THE BRIDGING EDUCATION AND LICENSURE OF INTERNATIONAL MEDICAL DOCTORS IN ONTARIO:
A CALL FOR COMMITMENT, CONSISTENCY, AND TRANSPARENCY

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
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Abstract

The widely acknowledged doctor shortage in Canada has recently motivated a more critical look at the licensure rates of International Medical Doctors (IMDs), also known as International Medical Graduates (IMGs). However, very little research has been conducted on the experiences of IMDs before they enter the Canadian medical system.

This qualitative study collected interview data from 15 diverse IMDs seeking licensure in Ontario, Canada. The participants varied with respect to age, country of origin, English language proficiency on arrival, and time in Canada. In addition, two bridging support programs were observed, and interviews were conducted with three educators from the programs.

The interviews were analysed using thematic content analysis (Boyatzis, 1998; Miles & Huberman, 1994). An analysis of metaphors used by the IMDs to describe their experiences during the licensing process supported the use of poetic representation for key findings, resulting in three poems that are interspersed in the body of the thesis (Ellingson, 2011; Glesne, 1997; Richardson, 2002; Richardson & Adams St. Pierre, 2005).
The theoretical framework of the research was informed by Vygotskian Sociocultural Theory, which views learning as inseparable from social interaction and context (Vygotsky, 1987). Third-generation Activity Theory (AT), which has descended from Vygotsky’s work, was applied to highlight the higher-level systemic issues related to medical licensing.

Results of this study indicate that IMDs with lower English proficiency face substantial difficulties on arrival, with limited access to the type of medically-relevant language instruction needed to support them. In fact, all pre-licensure IMDs struggle to access the interactional learning opportunities (i.e., Vygotskian “mediational means”) to support their entry into the system. Licensing challenges include limited exam preparation resources that support acquisition of Canadian cultural content; unequal access to clinical observerships; and a selection process which lacks transparency and emphasizes a screening tool unfamiliar to IMDs, the residency interview.

Implications of this study include the revisiting of immigration policy; increasing the transparency and effectiveness of the selection process/residency interview; reviewing the role of clinical observerships in the selection process and exploring the potential of observerships to function as a licensure portfolio assessment.
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Dedication

In memory of

Dr. Sylvia Bowerbank, 1947 – 2005

and

Carol Norton-Sargent, 1953 – 2010

two great mentors

who inspired me to be the best I could be
List of Acronyms

CaRMS – Canadian Resident Matching Service

CCC – Communication and Cultural Competence (an online course that focuses on communication and the C2LEO objectives of the Medical Council of Canada)

CE1 – Clinical Exam Part One (an OSCE-style examination used by CEHPEA to assess the clinical and communication skills of IMDs, now the National Assessment Collaboration OSCE (NAC OSCE))

CEHPEA – Centre for the Evaluation of Health Professionals Educated Abroad

CELBAN – Nursing language assessment exam based on the Canadian Language Benchmarks

CLBs – Canadian Language Benchmarks

C2LEO objectives – series of communication, ethical, cultural, and professional behaviour objectives from the Medical Council of Canada

CMG – Canadian Medical Graduate

CSA – Canadian Studying Abroad (i.e., Canadians who study medicine in other countries)

CPSO – College of Physicians and Surgeons of Ontario

CO – Clinical Observership

ECFMG – American organization that evaluates “foreign medical graduates”

EE – Evaluating Exam (first exam of the Medical Council of Canada)

ESL – English as a Second Language

FM – Family Medicine

HFO – Health Force Ontario

GP – General Practitioner

IEHP – Internationally Educated Health Professional

IEP – Internationally Educated Professional
IETLS – International English Language Testing System (British/Australian English language proficiency test)

IMG – International Medical Graduate (commonly used term)

IMD – International Medical Doctor (preferred term in this dissertation, as this acknowledges the fact that the vast majority of IMDs were practicing physicians in their home country before coming to Canada)

IPG – International Pharmacy Graduate (or refers to a bridging program in pharmacy of the same name)

LINC – Language Instruction for Newcomers to Canada

LMCC – Licentiate of the Medical Council of Canada (someone who has successfully passed all three examinations of the Medical Council)

M-CAP – Medical Communication Assessment Project

MCC – Medical Council of Canada

OB/GYN – common short form for Obstetrics and Gynecology

OSCE – Objective Structured Clinical Examination

PGY1 – first year post graduate studies, also called first year residency

PRA – Practice Ready Assessment (an assessment of a physician through supervised practice that is more independent than residency)

PRP – Pre Residency Program – Orientation to the health care system for new IMDs who have gained access to residency training

QE1 – Qualifying Exam Part One or just “Part One” – Second Canadian Examination

QE2 – Qualifying Exam Part Two or just “Part Two” – Third Canadian Examination

SOO – Structured Objective OSCE

TIEDI – Toronto Immigrant Employment Data Initiative

TOEFL – Test of English as a Foreign Language

USMLE Step One – First American Examination

USMLE Step Two – Second American Examination
Chapter One:  
Introduction

This introductory chapter will provide a background and rationale for this research, including a brief discussion of IMDs’ licensing pathway to practice in Ontario and relevant government programs. Then, two key areas related to licensing that impact on IMDs’ potential success in gaining entry into the system are discussed: language proficiency and the residency interview. Next, the theoretical framework that informs this research, Vygotskian sociocultural theory, is introduced. This is followed by a discussion of poetic representation, an alternative method used to represent the research findings, and then, the research questions.

Background and Rationale for the Research

Doctors who immigrate to Canada and seek licensure stand at the crossroads of a complex set of conflicting factors: While Canada is projected to be relying on immigration for all of its net labour force growth by 2011 (Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, 2004), the actual success rates, measured in terms of financial outcomes, of immigrants coming to Canada seem to be lagging (Reitz, 2006; Schellenberg & Hou, 2005; Weiner, 2008; Winnemore & Biles, 2006). This underutilization of the skills of arriving immigrants has been characterized both as an economic issue, where the wastage of skills reflects a loss of billions of dollars to the Canadian economy (Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, 2004), as well as an ethical issue, in terms of the expectations of

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1 IMD is the preferred term in this dissertation, as I feel it more accurately represents the professional expertise and knowledge of IMDs, the vast majority of whom were practicing physicians in their home countries before coming to Canada. In contrast, the more common term “International Medical Graduate” represents a linguistic “de-doctoring” of their status that places them on par with recent graduates of Canadian medical schools.
newcomers arriving under the Skilled Immigrants category (Winnemore & Biles, 2006). Using data from the 2001 Canadian census, Boyd and Schellenberg (2007) found that just over half of the IMDs in Canada aged 32 to 54 were working as physicians.

At the same time, Health Human Resource issues in Canada have led to a widely-recognized doctor shortage that has received significant coverage in the popular press. In fact, in 2007 “Canada [had] fewer practising physicians per capita than most OECD countries (2.1 physicians per 1000 population compared with an OECD average of 3 per 1000)” (Thind, Freeman, Cohen, Thorpe, Burt, & Stewart, 2007, p. 1330). By 2009, that number had not substantially increased, with 2.2 physicians per 1000 population, with the OECD average also slightly increasing to 3.1 per 1000 (OECD, 2009). This number leaves Canada ranked 26th out of 30 OECD countries for doctor-population ratio, with only Mexico, Japan, Korea and Turkey below us (OECD, 2009). In addition, when considering the diversity of the city of Toronto and choice of doctor, one recent study found that 88% of Mainland Chinese immigrants who had arrived in the last six years chose a co-ethnic medical doctor, citing both language and cultural issues as concerns (Wang, 2009). An analysis of the costs of integrating an IMD into the healthcare system through the Alberta IMG program demonstrates that this is a less costly, and thus, more efficient approach to adding MDs to the medical workforce compared to producing an MD graduate through four years of medical school (Emery, Crutcher, Harrison, & Wright, 2006). Thus, Canada’s current context regarding doctors includes a shortage of doctors; and increased demand, at least in major centres of immigration, for co-ethnic doctors: The integration of IMDs is one possible solution to these issues.
Historically, Canada has relied on IMDs to play a role in maintaining its medical workforce. Currently in Canada, IMDs represent approximately a quarter of the medical workforce, but these numbers are even higher in some jurisdictions, such as Saskatchewan or Manitoba (Lockyer, Blackmore, Fidler, Crutcher, Salte, & Shaw, 2006). Despite this proportion, which represents a number accumulated over decades of immigration, the barriers faced by IMDs for licensing are daunting to even the most dedicated newcomers to Canada: Even once the standard examinations have been passed and English proficiency has been established, access to the mandatory residency training positions is extremely competitive. The final step in the competition is a North American employment-style residency interview. The application process only runs once a year, which adds even more pressure during this high-stakes encounter.

In Ontario and all provinces in Canada, IMDs apply for residency training through the non-profit agency, the Canadian Resident Matching Service (CaRMS). CaRMS manages the application files of both Canadian medical graduates (CMGs) and the IMDs applying for training, and matches the program choices of the IMDs and CMGs with the hiring preferences of the programs who have interviewed them. There is an initial matching session, or first iteration, as it is called, and a second iteration that fills the places that remain unfilled after the first. In 2010, of the 1497 IMDs hoping for a match in the first iteration, only 18% were matched. This is compared to 96% of the CMGs who were matched after the first iteration (CaRMS, 2010a). For example, in Family Medicine, a program where there are a higher number of dedicated spots for IMDs, there were 1415 IMD applicants with 133 matched in the first iteration and 59 matched in the second iteration, for a total of 192 out of 1415, or a 14% match rate (CaRMS, 2010b). In total across Canada, out of the 1497 IMDs
seeking training positions, only one in four was matched. Considering these numbers, the competitive nature of the process becomes clear, along with the difficulty of facing another year without access to training for those over 1,000 IMDs who are unsuccessful in the match.

Certainly, there has been government recognition over the last few years of the need to streamline the assessment and licensing\(^2\) process for doctors entering Canada. The First Ministers’ signing of the Accord on Health Care Renewal established Health Human Resource as a key priority for Canada, especially in relation to reducing the amount of time Canadians were spending waiting for access to medical procedures. The year 2004 saw $5.5 billion committed over 10 years to the reduction of wait times, and in the next year, The Framework for Collaborative Pan-Canadian Health Human Resource Planning was approved, which recognized as a key priority the need to “accelerate and expand the assessment and integration of internationally trained health care graduates” (St. Pierre-Ellis & Hicks, 2007). An additional $75 million was dedicated exclusively in the 2005 budget to the Internationally Educated Health Professionals Initiative (Health Canada, 2010). This initiative encompassed many facets of the licensing process for Internationally Educated Health Professionals (IEHPs). Projects at the national level include a Faculty Development Program for Teachers of IMGs, a National Assessment Collaboration facilitated by the Medical Council of Canada, and a pan-Canadian orientation program to the Canadian Health Care System for IEHPs (Health Canada, 2010). Provincial projects include the formation of the Health Force Ontario IEHP Centre in Toronto, a comprehensive access centre for counselling and information that offers a variety of short-term support courses, mainly for IMDs.

\(^2\) The Canadian literature in this area most often uses the British spelling “licence” for the noun and varies with respect to the spelling of the verb (e.g., both licensed/licenced). This thesis will use –ce for the noun and –se for all occurrences of the verb, as this is the most common combination. See [http://www.mto.gov.on.ca/english/dandv/driver/drvlicen.shtml](http://www.mto.gov.on.ca/english/dandv/driver/drvlicen.shtml) for an additional example of this usage.
Many of these initiatives are directed at a key area of need: helping internationally educated doctors bridge the multi-faceted differences that exist between their previous medical practice and that of the Canadian context. Data do suggest that IMDs struggle with the challenges of adapting to a new cultural, and, often, linguistic context of practice (Horvath, Coluccio, Foy, & Pellegrini, 2004; ). The barriers are widely recognized, especially those relating to language and culture:

The transition into Canadian practice is recognised as being potentially difficult as patient expectations, language and language nuances, resource availability, referral processes and practices and standards of care can be quite different to those experienced by incoming doctors in their countries of origin. (Lockyer et al., 2006, p. 341)

Areas of difficulty can also encompass “trans-cultural challenges that include…lifestyle, sex-role differences, discrimination and change in status” (Steinert, 2006, p. 20). Programs designed to support the transition of internationally educated individuals into the workplace, or “bridging programs,” are difficult to access for IMDs seeking to gain entry into the system (R.A. Malatest & Associates Ltd., 2010). Although there is a mandatory bridging program for all IMDs in Ontario (the Pre-Residency Program, or PRP) who are about to enter the system because they have already won the difficult competition for training, the lack of availability of bridging education for IMDs who are in the midst of the licensing process often forces them to turn to high-priced private programs or simply go without the support they need.

How can IMDs best be supported as they seek licensure? What defines best practices for bridging education and what do participants learn in these programs? The small number of bridging programs for IMDs that do exist are so new that there has been relatively little research conducted on them. The IMG Taskforce of 2004, which brought together many of
the medical educators in Canada most experienced in working with IMDs, identified certain key research questions for further exploration, including “How many IMGs withdraw [from the current licensing process] or are stopped due to language or communication shortcomings? How many are stopped during the interview process? This constitutes important baseline information that would contribute to improvements to evaluation and the licensure process” (Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, 2004, p. 36, emphasis added). This identified gap in baseline information about licensing (IMDs stopped due to language and communication and IMDs stopped during the interview process) will each be discussed below in relation to the Ontario setting and what is currently known.

**Language Proficiency**

Every year, many IMDs arrive in Canada, but very little is known about how those with lower English proficiency fare during the licensing process. The Toronto Immigrant Employment Data Initiative (TIEDI), located at York University, has recently begun analysing census data to try and fill in some of the knowledge gaps regarding newcomers and employment, and they publish these as brief Fact Sheets. Of the 1,228 newcomers who settled in Ontario between 1995 and 2005 who planned on working as a general practitioner or family physician, the majority reported speaking English (80%) and 10% reported speaking neither French nor English, but further details about their language proficiency were not available (TIEDI, 2009b). Although the immigration selection process for Skilled Workers requires the applicant to take either the International Language Testing System examination (IELTS) or the Canadian English Language Proficiency Index Program (CELPIP), this requirement would not apply to the many IMDs who arrive as a spouse or
fiancé of an applicant, or to the 13% of those general practitioners above who arrived as refugees (TIEDI, 2009b). In terms of specialist physicians, 1,048 settled in Ontario between 1995 and 2005, and, again, the majority reported speaking English to some extent (80%), and 9% reported speaking neither English nor French (TIEDI, 2009a). As Watt, Lake, Cabrnoch, and Leonard (2003) observe regarding those IMDs who arrive with limited language proficiency:

> Developing professional language proficiency is a lengthy process and an immigrant IMG with very limited English or French language ability is unlikely to be able to acquire the necessary level of language proficiency to be integrated quickly into the profession. (p. 10-11)

There is another key factor added to the mix, Watt et al. (2003) observe, and that is time: The longer it takes an IMD to learn English in Canada, the longer they are out of practice; this alone impacts negatively on an IMD’s chance for entry into training. According to their own study, Watt and Lake (2004) estimate that the number of hours of instruction required for a highly educated immigrant to increase their proficiency two benchmarks -- for example, from a low-intermediate band 6 to a high intermediate 8, which is on the edge of advanced proficiency – is approximately 867-880 hours, which is approximately equivalent to one year of full-time study (Watt, Crutcher, & Lake, 2006). The proficiency Watt et al. (2006) refer to here is generic proficiency, and they also acknowledge that even after they meet this high standard, they “usually face a need to attune their proficiency to the professional communication demands” (p. 6). Thus, depending on their proficiency on arrival, IMDs face possibly multiple years of full-time study to reach a level of English that still must be polished within the professional context in which they wish to practice.

