or possible areas for discussion) are provided to further explore their experiences in these areas. It is not necessary (nor will it be possible) to ask all questions or cover all topic areas. Questions or areas to probe are provided in order of priority. General probe questions are also provided.

- It is important that the interview does not become negative in focus; this is not an interview to discuss why ORE qualified dentists struggle; but rather to explore their performance in the role, which could be equally as positive.

- The broad approach to the interviews will be Critical Incident Technique, however where appropriate it may be useful to draw upon comparisons with UK counterparts. This is not to define differences in performance, but rather as a mechanism to help them explore performance of ORE qualified dentists. This may be especially useful if an interviewee becomes overly negative or you suspect there may be some unconscious bias slipping in, as this allows you to explore whether this is an issue that spans country of training.

- This research is predominantly focussed on aspects of performance that can be directly attributable to the ORE. As such, areas identified in the literature review such as life events, work factors or mental and physical health are not the focus of this study. However, it is important to be aware of these, so as an interviewer you can explore whether the observed performance or behaviour is attributable to one of these other factors, rather than clinical or behavioural performance per se. The 'why' is therefore an important question to investigate if there are underlying factors that could be contributing or interacting.

- We are asking the interviewees to think about all the ORE qualified dentists they have worked with as a group, however it may become clear that this is not a homogenous group. If this is the case, then you should tailor your questioning accordingly.

- There are overlaps in the themes and therefore the probes/areas under one theme, could easily come under another theme. If an area of discussion arises that does not fit under that theme, allow the interview to continue its natural rhythm; coding can be done at later stages.

- It may be that some interviewees struggle to engage with the four domains. If this is the case, there are a small number of questions at the end of the document that can be used to try and elicit performance behaviour through these alternative approaches. These questions can also be included if there is time remaining in the interview.

Interview Instructions

You will have been provided with the name, role and telephone number of the interviewee. Ensure you have this information to hand prior to the interview time.

The following points should be covered as part of the introduction

- Thank them for taking the time to undertake the interview

- Provide a summary and the aims of the research project including WPG's role e.g. aim is to learn about the quality of work of ORE qualified dentists which will help inform understanding of the role of the ORE in the provision of dental services in the UK. Ensure the interviewee is clear about their role and expectations.

- Outline that during this interview we will be discussing with them their experiences of ORE qualified dentists and their views on their performance against the four learning outcomes; clinical skills, communication skills, professionalism and management & leadership as this is the framework against which the ORE is set. However, we appreciate that not all individuals will be able to comment in-depth in relation to each of these areas; therefore it may be that more or less time will be spend on each of these areas *(it may be useful prior to questioning in each theme that you establish their perceived level of contribution that they can make to that area to help guide questions/timing).*

- Explain that given the topic of the research, we are only interested in ORE qualified dentists, rather than overseas qualified dentists per se, or those that qualified prior to the introduction of the ORE in 2007 e.g. through the IEQ.

- Explain that where possible we would like them to draw upon their experiences of ORE qualified dentists as a whole, rather than the details of one particular individual

- Where appropriate, we may ask them to reflect on the similarities and differences between ORE qualified dentists and UK trained dentists to help draw our and further probe emerging themes, but we are not interested in the performance of UK counterparts per se.

- Explain that the interview should take no longer than 45 minutes

- Explain that you are not a dentist by trade, so you may be asking questions to clarify

- Reassure the interviewee about confidentiality; all interview outputs will be anonymised and anything they say will not be able to be directly attributed to them. In the reporting,

participation will only be reported on at a broad level (e.g. role) and it will be ensured that any comments that are quoted in reporting are unidentifiable.

- If the interview is being audio recorded, ask permission/gain consent to be able to do so.

Introductory questions about the interviewee

- What is your role?

- What is your organisation and what type of dentistry do you/your organisation provide?

- Where were you qualified (if a dentist)?

- How long have you been qualified (if a dentist)?/How long have you be in your role?

Introductory questions about their experience of working with ORE qualified dentists (ensure they have the relevant experience)

- How many ORE qualified dentists have you worked with?

- What time period has this been over?

- (for dentists) What is the context in which you are thinking about the graduates (e.g. VTE, assistant (worked under a dentist with a pro-forma number), associate (has own pro-forma number), examiner)

- What is your experience of the tenure or longevity of the ORE qualified dentists that you have worked with?

General probing questions (to be used throughout where applicable)

- Does this apply to all dentists or only ORE qualified dentists?

- Is this something that sets ORE qualified dentists apart?

- Is there a consistent pattern or trend you have observed?

- What in your view is the underlying reason for this? What other external factors may be contributing to their performance/quality of work?

- What positive aspects are there about working with ORE qualified dentists?

Clinical Theme

This area should predominantly be for VTE trainers, nurses and practice managers. However, the overarching question may wish to be asked of all interviewees

Can you share your thoughts on the clinical skills of the ORE qualified dentists you have worked with? What are areas of particular strength, or weakness?

- Any incidents of good or poor performance in relation to specific clinical skills e.g. crowns, radiographs?

- Has there been anything unusual in interactions with the laboratory (i.e. an unusual amount of lab work sent back, or concerns from the lab about particular dentists?) *Practice Managers only.*

- Have there been any clinical incidents? If so, what could these have been attributed to/what was the underlying cause? Have you observed any trend or unusual pattern of clinical incidents with ORE qualified dentists?