Regarding language proficiency, a recent comparative study of Internationally Trained Individuals (ITIs) and Canadian-educated individuals seeking licensure in a range of
regulated professions in Ontario, including the health care field, collected self report data. Over 5,000 internationally educated professionals were asked in a survey to rate their English language ability with regard to reading, writing and speaking. Almost 10% reported intermediate level capacity in reading and almost 20% reported intermediate level capacity in writing and almost 20% reported intermediate level capacity in speaking (R.A. Malatest & Associates Ltd., 2010). A much smaller number reported themselves to be basic users, around 2 or 3%, for reading writing and speaking (R.A. Malatest & Associates Ltd., 2010).³ This survey, commissioned by the Office of the Fairness Commissioner in Ontario, also reported that 38% of the respondents found English or French training helpful, although the type and nature of these language training programs was not explored in detail (R.A. Malatest & Associates Ltd., 2010).

For IMDs seeking to improve their language skills, the lack of harmonization between the federal immigration assessment process, the provincial path to licensure, and that of both federally and provincially publicly-funded language training programs in Ontario may present a challenge. As mentioned above, if arriving within the Skilled Workers class, it is mandatory to take an English proficiency assessment, which is currently either the British/Australian IELTS or Canadian CELPIP. However, due to the way the current points system operates, it is possible for an IMD to still receive two points towards immigration with only “moderate” language proficiency, if they are able to “communicate comfortably in familiar social and work situations” (Paragon Testing Enterprises Inc., 2010). This system thus allows IMDs with lower language proficiency to compensate for the points that they do not gain for their English proficiency through their high level of education. Due to the way

³ Although it is generally recognized that relying on self-report data alone is not ideal (Brown & Ahn, 2011), this is the only available comprehensive data on the language proficiency of IMDs.
the points system operates, this IMD might believe that his or her proficiency has been “approved” by the Canadian government to be adequate for medical practice.

However, if an IMD did not study medicine completely in English or French, in order to apply for licensure in Ontario, he or she must provide proof of language proficiency by submitting scores from the TOEFL: A pass on the internet-based test (iBT) is considered 93 out of a total of 120, with a minimum of 24 on the speaking section (CaRMS, 2010b). Suddenly, an IMD who might have only moderate language proficiency is now required to achieve a TOEFL score that is considered at the very top of the “Fair” category or in the “Good” category, in which test takers are considered to be “clear, fluid, and sustained” in their oral English with only “minor errors” (ETS, 2004, p. 6).

What kind of information is given to prospective immigrants regarding language proficiency and requirements for licensing in the regulated professions? The main immigration webpage for Citizenship and Immigration Canada does not acknowledge the gap between the level of English required for immigration and the level required to actually practice a profession⁴, although the page of the Foreign Credentials Recognition page does⁵. What happens to these IMDs or those who arrive with even lower proficiency? How can this information be used to improve the process for future IMDs? Very little research has been conducted to explore the experiences of IMDs in the midst of licensing in relation to language proficiency.

Thus, one of the most significant gaps in the literature related to IMDs is how language proficiency impacts on their ability to achieve licensure and what language training programs may or may not have been useful to them. Only recently has there been a shift in

⁴ http://www.cic.gc.ca/english/immigrate/skilled/language-testing.asp
⁵ http://www.credentials.gc.ca/individuals/language.asp
publicly-funded language training programs in Ontario to more occupation-specific content, (e.g., the call for proposals for the Enhanced Language Training program were only initiated in 2003 in Ontario (CLBC, 2004)). The one bridging program in the GTA aimed specifically at the medical language skills of IMDs seeking licensure in Ontario was offered for only five sessions over two years, and its funding was not renewed. Using a qualitative approach, the present thesis will seek to increase knowledge regarding this identified gap in the literature about language proficiency and the bridging education of IMDs, with the goal of improving the future experiences of IMDs during licensure.

Residency Interview

There is literature in the medical field regarding resident selection, a process described as recently as 2001 as “an area steeped in tradition and sparse in scientific rigor” (Gilbart, Cusimano, & Regehr, p. 221). Most often, the process involves the initial review of the applicant’s file, which usually contains some combination of curriculum vitae, academic transcripts, letters of reference, exam scores, and a personal/autobiographical statement. Candidates are selected from this initial pool for an interview. Interview practices vary widely, including unstructured, semi-structured and structured; in some interview processes, the interviewer has access to the candidates’ exam scores and other application information, and sometimes they do not; sometimes there is intensive training on how to rate the candidates’ responses, and sometimes very little. The candidates’ interview scores are then somehow combined with the application information to formulate a score and/or ranking of suitability for the program.

Research on the reliability of the residency interview in the selection process has found a variety of challenges, including conflicting “rumour mill” opinions about the
weighting of various parts of the candidate’s file (Ginsburg, Schreiber, & Regehr, 2004), a correlation between program performance and initial interview scores of IMDs which is “difficult” to apply in actual practice (Shiroma & Alarcon, 2010), and the inability of even trained interviewers to rate on a specific trait, rather than on their overall impression of the candidate (Bandiera & Regehr, 2004). With very few of these studies considering IMD candidates at all, and even fewer considering the linguistic and cultural barriers present to IMDs when participating in a North-American-style employment interview that is culturally unfamiliar to them, the gap in the literature regarding IMDs’ experience with the interview as part of the licensing process becomes apparent.

**A Sociocultural Theoretical Lens**

When considering what theoretical framework would be most suitable to apply to the experiences of IMDs seeking licensure in Ontario, I decided that one inspired by Vygotskian sociocultural theory would be uniquely effective. There are three main reasons for this effectiveness: (a) Vygotsky’s insistence on the social nature of learning; (b) his acknowledgement of the importance of psychological tools, such as language, in shaping thought and mental functions; and, finally, (c) the potential of Activity Theory, which has descended from Vygotskian sociocultural theory, to highlight what are called “contradictions,” or areas of tension, in the larger social system of medical licensing (Engeström, 2005). The particular position of IMDs, who are most often learners of English as an additional language, and who learned medicine within a different social and cultural context, makes these reasons all the more compelling. Sociocultural theory provides a theoretical framework which ensures that the focus of the present thesis will remain not only
on the individual IMDs themselves as they pursue licensure, but also on the larger social context they inhabit as they seek the knowledge they need to enter the Canadian system.

**Poetic Representation**

The creation of poetry from research findings was pioneered by sociologist Laurel Richardson (1990; 2002; Richardson & Adams St. Pierre, 2005), and has been taken up by many researchers in the social sciences since then, including many in anthropology and education. Proponents of poetic representation argue that some findings are better represented through poetry than academic prose (Richardson, 2002; Jones, 2010). As well, researchers who place an emphasis on the affective aspects of their data (Prendergast, Gouzouasis, Leggo, & Irwin, 2009) or who research from a social activist perspective (Kennedy, 2009; MacNeil, 2000) value how poetic representation can facilitate others’ understanding of their findings. The use of poetic representation in the current thesis is connected to the nature of the data: As the interviews progressed, I became increasingly convinced of the need to capture the affective content of the interviews and represent it in some way, along with the more traditional thematic content.

Richardson (2002) values poetic representation for its ability to “recreate moments of experience” for the reader. She argues that “short poems focus and concretize emotions, feelings, and moods – the most private kind of feelings – in order to recreate moments of experience. The poem “shows” another person how it is to feel something” (2002, p. 880). This thesis contains three poems that synthesize the findings using poetic representation. Each poem will be introduced with a frame on the page before that identifies the sources of the themes and voices in the poem. Depending on personal preference, the reader may choose to read the poem first and return to the frame afterwards. It is my hope that the three poems
in the thesis will add a further dimension to the more traditional discussion of the thematic findings of the experiences of IMDs as they seek licensure in Ontario.

**Research Questions**

The following research questions inform this dissertation:

1. What do IMDs learn in a bridging education program, according to the researcher, the IMDs themselves, and the bridging program staff?

2. What are the barriers and enhancers to IMDs’ success in the residency interview, as perceived by the IMDs themselves, bridging program staff and an interviewer?

3. How is the licensing process understood by IMDs in the midst of the process, with special reference to language proficiency?

These research questions are interrelated in a particular way: The first question is an exploratory research question that grounds the rest of the research in the experiences of a sample of IMDs undertaking bridging education. I also observed two different bridging programs (an interview preparation program and an English for Specific Purposes (ESP) medical bridging program) in which some of my participants studied, in order to compare and contrast my own perceptions with those of the IMDs and their instructors in the programs. Research Questions 2 and 3 form the core of the dissertation, as they focus on the experiences of IMDs during licensing.

**Thesis Organization**

Following this Introduction, this thesis contains seven further chapters. The second chapter is a review of the literature that, due to the already-mentioned shortage of research on
IMDs going through licensure, focuses on the most relevant literature on IMDs already in residency training and other literature from a variety of sources. The third chapter presents the theoretical framework for the study, in which I argue for the relevance of Vygotskian sociocultural theory for IMDs. The potential value of the application of Activity Theory to the licensing context is also discussed. The fourth chapter is an overview of the methods of the study, including a detailed discussion of the study goals and research questions, and a description of the participants and data collection and analysis procedures. The fifth and sixth chapters present the research findings for Research Questions 1 and 2, and then 3, respectively. Chapter Seven presents an Activity Theory model and analysis of IMDs’ experience of the immigration and licensing process as a larger system. In the final chapter, I reflect on the findings and the implications of this study for the medical licensing of IMDs and for government policy.
Poem One:
A Frame for “Doctor Shortage”

“Doctor Shortage” emerged from my interviews with the IMDs when I was struck by the juxtaposition of the stories of their previous medical education and practice with their current circumstances in Canada. So many emotions were expressed over the course of each interview: the hope associated with settling in Canada, a longing to return to practice, a sense of urgency for many, because of the consideration of recency of practice in the competition for training positions, and anger at feeling misled by the Canadian government regarding licensure. Beyond these all, there was the persistent identity of simply being a doctor. A number refused to relegate that identity to the past tense, insisting “I am a doctor,” despite the challenges they faced. An almost universal request from participants in the study was for improved bridging education supports, and thus, this is the requested bridge at the end of the poem.

In “Doctor Shortage,” the images and metaphors all arose from the interviews, so the images of medical practice came directly from, or were inspired by, the data. The words in quotation marks are direct quotations from the transcripts, except for the words of the daughter, which are imagined.
Poem One:
Doctor Shortage

Hope shining, I arrived
in this land of opportunity,
the future of my children.

These hands that had caught
And cradled countless babes
Over 20 years of practice
Or comforted parents at the news
Of their child’s cancer
Or consoled grieving family members.

Hands on the clock,
Ticking since arrival.
“I’ve heard that they take your recency
of practice also into consideration”
Time ticking away as we get settled,
Work, save for exams:
This one $800, that one $1600.

I dream of her,
That first patient in my third year
The hallways of the hospital where
Everyone knew me
My daughter asks,
“When will you be a doctor again?”

“If you were not in need of doctors, just say it:
‘You’re in the wrong country!’”
I knew there was a process,
Didn’t know how slim my chances.

“It was nothing to see 60, 70 patients a day”
“I didn’t come here to be a beggar in this country…”
A bridge, a real bridge
To that hope I carried here in my suitcase
“I am a doctor”
Is what I ask for.
Chapter Two:
IMDs: Challenges and a Deficit-based Approach

This chapter will first review the literature related to Internationally Educated Professionals from a variety of professions in order to highlight similarities across all professions including IMDs. Then, the literature specifically related to IMDs from North America and Australia will be reviewed. The American literature is included due to the recognized similarities of the two systems in relation to undergraduate medical education, and, in some cases postgraduate medical education,6 which is evidenced by increased ability to transfer back and forth between the US and Canada relative to other countries in the world.

The vast majority of this literature is related to IMDs already in residency training and/or practicing as fully licensed physicians, so wherever possible, issues that would also be relevant to IMDs in the licensing process will be emphasized. Finally, as one focus of the current thesis is the role of the residency interview in the residency training selection process, the relevant literature from interactional sociolinguistics that focuses on high stakes “gatekeeping encounters,” including interviews of a similar nature, will be discussed.

Overview

The challenges faced by IMDs are multi-faceted, crossing the domains of language, culture, and what is constructed as professional knowledge. Thus, a multi-disciplinary approach is most effective to approach these complexities. As discussed in the introduction, there are only a small number of studies about IMDs who are seeking licensure, a gap which this dissertation hopes to address. The vast majority of studies that do exist are in the medical

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education field, with a solid literature reaching back to the 1970’s documenting the
difficulties faced by IMDs once they enter training, and a more recent and parallel literature
that proposes various methods to assess IMDs’ language proficiency, professionalism, and
other constructs, sometimes in the context of high stakes examinations, and other times
within residency programs. Publications in these areas from both the United States and
Canada and Australia will be reviewed, with those from the Ontario context given a more in-
depth treatment.

One consistent issue in this literature is the categorization of challenges faced by the
IMDs in a way that parcels out language proficiency from culture and professional
interaction. For example, a recent study that examined the higher failure rate for IMDs in an
American surgical residency program in Seattle, Washington found that both knowledge-
related problems (including surgical and technical knowledge, as well as “poor command of
English”) and personal/cultural problems (including interpersonal difficulties and poor
adjustment to the pace of the program) contributed to the lack of success of IMDs (Horvath
et al., 2004, p. 494). It is clear that these categories do not address the overlapping nature of
language and culture that an interactional sociolinguistic approach can highlight. Similarly,
there is evidence in the literature of a “deficit-based approach” (Steinert, 2006, p. 17) to
IMDs, in which only their weaknesses or perceived deficiencies are focused upon, with less
emphasis on support in integration.

Within the Canadian context, Steinert’s comprehensive review of the literature for
Medical Educators working with IMDs identifies IMDs’ challenges to be the following:
“deficits in medical knowledge and clinical skills; a lack of proficiency in the English
language; a lack of training in communication skills; different study skills/techniques;
differing cultural perspectives; and significant life stresses” (2006, p. 14). More recent
Ontario studies have focused on needs assessment with a goal to improving supports for
IMDs. An interesting finding to come out of these is that, when IMDs’ own perceptions of
their needs are compared with those of program directors, there is significant variation, with
IMDs being more focused on immediate survival information, such as healthcare system and
hospital information, while program directors are more focused on the communication skills
of IMDs, particularly with patients and their families (Zulla, Baerlocher, & Verma, 2008).
However, it is worth noting again that these articles are still all focused on IMDs who have
already gone through the gruelling process to access training and are thus among the few
who are successful.

The focus of this research, the residency interview, in particular, means that the
literature from interactional sociolinguistics that investigates high-stakes encounters between
native speakers (NSs) and non-native speakers of English (NNSs) (called intercultural
gatekeeping encounters) can provide some themes and hypotheses that can be applied to the
high-stakes residency interview that the IMDs face. The pioneering work of Gumperz (1982,
1992) and his examination of the dynamics of misinterpretations of newcomers’ interview
responses by interviewers is highly relevant. As well, the more recent work of Kerekes in the
context of employment interviews for a temporary employment agency (2006, 2007), which
compares and contrasts the successes of native and non-native speakers of English, is also
relevant. Within the medical communication field, Cordella and Musgraves’ (2009) study on
the assessment of IMDs’ oral communication skills during an OSCE examination simulation
and Roberts, Sarangi, Southgate, Wakeford, and Wass’ (2000) study on the fairness of oral
licensing examinations for linguistically and culturally diverse candidates both offer insights
relevant to the licensure of IMDs. With the residency interview remaining a key gatekeeping encounter in the Ontario licensing process for medical doctors, these findings are relevant to IMDs’ experience of the interview and its efficacy as a screening tool.

**Internationally Educated Professionals (IEPs) and Related Literature**

One of the recommendations of Steinert’s (2006) review of the IMD literature referenced above was for medical educators to pick up on the “cultural/professional (re-learning)” strands of other international newcomers to Canada/North American, such as graduate students (ITAs) and engineers (p. 35). What do we know about occupation-specific language, culture, and professional knowledge and how they are defined? There is much to be learned from other professions which have a more established literature on the professional acculturation of internationally educated members of their profession. These studies involving the regulated professions, such as engineers, pharmacists and nurses, can provide insight into current trends, especially in terms of how bridging programs have/are developing and what are understood to be the key “components” of knowledge to be conveyed in each internationally educated professional’s transition to Canadian practice.

**International Teaching Assistants (ITAs)**

Hoekje (2007), an applied linguist with substantial experience working with IMDs in language and cultural support programs, also recognizes the resource that exists in the ITA literature, which records how universities, dating back to the 1980s, began dealing with the influx of these international graduate students into their departments. Although the initial focus of research efforts centered on credential and language proficiency screening, this was found to be inadequate to address the needs of the ITAs in terms of success in their teaching
assignments. Soon, an emerging research agenda was focusing on “the communicative setting of the ITA within higher education” (Hoekje, 2007, p. 328). Research within this area is relevant to attempts to define and further understand the challenges faced by IMDs in a new professional context. For example, Jenkins (2000) investigates the differences of perception between Chinese mathematics ITAs and the faculty within their department. The lack of mutual understanding between the two groups was documented as having cultural and linguistic elements in the case study: “The ITA’s polite deference and concern for maintaining appropriate face for unequal status interactions manifested itself as silence and avoidance in formal contacts with faculty…Most faculty interpreted this behavior as lack of motivation, isolationism and unwillingness to cooperate in ITA instructional assignments, or in improving their English” (p. 477). These types of intercultural dynamics are also documented in the IMD literature (see Bates & Andrew, 2001 for a Canadian example). As one IMD observes in a recent Ontario study, “I come from a culture where it’s a virtue to be modest and humble…whereas here, that can easily be misinterpreted as ignorance, or worse, stupidity” (Wong & Lohfield, 2008, p. 56).

Other relevant studies in this field include Gorsuch’s (2006) research, which questions whether university-wide or discipline-specific support programs are most effective for ITAs, and documents an attempt at a discipline-specific practicum. With similar programs underway in the field of medicine, it would be worthwhile to use the lessons learned here, particularly regarding how much interactive opportunity the practicum afforded the ITA. As well, Gorsuch (2003) uses the concept of “textual competence” to describe the language and cultural acquisition goals of the ITA, which is similar to Hoekje’s (2007) use of discourse system to describe the acquisition needs of IMDs. Of note is Gorsuch’s reference to the lack
of data in the literature regarding the “ITAs’ educational attitudes, and experiences and life circumstances which mediate them” (p. 9). A similar gap exists in the IMD literature which this research addressed by including questions about IMDs’ previous medical practice and reasons for immigrating in the interview protocol. Other studies, such as Bresnahan, Ohashi, Nebashi, Liu and Shearman (2002) look at the attitudes of American-born assessors to the accents of ITAs, and find that the level of formality of the setting and the strength of the ethnic identity of the assessor play a role in how positively an accent is viewed. Findings such as these, which show that in a more formal setting, accent is viewed more negatively, can be useful for this research in relation to conceptualizing various factors that may influence success and failure in the residency interview.

**International Pharmacy Graduates (IPGs)**

As they are also internationally educated newcomers seeking to practice in a regulated health care profession in Canada, the experiences of internationally educated pharmacists seeking licensure are applicable to the experience of IMDs. There is a particularly well-established bridging program for IPGs at the University of Toronto, and the literature associated with this extensively researched program is highly relevant to many aspects of the IMD situation. A review article on the program by Austin and Dean (2006) identifies a number of dynamics in the experiences of the IPGs, such as differences in the learning context: For example, because IPGs are less likely to have used simulated patients before, they often experience anxiety with the use of this new learning and testing tool. As well, according to a needs assessment study, the expectations for interprofessional practice and teamwork in the North American context remained “elusive” (p. 28) to many IPGs. Austin and Dean also refer to the concept of “epistemology of practice” to capture the
essence of the culturally-situated differences in practice in the North American context. As they observe, “reconceptualizing one’s professional paradigm of practice was a difficult shift for many foreign-trained pharmacists, particularly when coupled with Western democratic notions regarding patient autonomy, decision-making and confidentiality” (p. 29). Patient autonomy is also clearly a challenge for IMDs, who often come from countries where the culture of medical practice is considered less patient-centered than the North American context (Steinert, 2006).

What are some of the approaches used in this bridging program, which is regarded as an example of “best practices”? The model stands on four pillars: “prior learning assessment and recognition, university-benchmarked skills enhancement education, mentorship, and asynchronous learning opportunities” (Austin & Dean, 2006, p. 19). Interestingly, the program added a fifth pillar due to the students’ resistance to exclusive online learning: “a community of learners.” This was because the IPGs found the networking opportunities and in-class contact with other IPGs in the same situation to be an invaluable part of the program. Other studies, such as Austin and Dean (2004a), have identified issues similar to those in the IMD literature regarding IPGs lacking knowledge of certain illnesses, such as depression or hypertension, while having superior knowledge to CPGs in terms of other illnesses, such as malaria, or the treatment of child dehydration. They emphasize that the success of the program in addressing these gaps is rooted in the fact that pharmacy practice-related language instruction is embedded throughout the curriculum, which is tied closely to the undergraduate pharmacy program learning outcomes (see also Austin 2004b).

In addition, because the IPGs may lack experience in learning with Standardized Patients (SPs) (actors who portray patients in a realistic manner using standardized responses
from memorized scripts), the program provides many opportunities to interact with them, which is especially relevant due to the fact that the final pharmacy licensing examination has a similar format (an Objective Structured Clinical Examination, or OSCE, in which the candidate rotates through a series of evaluated encounters with SPs) to that of medicine. One study discussed students’ perceptions of simulated patients with less standardization as compared to the more typical standardized patient used in licensing examinations (Austin, Gregory & Tabak, 2006). This study found that student concerns about the consistency and fairness of evaluation overrode their desire to interact with a more “realistic” and freely-structured simulated patient. Another strength highlighted by the researchers in this program was that ESL specialists participate alongside pharmacy assessors in supporting the IPGs’ acquisition of the pharmacy-related discourse systems (see Austin & Tabak, 1998 for a detailed description of the role of the SPs in the program). Thus, the University of Toronto IPG program, now in its ninth year of operation and with an enviable success rate of a 96% licensing rate for those IPGs who complete the full program, has a great deal of relevant research to share with those who work with IMDs (Austin & Dean, 2006).

**Internationally Educated Nurses**

Certainly, the experiences of other internationally educated professionals are also relevant to the IMD context. Internationally educated nurses, for example, also function in many of the same work environments alongside doctors, and are part of the interprofessional team, so many of their communicative needs overlap with those of IMDs, especially in terms of understanding the Canadian medical context. One recent study focuses on Internationally Educated Nurses (IENs) who work with older adults: Hearnden (2007) conducted interviews with 21 participants and key themes that emerged included the nurses’ self-perceived lack in
understanding how to respond correctly to various situations in the workplace, such as “how to respond to verbal abuse, how to refuse in a contextually appropriate manner (e.g., if offered a gift by a patient)” (p. 95). Another related theme was the challenge of adapting to a nursing practice in Canada that was often different from their home countries in various ways, including the working relationship between nurses and doctors. Hearnden’s work also included participants discussing their experiences in bridging education in Canada, which they often felt was “inconsistent and inadequate” and she also found that many of the nurses felt unable to “confidently function” on their own, even after passing the required examinations (p. iii). Hearnden highlights a key point here: that challenges faced by IENs and IMDs do not end with accessing (re)training or even entering licensed practice.

**IMD-specific Literature**

Due to the similarities between the medical education systems and the presence of a similar proportion of IMDs in the American and Canadian systems, the North American literature specific to IMDs is worth considering.

**North America**

The American literature on IMDs deals mainly with those already in residency training and is fairly sizeable, covering a wide range of topics, including language assessment, cultural differences, and clinical knowledge. For example, some studies have surveyed attitudes and practices of Program Directors towards IMDs (Gayed, 1991; Gonsalves, Wrightson, Love, & Torbeck, 2005). Research in the US has shown that IMDs face challenges, first of all, with the attitudes of those running the Family Medicine programs that they are applying to. Gonsalves et al. (2005) found that although most US Family
Medicine residency directors who responded to their survey (N=162) would consider IMDs for an unfilled residency position (88%), only 40% “agreed that they would perform as well as U.S. graduates” (p. 1). One interesting finding of their study was that program directors were more likely to have a positive attitude about IMDs if their program had IMD faculty or a higher number of IMDs in the program. Another earlier study (1996) found that fourth-year students in medical schools across the US were less likely to rank programs highly that they perceived to have a high proportion of IMDs (Riley, Hannis, & Rice, 1996). Clearly, IMDs face challenges with respect to how they are perceived, both by program directors and American-born medical residents.

Two recent Canadian studies highlight these challenges. Andrew (2010) compares CMGs and IMDs in Family Medicine residency training in British Columbia. The location of the study was a training site that specialized in training the IMDs, with supportive faculty and extra time devoted to “analyzing doctor-patient relationships and communication issues” (p. e320). The main measures analysed were in-training evaluation reports (ITERs) used throughout residency training to evaluate the resident’s performance, and the results of each participant in the Canadian Certification in Family Medicine (CCFP) examination (Andrew, 2010). The participants were 21 CMGs and 24 IMDs in either first or second year residency. Using the 2-tailed Fisher exact test, the number of ITER evaluations in each group that fell under Exceeds or Meets Expectations, Needs Improvement, or Fail were compared.

While the first year groups were basically equivalent in the distribution of the above ratings, Andrew found that the second year IMD residents were more likely to receive Needs Improvement ratings. However, the numbers of Needs Improvement ratings were actually very small among these IMDs, totalling only 3% of all ratings. Finally, the success rates in
the CCFP examination were compared, with pass rates of only 58% for the IMDs passing and 95% for the CMGs (Andrew, 2010). Andrew (2010) postulates that this large difference in the failure rate might be attributed to the fact that

IMGs are disadvantaged by the format of the CCFP examination. It could be cultural; it could be the subtle nuances of the English language; it could be the more direct approach that some IMGs have in eliciting medical information; or it could even be that some examiners lack experience with IMGs (p. e322).

In addition to the above, I would add the possibility that the sociocultural translation of medical practice is likely a process that takes more than two years to complete, and that IMDs would likely benefit from intensive examination preparation over a period of several months, along with a mentoring relationship to support them as they transition into independent practice. While the UBC program represents a “dedicated site with highly experienced teachers,” it still follows the traditional format of residency training. It may be that more substantial changes to this traditional format may be required to support IMD success in the long run.

The second study, by MacLellan, Brailovsky, Rainsberry, Bowmer, and Desrochers (2010), is set in Quebec, and compared IMDs and CMGs and American Medical Graduates (AMGs) over an eight-year period. The main outcome measures were success rates on pre-residency and post-residency examinations, with the Collège des médecins du Québec (CMQ) family medicine certification examination being similar to the CCFP discussed in the previous study. When examinations taken before residency training were considered, IMDs were found to have lower scores on clinical OSCE exams. The authors reported that

When we analyzed candidates’ performance on the different components of the OSCE, we found that IMGs perform poorly in history-taking, investigation, differential diagnosis, and treatment….IMGs’ z scores were
approximately 1.5 to 2 standard deviations lower than CMGs’ scores on the same skills. (MacLellan et al., 2010)

Similar to the study above, the pass rates for the IMDs on the post-residency licensing examination were much lower than CMGs, with a 66% IMD pass rate compared to 90.4% for CMGs (MacLellan et al., 2010). The authors offer a number of explanations for these differences, including that the IMDs have failed to integrate into the Canadian medical system (Bates & Andrew, 2001) or that “poorer performance is not attributable to a lack of medical knowledge and competency in clinical skills, but rather to how and when an IMG learns to translate the knowledge and integrate it with clinical decision making” (p. 917). Another hypothesis is that the variability of the educational backgrounds of the IMDs means that the “educational process might not provide the foundation in knowledge, skills, and attitudes they need to succeed in Canadian residency training and Certification examinations” (p. 917). As I suggested above, I would add to these hypotheses that two years of training without substantial accommodation of the differences alluded to above may not be enough for an IMD to achieve the performance expected of a graduate of a Canadian medical school.