- Do they provide personalised care?

- Have you ever had to step in and assist an ORE qualified dentist?

Communication Theme

*Relating to **direct communication** with **patients**, it will predominantly be nurses who are able to respond to these questions. Practice managers will have good insight into broader communication issues with patients e.g. critical incidents or patterns of behaviour.*

There could be two underlying factors particularly relating to communication; second language and cultural background. These should be explored where appropriate.

Can you share your thoughts on the communication skills of the ORE qualified dentists you have worked with? What are areas of particular strength, or weakness?

- Could explore between peers (e.g. at practice meeting, have sensible ideas, able to contribute)

- With patients (e.g. about procedures, about bills, explaining the treatment, establishing the issue, gaining consent)

- Could explore verbal/written/non-verbal (e.g. personal space)

- Do they adapt to the target audience/change their approach where necessary?

- How do they communicate with different ages (particularly children as the ORE does not currently assess this)?

- Performance/skills in relation to:

  o Clarity

  o Listening skills, including checking for understanding, summarising

  o Putting the patient at ease/building rapport/demonstrating empathy

  o Dealing with anxious/phobic patients

  o Responding to different situations, and different cultures

  o Enabling the patient to make an informed decision

Professionalism Theme

Can you share your thoughts on factors relating to professionalism in ORE qualified dentists you have worked with? What are areas of particular strength, or weakness?

- Do they work within their knowledge, skills, competence and abilities?

  o How frequently do they ask for advice? (whether ask too much or not at all. There is a difference between asking advice when something goes wrong which is good, and asking for advice before they have been started).

- Do they keep up to date with techniques, demonstrate a willingness to learn?

- How popular are they with the patients? *Practice manager*

- Performance/behaviour in relation to:

  o Timekeeping

  o Trustworthiness/probity

  o Punctuality

  o Personal responsibility

  o Admitting mistakes

  o Putting patients first (works in best interest of the patient, is an advocate for the patient, says no as well as yes to the patient)

  o Clearly unprofessional behaviour (rudeness, failure to gain consent, failure to take views into consideration, issues of confidentiality)

  o Showing respect

  o Maintaining safe environment, cleaning instruments

  o Record keeping/making notes (must be made at the time and done adequately)

  o Inappropriate behaviour (patients/peers)

Management & Leadership Theme

This domain area is perhaps a little less clear cut in terms of what it is referring to. Introduce this domain area by explaining that it covers a wide range of management and leadership skills and behaviours (both big and little m's and l's) and broadly covers the skills and knowledge required to work effectively as a dental team, manage their own time and resources and contribute to professional practices

Can you share your thoughts on the management and leadership skills of the ORE qualified dentists you have worked with? What are areas of particular strength, or weakness?

- Teamwork; how do they interact with different roles within the team? *(the aim of this question is to get to the underlying behaviours in relation to respect, fairness, feedback provided etc. rather than transactional relationships e.g. I manage them)*

- Has there been any unusual patterns in relation to referrals (e.g. too many referrals as they can't or won't do the work, or none at all?)

- Performance/behaviour in relation to:

  o Time management (i.e. overrun on patients)

  o Involved in providing any training, teaching, audit, appraisal or peer review

  o Contribution to practice policy

  o Leadership skills (everyone has to be a leader to their team e.g. own team of nurse)

  o Accountability

  o Administrative side e.g. claims, accounts, completing paperwork

Final questions (may not have time to ask)

- For all dentists that you have worked with, have there been any pattern of complaints particularly in relation to any of the four areas? If so, are there any that specifically relate to ORE qualified dentists? *(not appropriate for nurses, receptionists etc. Please also note that this question is framed in this way as can be quite a sensitive area so want to initially keep quite broad).*

- If you ran the ORE, is there anything in particular you would focus on?

- Any advice to the GDC on how they should deal with ORE candidates?

Additional questions (to be used where appropriate)

- What are the particular challenges/barriers ORE qualified dentists face?

- What additional support/training do you think that ORE qualified dentists may need?

Closing Comments

- Would you be willing to be involved further?

- Are there anyone else who you could recommend could be involved in the research?

Four Preparing for Practice Domains

- *Clinical;* the range of skills required to deliver direct care, where registrants interact with patients, and also the essential technical skills, carried out in the absence of patients which support their care, for example, by dental technicians

- *Communication;* the skills involved in effectively interacting with patients, their representatives, the public and colleagues and recording appropriate information to inform patient care

- *Professionalism;* the knowledge, skills and attitudes/behaviours required to practise in an ethical and appropriate way, putting patients' needs first and promoting confidence in the dental team

- *Management & Leadership;* the skills and knowledge required to work effectively as a dental team, manage their own time and resources and contribute to professional practise

Appendix C: Demographic Breakdown of Participants

Male	11
Female	10

Table 2: Gender

26-34	0
35-44	6
45-54	5
55-64	4
65+	1
Not stated	5

Table 3: Age

White	14
Black	0
Asian	2
Mixed	0
Chinese	0
Other	0
Not stated	5

Table 4: Ethnicity