Another study that is currently underway by Brailovsky and MacLellan has preliminary results that indicate that IMDs who go back to pre-residency levels of responsibility in medical school, most often the clerkship, are closer in level to Canadian-educated trainees in their success rates in the licensing examination. These data suggest that other approaches need to be integrated into the current post graduate medical education system to better support IMDs’ success, along with increased sensitivity to how the OSCE exam format may impact on their lower success rates.

Other studies have examined whether differences exist in quality of practice and success of IMDs and American-born Medical Graduates (AMGs) after graduation (Blonski
& Rahm, 2003; Mick & Comfort, 1997). For example, Blonski and Rahm (2003) used a survey of all Family Medicine residency programs in the US to collect data on the residents’ match status (i.e., were they selected and matched earlier in the process, or accepted only to fill empty residency spots?), their status as an AMG or IMD, and their In-Training Assessment Evaluation (ITE) scores. Their findings indicated that residents matched later in the process did not tend to perform as well as those matched earlier, and that IMDs were more likely to fall in the lowest 10% of the exam scores and were also more likely to require remediation (7.8% vs. 3.2%). Blonski and Rahm (2003) emphasize in their conclusion, however, that the majority of IMDs performed well in their residencies.

Horvath’s study on the high failure rate of surgical IMDs at a hospital in Seattle, Washington found that the introduction of a preliminary “subinternship” program where the IMDs were evaluated in a setting equivalent to what a US fourth-year medical student would experience was a success for improving the selection of suitable IMDs for their residency program (Horvath et al., 2004). However, the students in this special placement were given no extra assistance, so it was basically a pre-residency “sink or swim” evaluation in which some were asked to stay and some were asked to leave. In this sense, the program does not function as a bridging program, due to the fact that the IMDs receive no extra instruction or support regarding the culture of the hospital practice, other than the extra eight weeks of exposure. In response to Horvath’s article, Dr. Guillermo Escobar, himself an IMD and a surgeon, wrote a letter to the editor in the Journal of Surgery. He emphasized that the reasons Horvath et al. give for the failure of IMDs are equally relevant for United States-trained residents, as they “often succumb for the same causes, as well as most of the knowledge-related ones found in the [paper]…I submit that communication impairments are often
stigmatized in IMG[s], but United States-trained residents and staff often require sensitivity, anger management, or communication training during their career” (Escobar, 2006, p. 281). Thus, Escobar tries to put the challenges faced by IMDs in the larger context of challenges faced by all trainees in the United States.

One recent American study had practicing psychiatrists and Family Medicine specialists review a videotaped scenario of late life depression in an elderly simulated patient. Kales, DiNardo, Blow, McCarthy, Ignacio, and Riba (2006) found that IMDs were significantly less likely than USMGs to make the expected diagnosis of depression, as well as less likely to prescribe anti-depressants for the patient. The researchers conclude that these results could be related to IMDs’ “lesser familiarity with depressive symptoms or different cultural conceptions of depression” (p. 171). Interestingly, Dr. G. Whelan, in a companion commentary in the same issue of Academic Medicine as Kales et al. and another IMD-related piece of research, chose to directly address these findings, not for the purpose of focusing on the perceived “deficiencies” of the IMDs themselves, but to draw attention for the need of American Graduate Medical Education to better support the acculturation of IMDs: “Specific programs and strategies need to be developed and put in place early in the GME [Graduate Medical Education] experience – or even before entry into GME – to assist IMGs in understanding issues that may not even be apparent to USMGs, which if not directly addressed may continue to be baffling to even the most intelligent and fluent IMG” (Whelan, 2006, p. 177). With this response, Whelan attempts to shift the focus from a deficit-based approach to IMDs, in which their deficiencies are highlighted, to a focus on how the system itself may be failing to support their adjustment. In this, Whelan shows sensitivity to the
enormity of the linguistic and cultural transition in which IMDs finds themselves during residency training.

Hoekje’s past work with ITAs and expertise in ESL instruction led her to take a particular approach to the challenges facing the IMDs with whom she works. She identifies a common thread in the literature, namely that simply raising the cut scores on English proficiency scores was expected to solve the problem with IMDs, “but did not prevent language and other issues from subsequently emerging” (2007, p. 332). Recognizing the complexity of the language and cultural issues facing the IMDs, she challenges the discreteness of the categories in the literature, observing that “language skills are interactive with other issues, such as the expression of care for patients and may affect strategic aspects of practice such as time management” (2007, p. 332). Her solution to this dynamic is to reframe what exactly it is that the IMDs are being asked to acquire: She argues that viewing the overlapping categories of acquisition holistically as a discourse system “allows the encompassing worldview of U.S. medicine and its practices and institutions to be made more visible. At the same time, seeing it as a system focuses on the individual practitioner less as a language learner and more as a communicator being socialized into new forms” (2007, p. 341). This ESP-based perspective on the challenges of IMDs in residency provides a helpful frame of reference to complement the more isolationist categories that separate language and culture in the Medical Education literature.

Kramer (2006) calls for a more bidirectional learning process to support IMDs in his article focusing on the educational challenges faced by IMDs in psychiatric residencies. In addition to the more common supports called for IMDs, such as “language, slang, and accent reduction training” (p. 163), he also observes that “It is incumbent upon us [i.e., Medical
Educators] to understand the cultural sources of the values and needs of our residents to enhance their learning experience” (p. 170). This call is reflected in a key outcome of the Canadian IMG Taskforce: the education modules for Medical Educators. Similarly, Whelan’s call for instruction that addresses culture and medical practice even before the graduate medical education has been answered to a certain extent by some of the bridging programs that are now getting underway in Canada and that allow for IMDs to gain an introductory knowledge of the contrasts between their previous mode of practice and the Canadian setting even before they enter residency training. One of these programs was observed during the course of this research, and those data will be presented in Chapter Five in detail.

Compared to the amount of research on the American context, there are a smaller number of articles which directly deal with IMDs in the Canadian context. Two relevant papers use a statistical focus to try to shed light on the questions “Who are Canadian IMDs? Where are they practicing, what are their specialty preferences?” (Thind, et al., 2007; Szafran, Crutcher, Banner, & Watanabe, 2005). Another interesting article seeks to compare the treatment choices of IMDs and Canadian medical graduates using Health Canada database data, demonstrating that, in contrast to the Kales et al. study above, they prescribe similar medications and interventions to treat Acute Myocardial Infarction (heart attack) (Ko, Austin, Chan, & Tu, 2005). In terms of the Canadian context, there are also a small number of papers published on experiences with bridging education, such as the Alberta Medical Communication Assessment Project (M-CAP), which includes a linguistic and cultural pre-training component, as well as practical placements (Emery et al., 2006). Studies from this program are informative in terms of best practices that have already been identified in other provinces. Thus, overall, the Canadian IMD literature has a descriptive
strand that is helping to answer the questions of “Who are IMDs? Where do they practice? Are their medical decisions different that Canadian Medical Graduates? What programs currently exist to support them?”

Data to date suggest that IMDs are generally older than Canadian-born applicants for residency positions and thus “may have increased family and financial responsibilities” (Bates & Andrew, 2001, p. 45). This is corroborated by a comparison study of IMDs with Canadian citizens born in Canada who choose to leave the country for medical studies, often because they are unable to get into a Canadian medical school. This particular group of Canadians seek to study abroad, often in medical schools in the Caribbean, for example, or Ireland, are called “Canadian IMDs” or more often, CSAs “Canadians Studying Abroad” because they are Canadians who are forced to become IMDs if they want to study medicine. The age and demographics of these “Canadian IMDs” are more closely related to those of CMGs, (that is, Canadians who go to medical school in Canada). On the other hand, IMDs tend to be different in demographics from either Canadian IMDs and CMGs: “Immigrant IMGs were older, had more postgraduate experience and were more likely to be married and have children than Canadian IMGs” (Szafran et al., 2005, p. 1243). Interestingly, in terms of practice choices, 45% of both IMDs and Canadian IMDs chose Family Medicine, compared with only 30% of CMGs (Szafran et al., 2005). Explanations for this trend could vary, including the recognition on the part of both IMDs and Canadian IMDs that, with such competition for positions, they will have a better chance of accessing Canadian training if they apply to Family Medicine, which tends to be less popular with Canadian Medical Graduates.
The federal Internationally Educated Health Professionals Initiative (IEHPI) funded a series of professional development modules for faculty members who teach IMDs. Yvonne Steinert’s literature review for these modules (2006) represents one of the most comprehensive attempts to conceptualize the challenges that IMDs face once they enter residency training. The key areas that Steinert identifies in the literature in terms of the needs of IMDs are as follows: deficits in medical knowledge and clinical skills; a lack of proficiency in the English language; a lack of training in communication skills; different study skills/techniques; differing cultural perspectives; and significant life stresses (2006, p. 14). To help teachers of IMDs best address these issues, Steinert recommends a series of content areas for faculty development. One of the key themes of these content areas is the necessity to develop a shared understanding with the IMDs as to what the goals and expectations are for learning and evaluation: “the need for assessing needs and expectations becomes even more pronounced in this context [with IMGs] because of issues related to personal loss, previous medical training and cultural differences” (2006, p. 19).

These findings from Steinert’s review of the literature are in agreement with recent American studies, such as Porter, Townley, Huggett, and Warrier (2008). Porter et al. (2008) used a multidimensional needs assessment by program directors to identify the major areas of knowledge where improvement was needed in the knowledge of IMDs in their programs; these were seen to include certain medical procedures, such as gynaecological exams or ECGs, as well as particular communication tasks, such as “explaining illnesses to patients, occasional poor interactions with nursing staff, and a perceived lack of knowledge of the IMGs’ due to nonparticipation in dialogue on rounds” (p. 38). Interestingly, focus groups with the IMDs themselves already in the Porter et al. program identified different topics more
related to their daily practice and content regarding the health care system, such as “patient privacy rules [and] communication with patients’ family members” (p. 38). Thus, there is a difference between what teachers of IMDs perceive to be their knowledge needs and what the IMDs themselves perceive those needs to be.

A more recent paper by Wong and Lohfield (2008) reports on the findings of a phenomenological, interpretive study of the experiences of IMDs retraining in four Ontario universities. The 12 participants came from a variety of countries, including “Asia, Latin America, the Middle East, the Caribbean, and Eastern Europe” (p. 55). Even though these doctors were among the small number who were successful in accessing (re)training, it is interesting that two of the four major themes to emerge are regarding the challenges faced before accessing training. First, the theme “Training Entry Barriers,” which highlights the participants’ descriptions of the admissions process, vividly captures its daunting nature: “logistically difficult, impersonal and stressful as a result of ambiguous selection criteria and lack of feedback” (p. 55). The other three major themes to emerge from the study describe the three-phase process of their becoming a Canadian doctor.

The first phase is loss, which is also a pre-admissions theme: “loss” captures the losses experienced by these doctors during the settlement process, including both the personal sacrifices to work towards recertification, as well as the professional loss of starting again: “You felt dehumanized, in a sense, as if you had lost something that you had already achieved” (p. 56). The next theme, “Disorientation,” reflects entry into the training process and the challenges they face. As such, “Disorientation” is more reflective of the literature, as it focuses on training challenges: themes here are similar to those already described, including lack of knowledge about the hospital hierarchy and how to behave with peers and
superiors, and also insecurity about the expectations for their own work and performance. In addition, there was also confusion about “the Canadian medical system, the use of medical technology and therapies and inter-professional relationships, and medico-legal and ethical issues” (p. 56). Finally, the last theme is “Adaptation,” which points to strategies for success used by the IMDs during their residency training. Three factors were identified as contributing to that success: “support from designated faculty mentors…peer support from other IMGs in training…and sufficient time spent in the training programme” (p. 57). One interesting finding from this study is that IMDs who are recent graduates and had not practiced in their home countries experienced the phase of loss to a lesser degree than those who practiced before arriving in Canada.

A needs assessment study conducted by Zulla et al. (2008) at the University of Toronto surveyed both program directors and IMDs currently in training to ask what the knowledge needs are for IMD success. While “both groups agree that an orientation program is necessary for incoming IMGs prior to starting their residency training” (Program Directors – 93% and IMDs – 63%) they disagree on what the priority content is (p. 42). In an echo of the findings of the American study described above (i.e., Porter et al, 2008), program directors felt that the key areas for improvement included “communication with patients, team members, and also basic clinical skills,” while the IMDs felt that they needed more preparation in “the Canadian Healthcare system,…pharmaceuticals and hospital formularies,…[and] knowledge of the hospital system” (Zulla et al, 2008, p. 42). Findings so consistent across North American contexts suggest that bridging programs need to be designed to meet the perceived needs of both of these groups. In addition, it must be noted that for the IMDs, the most pressing needs of acquiring the knowledge that they need to
function in the medical environment may be perceived as more pressing than cultural and linguistic knowledge that they may not even be aware they are lacking. Zulla et al. suggest that next steps for the University of Toronto could include focus groups with IMDs and in depth interviews with the program directors. The study concludes that “a proliferation of IMG entries has not been accompanied by robust strategies to optimize their integration and bridge their transition into residency…A comprehensive and integrated program is needed to facilitate the success of IMGs” (p. 45).

An earlier article by Hall, Keely, Dojeiji, Byszewski & Marks (2004) details a needs analysis conducted at the University of Ottawa. However, the IMDs that are the focus of this needs assessment are not IMDs who have immigrated to Canada after obtaining permanent residency, but IMDs who come to Canada temporarily for post-graduate training under a special international agreement and who will return to their home country upon completion (also called “Visa Trainees). Although these are a different group due to their status, a review of the results of the needs assessment reveals that, overall, the challenges they face are similar. The five main recommendations of the study include: “English language skills…hospital/healthcare [knowledge,…opportunities to practice certain skills, e.g. negotiating treatment…adequate support system for IMGs…[and] faculty and staff education on the cultural challenges faced by IMGs” (p. 120). An interesting difference in these results, however, is that unlike the Canadian and American IMDs, “the opportunity to practice communication skills” was listed by these international IMDs as the top priority for a support program. This needs assessment also collected input not only from program directors and IMDs, but also from allied health professionals and an expert focus group of communication skills educators. As very few studies have been conducted on this particular group, this study
makes a unique contribution. Its findings also emphasize the importance of language ability and communication: “understanding dialect, colloquialisms and nuances of spoken language, as well as local humour and non-verbal communication, requires high levels of language skills” (p. 124). This study identifies the top priority for a support program to be English language support, for both speaking and writing.

There are some studies in the literature on existing bridging supports for IMDs in Canada that raise important issues for consideration. One online offering aimed at IMDs and funded by the Ontario government focuses on content related to the C2LEO objectives, which cover “communication, culture, legal, ethical and organizational aspects of medicine” set out by the Medical Council of Canada (Lax, Russell, Nelles, & Smith, 2009, p. 55). Recognizing that these aspects of medical practice, while “tacitly understood by Canadian-trained physicians, are often obscure to IMGs” (Lax et al., 2009, p. 55), the team set out to design an online environment that would simulate “authentic real-world practice to support active cognitive engagement and complex knowledge work” (Lax et al., 2009, p. 55). To ensure that participants have adequate language proficiency for the program, the Communication & Cultural Competence Program (CCC) offers an English language proficiency test which takes approximately two hours to complete and is benchmarked to the Canadian Language Benchmarks (CLBs). There are five cases that deal with content that is relevant to the C2LEO objectives, such as an HIV case that deals with complex issues, such as consent and confidentiality. Instructional design strategies were applied that provide IMDs with the opportunity to first view a simulated doctor-patient visit, as well as view relevant resources and receive feedback on knowledge checks. Studies on the use of the online environment are promising, in that they indicate that participants continued trying and retrying the reflective
exercises and quizzes even when not prompted to do so. Lax et al. (2009) conclude that these kind of online video simulations “retain domain complexity and authenticity resembling real-world practice. Web-based access provides opportunities to revisit and review scenarios” (p. 57). This program offers an innovative approach to online instruction, and is worthy of further study to see how IMDs perceive its role in their overall licensing process, as well as further research, as the authors themselves suggest, to assess how this online learning translates into practice.

In Alberta, the Medical Communication Assessment Program (M-CAP) is an Enhanced Language Training (ELT) program that focuses on the language acquisition of IMDs through a curriculum that emphasizes strong ties to the field through practising physicians and an authentic curriculum (Watt et al., 2006). Participants must have passed the first two MCC examinations, the EE and the QE1, and also meet a minimum language benchmark to participate (M-CAP, 2011). This 12-week program that includes 8 weeks of in-class instruction and 4 weeks of observation with a practising physician, and aims to “accelerate the rate at which AIMG’s [i.e., Alberta IMDs] could develop their professional language proficiency through a performance based teaching approach” (Watt et al., 2006, p. 1). In focusing on performance, the M-CAP team was trying to address one of the identified gaps in the literature regarding bridging education initiatives for IMDs: the need for “systematic empirical research to assess... [bridging education] efficacy” (Watt, Violato, Lake, & Baig, 2010). Results of the two studies presented are promising: the IMDs demonstrated large gains in language proficiency and also were rated highly by their preceptors in their placements. Two other dimensions of interest were that IMDs in the program out-performed the comparison group “on clinical skills and professionalism” (Watt...
et al., 2010, p. e70) and the IMD participants also rated the program highly. The researchers identify several areas for future research that include longitudinal studies following the M-CAP graduates into residency training and comparing their performance to non-M-CAP graduates. In addition, future studies could explore “the long term benefits of the M-CAP program” (Watt et al., 2010, p. e76).

**Australia**

It is also worthwhile to examine the case of the Australian system due to the common impact of globalization and the similar issues faced by developed countries in providing for their Health Human Resources (HHR) needs. Like the American and Canadian literature, the vast majority of the literature focuses on the transition of IMDs once they enter the medical system, most often as residents but also as practicing physicians. Research from Australia demonstrates that IMDs there face similar issues to IMDs in North America when they move into training; a global literature review from an Australian perspective identified themes that should, by now, be familiar: “[they] need to quickly grasp the protocols of the medical practices of the…state and federal health systems. In addition they have to cope with changes in self-esteem, differences in learning styles, new patterns of disease, and communication issues” (Pilotto, Duncan, & Anderson-Wurf, 2007, p. 225). Due to the acute doctor shortage in Australia, IMDs have been fast tracked into “conditional registration to practice in so-called ‘area of need’ positions and geographic ‘districts of workforce shortage’ [and this registration] does not encompass standardized assessment processes and may compromise patient safety” (McGrath, 2004, p. 640). This kind of fast tracking is less common in Ontario, where most of the IMDs settle, but more common in other provinces, such as Saskatchewan.
or Manitoba, where attracting IMDs is more difficult (Lockyer et al., 2006). McGrath’s (2004) major recommendations for improving the Australian system are not unlike those to come out of Canada’s 2004 IMG Taskforce, with the key ones being related to standardization of assessment for language as well as communication and clinical skills. Overall, the Australian system seems to be facing similar challenges to the Canadian one, with the situation in Ontario a bit further ahead in the development and standardization process due to the fact that it has the most stringent practice requirements and, by numbers, is the main welcomer of IMDs to Canada.

One Australian initiative relevant to the Ontario setting is the work of Chur-Hansen, Elliott, Klein, and Howell (2007), in which they report on the implementation of a needs assessment of English-language proficiency for General Practitioner residents in the “Adelaide to Outback GP Training Program (A2O)” (p. 37). What is innovative about their approach is that it focuses on language needs immediately after the residents have entered the medical system. In Ontario, there are few programs that exist to assess and support the language needs of residents once they enter training (see Goldszmidt, Kortas, & Meehan, 2007 for one example). Much of the support occurs once the residents have been identified as having problems and are in remediation, which is a high stakes process which can lead to their being ejected from the program. Chur-Hansen et al.’s work draws on the earlier described assessment and validation work from the United States, where physician examiners and SPs are used to assess the language proficiency and communication skills of the IMDs. The scales used to assess interview and written skills are validated scales developed by Chur-Hansen and Vernon-Roberts. The needs assessment for language proficiency included one encounter with an SP, who rated the IMD’s proficiency, along with four other raters, who
rated a videotape of the interview. After the interview, the IMD wrote up a narrative summary of what happened, which was rated by all five raters on written English and handwriting. Findings indicated that, of the 18 assessed, five “were found to have no need for any assistance…5 had poor handwriting, 5 were considered to have minor difficulties, and 3 were identified as having substantial spoken and written English-language difficulties” (p. 36). Based on the results, the participants were referred to one of the self-paced modules on handwriting and advanced writing skills, or referred to a specialist English language tutor for one-on-one support. This kind of proactive approach, in which the results of an initial needs assessment are used to tailor support to each candidate, would be an effective addition to the current approach in Ontario.

*Interactional Sociolinguistics and the Intercultural Gatekeeping Literature*

As discussed in the Introductory Chapter, IMDs face a complex selection process as they compete for training positions in Ontario: the residency interview is the final screening tool in this process. For this reason, sociolinguistics has much to offer. As Gumperz observes, “interpretive sociolinguistic approaches to human interaction…account for the role that communicative phenomena play in the exercise of power and control and the production and reproduction of social identity” (Gumperz, 1982, p. 1). Thus, what sociolinguistics has to offer this study is its focus on contextualized, social discourse and its ability to illuminate power discrepancies behind sociolinguistic actions. Within sociolinguistics, the interview is a particular genre, with its own expectations and rules. Fairclough (2003) defines genre as “Different ways of (inter) acting discoursally” (p. 26). The residency interview contains many different ways of acting discoursally: each one has boundaries, and many “unwritten”
rules and conventions which govern whether the interaction will be judged as successful by the interviewer.

The conventions of the residency interview, which is simply a specialized type of employment interview, mean that it can be considered a gatekeeping encounter, which is a particular kind of interaction studied by sociolinguists. By definition, gatekeeping encounters are “asymmetric speech situations during which a person who represents a social institution seeks to gain information about the lives, beliefs, and practices of people outside of that institution in order to warrant the granting of an institutional privilege” (Schiffrin, 1994, p. 147). How does the residency interview reflect Schiffrin's definition? It is asymmetric in that the power rests in the hands of the interviewers of the IMDs, who are, for Family Medicine interviews, generally a faculty member and a resident in the program. The privilege that the IMDs are seeking is to (re) join their profession in Canada. The information that will be discussed, are “the lives, beliefs and practices” of the IMDs, as conceptualized within the genre of the North American employment interview. As such, the interviewer tends a metaphorical gate, which essentially means that he/she regulates the interviewee’s passage or entry into “‘bureaucratic, technological, or legal institution[s]’” (Scollon & Scollon, 1981, p. 4). What makes this gatekeeping encounter particularly challenging for the IMDs is the fact that the vast majority of them have never encountered the genre of the North American job interview before, and the stakes for them in these interviews are extremely high.

The pioneering work of Gumperz in the area of intercultural interviewing is relevant to this discussion, given that the IMDs, by definition, come from another culture, and are very likely to be unfamiliar with the genre. Gumperz defines the particular challenges of the interview from the perspective of the demands placed on the interviewee that go beyond
“regular conversation”: “In situations of differential power and interethnic stigmatization, problems that in other cases might pass as simple instances of lack of shared linguistic knowledge come to be seen as reflecting the speaker’s ability, truthfulness, or trustworthiness” (Gumperz, 1992, p. 327). Thus, the first quality of the interview that is relevant is the fact that it goes beyond the “surface level” meaning of the questions being asked, and these are cues that are differentially available to participants often “based on their differential access to mainstream culture and the rhetorical strategies of bureaucratic discourse” (Akkinnaso & Ajirotutu, 1982, p. 144).

Gumperz (1992) further expands the definition of the intercultural misunderstandings of the interview to include the participant's lack of self-praise, as well as the use of appropriate backchannel cues and voice tone used in conjunction with particular reporting functions. Gumperz also emphasizes the importance of providing the “expected” kind of responses to greetings in the key opening moments of the interview. Failure to do so can result in the interviewer resorting to foreigner talk (i.e., loud, simplified English). To elucidate the impact of these determining factors, Gumperz discusses the differential outcomes between two applicants for training positions, one for bricklaying and the other for electrician, in relation to the different ways they respond to key questions: The bricklayer goes beyond the literal question to take each opportunity to represent his positive qualities and initiative, for example. The electrician, although sometimes aware that he is not providing the desired responses, answers the surface level questions and thus does not take key opportunities in the interview to promote himself: “Whereas the native speakers are seen as showing initiative and willingness to cooperate, the non-native speakers appear to be
inordinately reticent and seeking to downgrade or minimize what they have done, when judged by our English conventions” (p. 322).

The work of Kerekes (2005, 2006, 2007) is also relevant to this discussion. Rather than focusing only on intercultural interviews, her research data contain employment interviews from a diverse group of 48 job seekers, including both those who are speakers of English as an additional language, racialized people and those considered mainstream/Caucasian. Kerekes' study involves recorded gatekeeping interviews at FastEmp (a pseudonym), a large temporary employment agency that hires a variety of workers, including those for construction, manual labour, and clerical/admin assistant positions. The particular focus of this research was to examine the talk within the interviews with the female, Caucasian middle-class interviewers to identify strategies that would allow participants to be successful, regardless of their background. What turned out to be particularly relevant was the talk that focused on the candidates’ skills and previous experience: “Specifically, with regard to employment interviews, what actually gets discussed, including, but not limited to, the candidate’s job skills and previous work experience, is considered by the interviewer (the gatekeeper) as she assesses the candidate (the gatekeepee)” (Kerekes, 2007, p. 1904). Thus, by examining the different ways that the diverse participants described these two areas, Kerekes was able to identify some promising findings.

What was interesting about Kerekes' findings (2006) was the concrete strategies to come out of the research, which show promise for future educational support programs. According to Kerekes (2006), “approximately as many nonnative speakers (NNS) as native speakers (NSs) achieved successful interview with their NS interlocutors (the staffing
supervisors)” (p. 29) Thus, the status of a “non-native speaker,” within Kerekes’ research is not a determining one that defines the successful gatekeeping outcome or not: while the successful candidates may not share the same first language, “what they [do] share is the ability to present themselves positively, to establish rapport/solidarity with their interlocutor, and to demonstrate flexibility regarding job requirements and preferences” (2006, p. 27).

In fact, Kerekes (2007) identifies the ability to establish trust as connected to other positive verbal actions identified in the interviews, such as “compliments, selling a job, collaborative completions” (p. 1970). What is interesting is that the ability to convince the interviewer that one is trustworthy was not necessarily correlated with one's actual trustworthiness, leading Kerekes to conclude: “As it happened, many of the instances in which the staffing supervisors felt they could trust the candidates were not warranted (as evident by job candidates who were placed but did not reliably fulfill their assignments), but based perhaps on preconceived notions of what a trustworthy candidates ‘‘looks’’ and ‘‘sounds’’ like. It is thus very much in the interest not only of job candidates and their advocates to learn how to make a positive impression, but also in the interest of FastEmp to accurately determine who is truly deserving of a positive impression” (p. 1970). Thus, in the end, abilities recognized to create positive rapport with an interviewer, such as understanding when to strategically offer positive information about oneself can be a crucial skill in getting an opportunity to prove oneself.

Other studies in the area of interview research are also of interest. Although not directly on the topic of interviews, specifically, Young's (1982) discussion on indirectness and Chinese discourse gives vivid descriptions of how communication can be misinterpreted when evaluated from a different discourse perspective. This kind of analysis provides a
useful echo to Gumperz's analysis, and that of the research in the ITA field. Describing English speakers’ attempts to understand a simulated budget meeting in which some participants were native speakers of Chinese speaking English: “The different ways of structuring information receive different valuation in English-speaking and Chinese-speaking cultures. Viewed callously, the Chinese discourse appears imprecise, unwieldly, and downright inept” (1982, p. 81). As well, the work of Akinnaso, who researched interviews with young African Americans at an employment skills centre is relevant: “To the extent that the signaling of intention and interpretive or inferential processes are based on culturally specific discourse conventions, interview questions may be ‘wrongly’ interpreted where such conventions are not shared between interviewer and interviewee” (1982, p. 127). These additional studies enrich the data on the interview as a screening tool, especially regarding those who do not come from the mainstream/dominant society.

One recent research study recognizes the challenge for an IMD to perform like a Canadian-born resident on the employment-style interview, and suggests an alternative method to select IMD residents: a Multiple Mini Interview. In some ways, this methodology represents more of an OSCE-style examination, where the candidate rotates through a series of stations where they read an introductory “stem” that gives them a hypothetical situation that they have to discuss or role play. Here is one example:

An elderly patient at the practice was admitted to the senior citizens’ home 6 weeks ago and is not doing well because of progressive dementia. A case conference is called by the family because the patient wandered off and was missing for 18 hours. The nursing home manager feels that her facility does not have the resources to care for someone with this level of dementia. The meeting is to be attended by the appropriate staff from the home, family members, community nurse, social worker, and yourself.

Using the whole team, how would you manage the meeting to resolve this situation? (Hofmeister, Lockyer, & Crutcher, 2009)
While this kind of interview for the most part allows for the selection of IMDs on more spontaneous responses than memorized interview questions – two of the stations remain traditional interview questions – the issue still remains as to how they can access the kind of local, cultural knowledge about Canadian nursing homes, and the roles and responsibilities of Canadian community nurses and Canadian social workers to effectively respond to this question. In my opinion, this sample station still requires a great deal of knowledge of the local system to mediate an acceptable response. Although the construct measured could be more relevant to assessing a candidate’s ability to function in a residency position compared to “Tell us about your greatest strength,” how can an IMD gain this knowledge without a significant clinical observership or substantial bridging education? Particularly when many IMDs come from medical cultures which are very doctor-centered (Steinert, 2006), a team approach to case management may be unfamiliar and could lead to an inappropriate response at this station. This appears to be a Catch-22 that requires more creative solutions and further research before the selection process can be optimized, especially with regards to fair access to the needed interaction and mediation from this cultural context.

Cordella and Musgrave (2009) also focused on IMDs, but this time the setting was an OSCE practice session for the Australian licensing examination. Most of the 11 IMDs in their study were from Asia and were participating in a bridging education program to prepare for the Australian Medical Council (AMC) licensing examination. The AMC assessment criteria “Approach to patient,” was the focus of the study, and the researchers specifically looked at how successfully the IMDs were able to express empathy during the course of one role play station, as assessed by an OSCE examiner. The station evaluated involved the breaking of bad news to a patient in his 60’s who faces a diagnosis of bowel cancer and who,
at least initially, refuses treatment. Cordella and Musgrave (2009) found that there were behaviours that were associated with the candidates who were judged by the examiner to be empathetic: these included proactively focusing on positive aspects of the diagnosis (e.g., a small tumour, localized), responding appropriately to the patient’s request for reassurance, and mirroring the patient’s choice of language regarding the diagnosis. In addition, Cordella and Musgrave (2009) found that turn-taking was another key area, where unsuccessful candidates tended to have transition times (between turns) that were higher than the mean. They conclude that “Some candidates failed to give and read turn-taking cues in an appropriate way...The candidates who had problems in this area were consistently assessed as unsatisfactory, suggesting that such problems significantly affect OSCE examiners’ perception of the consultation” (p. 138). Cordella and Musgrave’s (2009) study design was not able to identify the source of these longer pauses, however: was it linguistic? A processing issue? Cultural? These questions and their study’s findings suggest that further research regarding the success of IMDs on OSCE-style assessments would be beneficial, and could positively impact on bridging education and even OSCE design and the training of examiners.

A study by Roberts et al. (2000) focuses on a different kind of interview, an oral examination used by the Royal College of General Practitioners in the United Kingdom (UK) to assess potential candidates for membership that would allow them to practice medicine in the UK. Data available to the college had shown that certain groups were consistently not scoring as well as British-born candidates, and the examination board approached the team of researchers to explore possible reasons why. The researchers used an ethnographic approach, observing 24 oral examinations in person, mainly with candidates from “ethnic minorities”
Roberts et al. (2000) found that, although the interview purported to measure the professional discourse of the candidates, it was dominated by institutional discourse and a hybrid of all three. When candidates did not produce the expected discourse in response to a question, the examiner would sometimes try to provide a cue or reframe the question for them; however, the researchers noted that these cues included “subtle features in intonation and voice quality, which may be particularly difficult for candidates from non-English speaking backgrounds to pick up on” (Roberts et al., 2000, p. 372). In addition, there were a number of “slippery areas” identified which ethnically and linguistically diverse candidates were challenged to discuss in “institutionally appropriate ways” (p. 373). These included “values and attitudes,” “areas of uncertainty” and “cultural differences” (p. 373). Roberts et al. (2000) conclude that the current format of the examination disadvantaged these diverse
candidates. They recommend that the examination board take action to educate their examiners about these difficulties and encourage them to make all discourse shifts in the oral examination explicit to the candidate, and that the examination board should also publish examples of typical questions and candidates’ answers along with examiners’ comments to increase the transparency of the assessment.

Summary

This chapter has reviewed the literature relevant to IMDs seeking licensure in Ontario, Canada. Although a gap exists in terms of research focusing on those IMDs before they gain entry into Canadian practice, the existing literature which focuses on those who have gained entry into practice has been considered, including relevant research from Ontario, and the United States and Australia. Finally, due to the unique focus of this research on the licensing process, and especially on the residency interview, the interactional sociolinguistic literature which focuses on high-stakes encounters such as employment interviews, called gatekeeping encounters, has also been considered.

Several implications relevant to applied linguistics emerge from this review. First, the earlier responses to the language and cultural challenges faced by IMDs upon entry into the system tended to be to further increase the language proficiency requirements using standardized tests, such as the TOEFL, or the American Clinical Skills Assessment. Unsurprisingly, this did not eliminate the problem. Overall, the medical education field has tended to view language proficiency in isolation from the other challenges faced by IMDs, and this mindset may have complicated the development of support programs needed to address the overlapping complexity of language and culture. Language-oriented bridging programs, such as the M-CAP that are appropriately researched and that support language
acquisition through authentic medical activities and placements with practising physicians, can support significant language gains for IMDs before licensure. The CCC program, with its built-in language assessment and online accessibility also offers promising results. The work of Hoekje (2007) for IMDs and Steinert (2006) for the medical educators of the IMDs, show promise, due to Hoekje’s insistence on a more integrated discourse-based approach to learning, and Steinert’s encouragement for educators to look beyond the “deficit-based” approach to IMD education that dominates in the medical education literature.

Several recent studies, including two in Ontario, have begun to look more deeply at the question of how best to support IMDs already within the system. The needs analysis conducted at the University of Toronto shows a promising recognition of the need to create supports that are more comprehensive than in the past, and that reflect the perceived needs of the IMDs themselves: “A comprehensive and integrated program is needed to facilitate the success of IMGs” (Zulla et al., 2008, p. 46). In addition, the phenomenological study by Wong and Lohfield (2008) identified key supports that IMDs felt allowed them to be successful in retraining, such as a faculty mentor and peer support from other IMDs in the program. Thus, for those IMDs who are able to access retraining, there are some signs that the system is beginning to perceive and act on the need for more effective supports for their success. However, for those who are still in the midst of the licensing process, substantial challenges remain, including the difficulty of facing the residency interview. As the discussion of such gatekeeping encounters from an interactional sociolinguistics perspective has demonstrated, the use of interviews in high stakes selection processes requires careful attention to how culturally and linguistically diverse candidates may be disadvantaged by the sometimes invisible assumptions that guide assessment of success and failure.
Chapter Three: Theoretical Framework

This chapter will present the theoretical framework that supports the analysis of the data in the present thesis. First, key concepts from Vygotskian sociocultural theory – mediation, internalization, the zone of proximal development and emotion/consciousness – will be discussed and their relevance to the context of IMDs highlighted. Then, Activity Theory, which has descended from Vygotsky’s ideas, will be explained, including studies which use it in language learning research. A particular emphasis will be placed on the Activity Theory model in this discussion. Finally, the chapter ends with a five-point summary that synthesizes the rationale for applying this theoretical framework to the experiences of IMDs during licensure.

Key Concepts From Vygotskian Sociocultural Theory

Certain key concepts of Vygotskian sociocultural theory are worth examining in detail, as they are particularly relevant to this research. Mediation, internalization, the zone of proximal development, and emotion/consciousness are concepts that collectively delineate Vygotsky’s focus on the social origins of learning and the movement of learning from the social plane into the individual’s mind (Vygotsky, 1987). For IMDs who have, in most cases, learned English as an additional language and practiced medicine in another culture, Vygotskian sociocultural theory can enhance understanding of the specific learning challenges that they face when seeking medical licensure in Ontario. Below, each of these four concepts from Vygotskian sociocultural theory will be discussed, along with some commentary on how the concept is relevant to the IMDs’ context.
Mediation

Wertsch (1985) identifies mediation as one of the three key themes at the core of Vygotsky’s theoretical approach. He defines the importance of mediation to Vygotsky’s theoretical framework in the foundational “claim that mental processes can be understood only if we understand the tools and signs that mediate them” (p. 15). But what is mediation? In English, the noun mediation originates from the Latin root of mediare, which means “to be in the middle”\(^7\). While current usage is more commonly that of the work of a go-between who settles disputes between parties, in this context, mediation literally means to “exist between.” Mediation can occur in the physical world, with tools that help accomplish a task, such as a knife or scissors to cut, or a bicycle or car to go from point A to B. Mediation can also occur in the psychological realm, with tools that are more abstract.

![Figure 1. Original Vygotskian model of mediation, from Vygotsky, 1987.](image)

Vygotsky’s model of mediation shows that between a stimulus and response is a complex act which is mediated by tools. One example would be an individual with a task that he or she wants to accomplish, such as counting a number of items. How does one go about this? Counting on one’s fingers? On knots on a piece of rope? These would represent external

tools to come between, or mediate, the accomplishment of the task. Using a number system would represent a psychological tool that has been learned and allows the individual to forego external aids, such as the knots on the piece of rope. A key aspect of mediation is that it changes us: The tools we use not only impact on how we approach and complete a task, but also on how we understand it. As Vygotsky said, “the psychological tool alters the entire flow and structure of the mental functions…by determining the structure of the new instrumental act, just as a technical tool alters the process of natural adaptation by determining the form of labor operations” (Vygotsky, 1987, p. 20).

Another example of a psychological tool would be any aid used to consciously remember something, even a physical object that reminds the person of what is to be remembered. Vygotsky (1997) tells a story in his own writings that demonstrates this dynamic:

V. K. Arsen’ev, a well-known researcher of the Ussuriysk region, tells how in an Udeg village in which he stopped during the journey, the local inhabitants asked him, on his return to Vladivostok, to tell the Russian authorities that the merchant Li Tanku was oppressing them. The next day, the inhabitants came out to accompany the traveler to the outskirts. A gray-haired old man came from the crowd, says Arsen’ev, and gave him the claw of a lynx and told him to put it in his pocket so that he would not forget their petition about Li Tanku. The man himself introduced an artificial stimulus into the situation, actively affecting the processes of remembering. (pp. 50-51)

Thus, in this case, the claw of the lynx becomes the psychological tool which is intended to stimulate first memory, and then, action on the part of Arsen’ev. While he acknowledged above that physical tools do shape the completion of tasks, Vygotsky’s own primary interest was in psychological tools, and of these, he had a particular interest in language and speech, because he felt that speech “is the mechanism common to both social behavior and the psychological processes that are unique to human beings” (Vygotsky, 1987, p. 20).
The concept of mediation is particularly relevant to IMDs in light of the fact that Vygotsky emphasized mediation through language in his analysis. Almost all IMDs are learners of English and, in most cases, when they seek licensure in Ontario they seek to shift the mediating language of their medical practice from their previous language of practice to English. Language is not the only mediating tool between the individual physician and medical practice, however. Culture, too, mediates medical practice in important ways. What is a good doctor? What is the role of the doctor in medical decision-making? These are not universal values, but are culturally determined. Just as IMDs are shifting the language of their practice when they seek licensure, they are also shifting the culture of their practice. Access to this mediating tool is much harder to come by for IMDs, because it most often must be experienced to be learned, such as in a clinical observership where an IMD has the opportunity to observe a practicing physician with his or her patients. Thus, the concept of mediation is relevant to this research in that it can be used to define exactly what it is that IMDs are changing when they seek to move their medical practice to Ontario.

**Internalization**

In Vygotsky’s analysis of the origins of higher mental functions, the concept of internalization plays a key role. This is due to another theme that Wertsch (1985) identifies in Vygotsky’s theoretical framework: “the claim that higher mental processes in the individual have their origin in social processes” (p. 14). As Wertsch (1985) observes, “In this account, internalization is a process involved in the transformation of social phenomena into psychological phenomena” (p. 63). An example of this comes from Vygotsky’s observation that “In general, children do not create their own speech; they master the existing speech of
surrounding adults.” (as quoted in Wertsch, 1985, p. 107). Thus, according to Vygotsky, the social context is not only the source of learning for the developing child, but also psychological tools which are internalized, and become his or her own. Vygotsky’s genetic law of cultural development, in fact, states that “every function in the cultural development of the child appears on the stage twice, in two planes, first, the social, then the psychological, first between people as an intermental category, then within the child as an intramental category.” (Vygotsky, 1997, p. 106). Thus, internalization is the process in which the social interactions a child experiences are taken on, first socially (externally) and then are taken inside (internally) to function as tools over which the child has gained independent use and control. Internalization is significant, in that it changes the basic question of developmental psychology as it existed in Vygotsky’s time. As he observes, “In contrast to Piaget, we believe that development proceeds not toward socialization, but toward converting social relations into mental functions….The usual question is how does one child or another behave in a group. We ask how does the group create higher mental functions in one child or another” (Vygotsky, 1987, p. 107). Thus, to Vygotsky’s theoretical framework, the social environment is not simply the milieu in which development proceeds, but it is indeed the source of the development of the higher mental functions of the child, which they first encounter socially and then master and internalize.

Internalization is also relevant to the context of IMDs, even though Vygotsky’s original arguments were regarding the development of higher mental functions in the child. If we apply the genetic law of cultural development to adult learning, then the same process of internalization must occur in the adult learner of language, for example. Note that, in this theory of development, the first plane is the social. As suggested above, IMDs face both
linguistic and cultural challenges as they seek licensure and prepare for the examinations that will allow them to compete for residency training positions. As the examinations progress, they include more “Canadian content,” meaning Canadian cultural, professional, and ethical content from the C2LEOs. The C2LEO resource is a compilation of the cultural, communication, professional, and ethical competencies expected of a Canadian physician. After the initial examination, the Evaluating Examination, which is focused on clinical medical knowledge only, the next exam contains questions that relate to these ethical issues. The subsequent examinations are Objective Structure Clinical Evaluation-style exams, or OSCEs, which entail interviewing a standardized patient in a simulated office setting. Thus, the examinations move towards a setting which is, in some ways, more like an encounter with an actual patient. However, if learning does occur in the social plane, as Vygotsky suggests, where are the opportunities for IMDs to access this cultural knowledge through social interaction and then internalize it? These are extremely difficult to come by. Thus, regarding internalization, IMDs find themselves in a situation where they are required to perform behaviours that are culturally based, yet their access to the social-medical plane they need to internalize these behaviours is limited.

Zone of Proximal Development

The Zone of Proximal Development, or ZPD, as it is often called, is a concept from Vygotsky’s developmental research that has had significant impact on education, including current attempts to integrate the idea of the ZPD into assessment. Vygotsky introduces the idea of the ZPD using the metaphor of the orchard. Vygotsky asks if a gardener would only want to know the state of the fruit which is already harvested or fully ripe? Looking only at
the harvested fruit will not tell the gardener what s/he needs to know about the ongoing and future development of his orchard. This is the equivalent of educators only assessing the level of the child’s development which has matured, meaning “tasks that the child solves independently” (Vygotsky, 1987, p. 208). In order to truly assess either the orchard or the development of the child, Vygotsky argues that assessment only begins when we know the highest level of task the child can perform independently. Then, a second phase of assessment must be undertaken of tasks for children which requires the “help or collaboration” of the facilitator. Results from this assessment will show the functions which are in the process of maturing, and thus will give a much better picture of the true mental development of the child.

The implication for educators here is that Vygotsky argues that instruction must be directed to the ZPD: “The teacher must orient his [sic] work not on yesterday’s development in the child but on tomorrow’s” (Vygotsky, 1987, p. 211, emphasis in original). Vygotsky’s analysis tells us that, in order to teach productively, a teacher must focus not on the already harvested fruit (i.e., tasks that can already be independently completed), but on the maturing fruit (i.e., tasks that can be completed with support). The concept of the Zone of Proximal Development functions thus as “not only a model of the developmental process, but also a conceptual tool” (Lantolf & Thorne, 2006, p. 267).

The Zone of Proximal Development is particularly relevant when considering the learning of IMDs in the limited bridging programs that do exist. What kind of instruction do IMDs receive in bridging education? Are they functioning in their zone of proximal development? How is this evident? As Lantolf and Thorne have observed, the zone functions also as a “conceptual tool,” and thus is not only involved in charting development. Given that
activity in the ZPD involves interaction, another relevant question is whether IMDs feel that they have adequate access to the kind of interaction that can lead them to their ZPD. By definition, this would necessitate learning activity with a licensed physician (likely one licensed in Ontario and perhaps a medical educator), or else a more competent peer. Another question relevant to IMDs in relation to the ZPD is their perception of the existing examinations that have been designed to evaluate their medical knowledge and competence. Are these examinations measuring the “maturing” fruit, to use Vygotsky’s analogy? Is there any sense in their description of the licensing process that they perceive their potential development is being measured? Where applicable, the experiences of the IMDs during licensure, their perceptions of the licensing process and its examinations, and their opinions about access to physicians/medical educators who have the expertise to move them into their ZPD can be explored, and the ZPD itself can be a conceptual tool illuminating these dynamics.

**Emotion and Consciousness**

Just as Vygotsky had posited a view of the individual as inseparable from his or her social context, and a process of assessment of development that was inseparable from social interaction in the form of support and facilitation, so, too does Vygotsky see emotions as inseparable from intellect: “Affect and intellect are not two mutually exclusive poles, but two mental functions, closely connected with each other and inseparable, that appear at each age as an undifferentiated unity” (Vygotsky, 1998, p. 239). In fact, regarding methods of psychological research, Vygotsky repeatedly argued against those which isolate processes and elements from each other for the purposes of analysis. For example, regarding many
studies of thought and speech, he observes: “They decompose verbal thinking into speech
and thinking, elements that do not contain the characteristics inherent to the whole. This
closes the door to any real explanation of these characteristics.” (Vygotsky, 1987, p. 244). In
his own analysis of thinking and speech, Vygotsky argues for the inseparability of emotion in
the psychological system:

> The affective and volitional tendency stands behind thought. Only here do we
find the answer to the final ‘why’ in the analysis of thinking. We have
compared thought to a hovering cloud that gushes a shower of words. To
extend this analogy, we must compare the motivation of thought to the wind
that puts the cloud in motion. A true and complex understanding of another’s
thought becomes possible only when we discover its real, affective-volitional
basis. (Vygotsky, 1987, p. 282)

Given the consistency of his belief in and application of an integrated methodology to
explore the higher mental functions, it is not surprising that Vygotsky was critical of
reductionist approaches: “the separation of the intellectual side of our consciousness from its
affective, volitional side is one of the fundamental defects of all traditional psychology” (as

Emotions are crucial to the experiences of IMDs going through the licensing process
due to the very emotional experience of immigrating, losing one’s status as a medical doctor,
and then facing sometimes insurmountable challenges to regain it. In addition, the process of
“translating” oneself into another language and cultural setting can also be an emotional one
that is related to one’s very identity. Benson and Nunan (2005) observe that stories from
language learners allow us to see that

> The acquisition of a new language raises questions of subjectivity and desire:
the problems confronted by the learner are not just technical or mechanical
(‘how do I say X in this language?’), but involve complex issues of identity
(‘who am I when I speak this language?’ or alternatively ‘can I be “me” when
I speak this language?’). (p. 13)
IMDs thus exist at the intersection of language, culture, and professional knowledge when they seek licensure in a new country.

**Activity Theory**

However, even the use of these concepts from sociocultural theory could still “miss” some aspects of the context of IMDs seeking licensure in Ontario. The above concepts from Vygotskian sociocultural theory put the focus on the individual IMDs and their sociocultural (learning) environment. What about the larger medical licensing system? Vygotskian-inspired Activity Theory provides a solution to this quandary. There are three aspects of Activity Theory that make it an ideal addition to the theoretical framework: its focus on collective activity, the value of historicity, and the impelling role of contradictions within activity. First, its focus on collective activity: As Engeström observes, “Behind a momentary action performed by a singular actor there is a long-term collective activity” (2005, p. 54). Rather than viewing the IMDs as individuals each seeking a singular goal, it is equally as appropriate to analyze them within their sociocultural setting, taking part in the collective activity of medical licensing in Ontario. Second, historicity: Another aspect of AT is that the cultural-historical focus emphasizes the necessity of understanding the historical origins of the current situation. “problems and potentials [of activity systems] can only be understood against their own history” (Engeström, 2005, p. 64). In the case of IMDs, this requires that attention be paid not only to the current state of the licensing process, but also to its history. Third, contradictions: Another potential strength of AT is that it has a built in interest in tensions or contradictions, which are a source of “change and development” (Engeström, 2005, p. 64). As Engeström (2005) identifies the primary contradiction in all capitalistic activities to be that between the “use value and exchange value of commodities” (p. 137), it
may be helpful to consider the commodity of the international medical licence against the current immigration context.

*Figure 2. Model of a Human Activity System, from Engeström & Sannino, 2010.*

It would be helpful now to focus on Engeström’s model (Figure 2) in more detail. Notice that the triangle -- that is, Vygotsky’s original meditational triangle -- is inverted, but still part of this new model, here labelled “Subject” on the left for the individual, “Instruments” on the top, representing tools and forms of mediation -- be they semiotic or concrete -- used in the activity and finally, “Object” is on the right hand side, which represents the object of the collective activity. Engeström draws attention to the fact that “object-oriented actions are always, explicitly or implicitly, characterized by ambiguity, surprise, interpretation, sense making, and potential for change” (Engeström, 2001, p. 134). This emphasis connects well with the previous discussion on Activity Theory, which
highlighted the important function of contradictions to lead “change and development” within the activity (Engeström, 2005, p. 64).

Among the challenges that Engeström has identified for third generation activity theory to address include “to develop conceptual tools to understand dialogue, multiple perspectives, and networks of interacting activity systems” (Engeström, 2001, p. 135). In order to rise to this challenge, the third generation of activity theory is often found to use not only one of the representational models first proposed by Engeström above, but to represent two or more of the activity systems of different stakeholders interacting. The model that follows (Figure 3) shows an example of the workplace in which the activity systems of the manager, his or her work unit and the client all interact. Notice the Venn diagram-style ovals that represent the objects of these interacting activity systems: not all of the objects of these groups overlap 100%, a fact which can lead to the kind of contradictions discussed above.

![Activity system model of workplace power relations](Figure 3. Activity system model of workplace power relations, from Engeström (2008).)
**Activity Theory and Language Learning Research**

As Lantolf and Thorne (2006) characterize it, AT “has proved a productive framework for mapping and transforming the complexities of social practice in a wide array of social settings” (p. 222). The activity itself is the “broader level process” within the system and represents something carried out not just by the individual, but by a community or society (Lantolf & Thorne, 2006, p. 217). Thus, in terms of the IMDs, the activity would represent, in the largest sense, the licensure process, a process shared by the community of IMDs with one possible goal being to practice medicine in Canada. It is important to note that the other stakeholders (bridging program staff and those who interview residents) also participate in this activity from different vantage points. What is interesting about AT is that it allows the researcher to explore and chart changes and shifts in the system/s of the participants. As Lantolf and Thorne (2006) observe, “If…one is interested in actual processes of learning and development, then we would encourage a focus on *activity*” (p. 238). Two studies that apply Activity Theory to settings relevant to language acquisition have been selected for discussion to provide a sense of the potential of AT to elucidate language learning in a novel way.

The first study relevant to language learning and Activity Theory is a case study of a graduate student who needed to learn Chinese to meet her program requirements (Lantolf & Genung, 2002). She was a highly accomplished language learner and very motivated to learn Chinese. However, the decontextualized and teacher-centered style of her instructor threatened her initial motive of learning the language within the activity of taking the language class. Finally, when her attempts to speak to the instructor and program director in order to shift the activity to align with her motive were unsuccessful, she abandoned her
initial motive of “learning Chinese” and substituted an achievable motive of “passing the course and meeting the program requirement” (Lantolf & Thorne, 2006, p. 242). Here, the framework of Activity Theory allows us to understand the shifting motives of the graduate student in response to a learning environment she experienced as hostile. Activity theory allows us to recognize that, although the actions on the part of the student might appear the same to an outward observer, the abandonment of her initial motive of “learning Chinese” led to her participation in a different activity. Finally shifting to a new activity, she recognized that, in the very least, she could meet the language requirement of her PhD program by being successful in the course, and thus undertook that activity and motive, although it was nowhere near as satisfying to her. Thus, an Activity Theory analysis helped elucidate this situation where a learner responded and adapted to a contrasting institutional activity; this is a dynamic with potential application to the experiences of IMDs, who are also relating to a larger institution.

Another example of the application of Activity Theory also in the language learning field is that of Cross (2009, in press), which reports on a study of Japanese EFL learners engaged in pair work in a series of lessons designed to improve their L2 listening. Cross’s learners had to establish and maintain a certain hierarchy in the interactions, which was based on traditional respect for elders. In his study, however, English language proficiency also interacted with age, as the younger of the pair was the more proficient. Cross (in press) decided to instead approach the representations of the contradictions from within AT, using an innovative adaptation of Wells’s (2002) activity model (see Figure 4).
Figure 4. Cross’s skewed joint activity system model.

On first sight, this model appears quite different from the aforementioned third generation Activity Theory model proposed by Engeström (Figure 2). Notice that Cross’s model includes two subjects instead of one, and thus functions to represent a joint activity system. Wells’s original model is normally balanced, looking much like a house with a symmetrical roof, the peak of which is the outcome of the shared activity. For Cross (in press), however, the data indicated that the activity was not equally shared:

Tomoko had been worried about limiting her partner’s participation through her own domination of the required pair work. On the other hand, Nami had felt the strain of responsibility for participating equally in the required pair work because she felt her participation had not been adequate.” (p. 59)
Additional unresolved contradictions occurred due to the interaction of age and proficiency, which lead to unaddressed disagreements between the two. Cross’s use of a multidimensional data collection process, which included interviews, recordings of the pairwork, and individual written journals, allowed these unresolved contradictions to be uncovered and included in the activity system representation.

Due to the unequal participation in the activity system, Cross skewed his model outcome away from the partner who participated less, Nami. This can serve to represent not only more access to the outcome for the partner who participated more, but also that the partner who participated less used less of the “mediating artifacts,” namely dialogue in the pair work. Cross concluded that “the joint activity system analysis illustrated that a number of social-cultural-historical contradictions were both driving and inhibiting learners’ metacognitive development” (in press, p. 1). He recommends further research be undertaken using activity systems to examine “the cause and nature of tensions motivating actions in joint activity by [exploring] the underlying pre-existing idiosyncratic and evolving conditions involved” (p. 62). In the context of IMDs, there could be different tensions in the activity system of seeking licensure, especially when considered in relation of that of the licensing authorities. Cross’s innovation of the Activity Theory model to accommodate his findings is exactly the kind of development that Engeström (2008) calls for, as he acknowledges that research applying Activity Theory is a developing activity in and of itself that will only move forward with creative innovation and exchange. It is possible that the unique activity system of the IMDs and its relation with that of the licensing authorities will also call for an innovation in the activity system model that reflects the findings of this study.
**Reflections on Applying Activity Theory to IMDs**

This brief review of two language learning studies that use activity theory has demonstrated that third generation activity theory is, in itself, a vibrant activity system with multiple worldwide participants. What these studies seem to agree on is that individuals cannot be considered in isolation from the social and cultural context that they inhabit. On the contrary, these studies show that interaction -- whether it be a dyad completing language learning tasks or a student learning Chinese in a classroom -- is the key to moving knowledge from Vygotsky’s intermental plane to the individual’s intramental plane. This is also true for IMDs, who acquired their first language and medical culture of practice through interaction, and now seek to acquire and join another culture of medical practice. They will need access to interaction, and the appropriate interaction, to make this transition. How do IMDs relate to the activity of medical licensing? How do they understand their own activity of seeking licensure? By using an Activity Theory-inspired approach, this research will ensure a focus on both the individual IMDs seeking licensure and also their relationship to the larger medical licensing system.

**Sociocultural Theory: Reflections on the Whole**

There are, undeniably, numerous lenses through which the experiences of the IMDs seeking licensure in Ontario could be viewed, all having their own pros and cons as to what they would bring to the analysis. This summary will argue the case of the benefits of Vygotskian-inspired sociocultural theory to best frame the interview data of the IMDs and bridging program staff and to answer the research questions that drove this research. Here are the key benefits:
1. The Vygotskian sociocultural view that individual learning is inseparable from sociocultural context is particularly suitable for individuals who have acquired competence in one professional setting and now are attempting to translate that competence into another setting.

2. Vygotsky’s insistence on emotion and intellect as an “undifferentiated unity” (Vygotsky, 1998, p. 239) suggests that, to him, a methodology that ignores the emotion of participants to report only their intellectual understanding of an event would be reductionist. In fact, Vygotsky argues that “A true and complex understanding of another’s thought becomes possible only when we discover its real, affective-volitional basis (Vygotsky, 1987, p. 282).

3. Activity theory, with its ability to represent multi-voiced activity systems with “individual and social levels interlinked at the same time” (Kuutti, 1996, p. 25) provides a productive lens through which to view the efforts of the IMDs seeking licensure as an individual activity that is situated in a larger, politicized national and provincial context. The Activity Theory analysis is the final stage of the data analysis, as it will draw on the results of all three research questions for the construction of the Activity system model.

Thus, while this chapter provides my rationale for the adoption of a Vygotskian sociocultural framework for this research, I acknowledge that it represents one choice among many. As Denzin and Lincoln (2005) suggest that “All research is interpretive; it is guided by the researcher’s set of beliefs and feelings about the world and how it should be understood and studied” (p. 22). In the end, this research does reflect my belief in the benefits of viewing learning as a collective sociocultural process.
Chapter Four: Methods

This chapter first presents the goals of the research and the research questions. Then, I describe the various sources of data and how they combine, including observational data, interviews with IMDs, and program staff. After presenting the participants in the study and their profiles, the chapter moves on to data analysis, describing the main methods used to analyse the data. As the present thesis uses poetic representation, drawing on Richardson (1990; 2002; Richardson & Adams St. Pierre, 2005) my specific approach to this type of representation of research results will be discussed. Finally, the necessity of ensuring the quality of qualitative research will be argued, and the approach used in the present study will be outlined. The chapter ends with a description of the inter- and intra-coder reliability check, which is one of the ways that the rigor of the research was ensured.

Research Goals

This thesis research has multiple goals which are reflected in the research design. The paucity of literature that focuses on the experiences and needs of IMDs who are going through the licensing process was a primary motivator: In this sense, this research aims to contribute to the literature in terms of IMDs who have not yet obtained a residency position, with a particular focus on the residency interview as a high-stakes gatekeeping encounter. An additional facet of this contribution is the focus on IMD-specific bridging education, which is a more recent arrival on the Ontario scene, coming from the 2005-2010 IEHP initiative discussed earlier. So, this research can contribute to the literature regarding the experiences of IMDs going through the licensing process and their perceptions of the supports that
existed at the time of research. The ultimate goal of these contributions, however, is to improve the situation of future IMDs who immigrate to Ontario.

An additional goal of this research is to expand critical thinking related to Activity Theory, which is descended from Vygotsky’s body of work. With its focus on collective activity and internal tensions or contradictions within the system, Activity Theory is ideal to represent the medical licensing process with which the IMDs find themselves in contact. Every theoretical framework has its strengths and weaknesses, however, and a goal of this research related to sociocultural theory is to contribute to the ongoing development of the Activity Theory model. Yrjö Engeström, the main proponent of third-generation Activity Theory, has acknowledged that Activity Theory is a developing activity in and of itself and that more work is needed to adapt and improve it in the future (Engeström, 2008). As Engeström (2005) observes, “there are other kinds of communicative relations, typically those where representatives of different activity systems interact. Those relations need further elaborations of the model, perhaps entirely new models” (p. 32).

**Research Questions**

This study seeks to answer three research questions in the context of medical licensing in Ontario:

1. What do IMDs learn in a bridging education program, according to the researcher, the IMDs themselves, and the bridging program staff?

2. What are the barriers and enhancers to IMDs’ success in the residency interview, as perceived by the IMDs themselves, bridging program staff and an interviewer?
3. How is the licensing process understood by IMDs in the midst of the process, with special reference to language proficiency?

Interview data were collected from both IMDs and bridging program staff for the purpose of understanding the learning experiences of IMDs in a bridging program. The data collected from these two stakeholder groups were then contrasted and compared, with a view to identifying the areas of agreement and disagreement between teachers of IMDs and the IMDs. In terms of the residency interview, there are three stakeholders from whom data were collected: In addition to the IMDs and bridging program staff, one IMD who had successfully entered medical practice and had been involved in interviewing candidates for residency was also interviewed. Thus, these three perspectives are combined in order to answer the second research question.

The third research question focuses on the experiences of the IMDs as they strive to gain the right to practice medicine in Ontario, Canada. The multi-faceted nature of Activity Theory is well suited to this exploratory question, as there are numerous aspects of the activity of seeking licensure and numerous participants (e.g., medical schools, program directors, licensing bodies) that need to be considered. Language is a particular focus here, due to my own concern, as an applied linguist, about the possible impact that having lower English proficiency on arrival might have on licensing outcomes for IMDs.

**Participants and Recruitment**

What follows now is a description of the research participants and recruitment, organized by the different stakeholder groups: IMDs, and bridging program staff. After profiling who participated and how they were recruited, I describe the data collection procedures in more detail.
International Medical Graduates

Participant profiles.

IMDs participating in this study were currently participating in some kind of bridging program and actively seeking licensure. I wanted to collect data that captured their in-the-moment reflections on what they were learning in the bridging program and their experiences of the licensing process. I aimed to attract the participation of IMDs whose characteristics varied in a number of ways: both men and women, from diverse countries of origin, with some variety in their time of arrival to Canada, and in their medical specialty and time in practice in their countries of origin, and whether they studied medicine in English or not, if possible.

Participant recruitment and data collection.

In the spring and fall of 2008, participants were recruited and initial interviews were conducted with those interested between October 10, 2008 and June 18, 2009. The main method to reach potential participants was posters in bridging program locations and government agencies. The target number for initial interviews was twelve to fifteen diverse IMDs, as described above. This target was met, with a total of fifteen IMDs participating in initial interviews. Table 1 below describes the participants in terms of gender, age, and country of origin. Due to the small and close-knit nature of the IMD community, these are presented in aggregate and not as individual profiles or pseudonyms, as this level of detail would disclose the identities of the participants to various members of the IMD community, including other IMDs or medical educators. Where it was necessary to preserve anonymity (e.g., the IMD practiced a unique specialty or came from a country with very few doctors
immigrating to Canada) certain details have been omitted. For the same reason, when interviews with individual IMDs are cited, these are cited by interview number only.

**Table 1**

*IMD Participant Profiles*

<table>
<thead>
<tr>
<th>Profile Characteristic</th>
<th>Sample Proportion (N=15)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>F=10 ; M=5</td>
</tr>
<tr>
<td>Age</td>
<td>Age Range=24 to 54 years</td>
</tr>
<tr>
<td></td>
<td>$M=40.2$ years</td>
</tr>
<tr>
<td>Countries of Origin</td>
<td>Iran, China, Pakistan, India, Belarus, France, Bangladesh, Ukraine, Other$^1$</td>
</tr>
<tr>
<td>Language of Medical Education</td>
<td>English=8 ; Non-English=7</td>
</tr>
<tr>
<td>Specialties</td>
<td>General Practitioner (9), Obstetrics/Gynecology (2), Surgery, Hematology, Internal Medicine/Anesthesiologist, Other$^2$</td>
</tr>
</tbody>
</table>

$^1$This IMD’s country of origin is so uncommon that it would likely identify her, so it is omitted.

$^2$This IMD’s specialty is so rare that it would likely identify the person, so it is omitted.

Interview protocols were drafted based on the literature and principles of Vygotskian sociocultural theory. Initial interviews were between 1.5 and 2 hours long, with the goal being to collect data relating to participants’ previous medical careers, reasons for coming to Canada, the details of their licensure attempts to date, and experience within whatever bridging programs they may have participated in (see Appendix A for the complete interview protocols). From these initial 15, only three were successful in the 2010 match process and
gained a residency training position. Using funding from the CERIS Graduate Student Award, an honorarium of $30 was offered for each initial interview. While it was recognized that this was only a small amount for the time offered and could not fully represent my gratitude for their participation, given the difficult financial straits that many IMDs find themselves in, it was hoped that the honorarium would serve as a small token of appreciation. Table 2 summarizes the IMD data collection and the type of sample.

Table 2
IMD Data Collection

<table>
<thead>
<tr>
<th>Type of Data</th>
<th>N of IMDs</th>
<th>Type of Sample</th>
<th>Method</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviews</td>
<td>15</td>
<td>Convenience:</td>
<td>Single Interviews</td>
<td>Fall 2008 – Summer 2009</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diverse IMDs</td>
<td>(approx. 1.5 hours)</td>
<td></td>
</tr>
</tbody>
</table>

Bridging Program Staff

Participant profiles and data collection.

Another interest, for the purposes of cross comparison, was to interview staff members of current bridging education programs that support IMDs. Bridging program staff participants were recruited from the staff of two programs that help IMDs as they seek licensure: one program focuses more on interview preparation and the other is a pilot project aimed at supporting the language and cultural transition of the IMDs. The number of core staff who work with IMDs at these sites is relatively small: In the interview support-oriented program, there are three full-time and one part-time staff member who are involved primarily
in the interview preparation program. The director of this program has extensive experience working with IMDs, as well as in the health care field in general. In the language and culture-oriented program, there is a lead instructor who is a medical doctor, as well as a core team of five facilitators, along with a team of standardized patients/actors, so the total number of staff for this site is quite a bit higher. Because the content of these two programs and method of delivery are quite different, it was hoped that the data elicited would provide some interesting contrasts and comparisons.

Those staff members who were willing to participate in the research were interviewed for approximately 1.5 hours each, independently. The interviews addressed what these bridging program instructors believe the IMDs in their programs are learning, as well as what they perceive to be the enhancers of and barriers to success for IMDs in the residency interview. These interviews also elicited data regarding the participants’ background in the field, their professional experience and understanding of bridging education, and their beliefs about the profile of a successful IMD. The staff members of these two programs had a wealth of experience working with Internationally Educated Professionals in general, and also with IMDs this expertise encompassed a wide range of experiences, including one-to-one counselling, interview preparation, ESL instruction, and communication skills instruction. As the bridging program staff participants in this study are even smaller in number than the IMDs (three), the details of their professional backgrounds have not been revealed, as these details would easily identify them. Table 3 provides a summary chart of Bridging Program Staff data.
### Table 3

*Bridging Program Staff Data Collection*

<table>
<thead>
<tr>
<th>Type of data</th>
<th>N of Staff</th>
<th>Type of Sample</th>
<th>Method</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviews</td>
<td>3</td>
<td>Convenience</td>
<td>Interviews</td>
<td>March 2009-August 2010</td>
</tr>
<tr>
<td>Program Observation</td>
<td>9 to 15</td>
<td>Convenience</td>
<td>Observation</td>
<td>October 2008-March 2009</td>
</tr>
</tbody>
</table>

*Interview Data Collection Summary*

Data collection spanned a period of 23 months from October 10, 2008 to August 28, 2010. A total of approximately 22 hours of interview data were collected and over 15 hours of observation were completed that included two separate programs and occurred periodically over the course of 5 months from late October, 2008 to the end of March, 2009. Table 4 summarizes the data collected in the overall study, compared to the originally proposed goals, along with the amount actually collected (in hours).
Table 4

Data Collection Summary

<table>
<thead>
<tr>
<th>Participant Type</th>
<th>Original Proposed</th>
<th>Completed</th>
<th>Hours of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMDs Initial Pool</td>
<td>12 to 15</td>
<td>14</td>
<td>15+</td>
</tr>
<tr>
<td>(one interview)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bridging Staff</td>
<td>5 to 7</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Observation 1</td>
<td>1 interview prep</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>workshop</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation 2</td>
<td>1 session Bridging</td>
<td>15+ hours</td>
<td>15</td>
</tr>
<tr>
<td>Course</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interviewer</td>
<td>2 to 3</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Observational Data Collection Summary

Observation was an important component of the data collection that involved bridging program staff. I felt that it was important to have a sense of the program offerings before interviewing the staff, to ensure that I was on the same page in terms of what was being taught by the program. As one of my research questions focuses on the perceptions of both staff (instructors) and learners (IMDs) in bridging education, I felt that it was key to gain my own sense of the content and approach to instruction in more than one program. This study received ethical approval for observation at two programs designed to support IMDs in the midst of licensure:
1 **Interview Preparation Program** – This interview preparation program, run in a large Ontario city, provides an initial group orientation to residency interview preparation for IMDs, as well as up to three mock interviews with an agency staff member experienced in interview preparation for newcomers to Canada. The initial group orientation session of 1.5 hours was observed, and detailed notes were taken, and the main themes were identified in a summary chart. Two staff members working in this program were also interviewed, as well as four IMDs who had participated in this interview preparation program.

2 **ESP Medical Bridging Program** – This bridging education program of 40 hours in total was funded by MCI at the time of the study. It has since been discontinued, as its funding was not renewed. IMD participants’ interview and language skills were assessed pre- and post- using CLB benchmarked tests. The course materials described the course as offering “practice in patient-centered interviewing, emphasizing the language skills of listening, speaking, reading and writing in a professional medical context. Activities included small group work, practice in oral presentations, writing chart notes, reading the medical literature, and use of web-based interactive cases.” One of the unique features of the course was that participants had the opportunity to engage with Standardized Patient educators (SPs) in simulated doctor-patient interviews. These interviews were facilitated by experienced medical educators who supported the IMDs’ learning by asking them reflective questions and by acting as a go-between for the feedback from the SPs. It is important to note that, although each SP had a complete medical case memorized with all supporting details mapped out, the focus of these interviews was not on the medical content, but on the quality of
communication between the doctor and patient, with a particular focus on questioning skills.

**Representativeness of the Sample**

In total, 18 interviews were completed, with 15 IMDs (including one IMD who had already entered the system, was practicing Family Medicine, and had participated in residency interviewing) and three instructors at bridging programs. The ages of the IMD participants ranged from 24 to 54 years old, with an average age of 40. Nine of the participants were general practitioners, and the other six were specialists in such areas as haematology, obstetrics and gynaecology, surgery, and internal medicine/anaesthesiology, and other. According to recent census data, most GPs arriving in Ontario tend to be a bit younger than this age group, although most specialists are between 35 and 44 years old. (TIEDI, 2009a). The countries of origin of participants and the number from each country were Bangladesh (2), Belarus, China, France, India (3), Iran (1), and Pakistan (4), Ukraine (1), and another unnamed country. In relation to current research on the profile of IMDs in Ontario, these participants are relatively representative, as the top source countries for General Practitioner IMDs who immigrated to Ontario between 1995 and 2005 were India, Pakistan, Iran, Bangladesh, and Egypt, and China was 7th (TIEDI, 2009b).

The top source countries for specialist physicians were India, Egypt, China, Pakistan, and Iran. The Ukraine, Russia, and Bangladesh were 6th, 7th, and 9th (TIEDI, 2009a). Similar to this profile pattern in the immigration data, the specialists from my sample were from Ukraine, Russia, and China, and one was from Bangladesh. Regarding gender, women are slightly over-represented in the sample, with 10 women and 5 men. The IMDs immigrating
to Canada who are General Practitioners tend to be split fairly evenly between the genders, but there tend to be more specialists who are male, with 60% men (TIEDI, 2009a). However, it can be concluded that, overall, for a qualitative volunteer sample, the profile of participants was relatively representative of the overall IMD population in Ontario, with participants from almost all of the top source countries of IMDs, with the notable exception that the study did not attract any participants from Egypt.

**Data Transcription**

With the permission of the participants, all interviews, including phone interviews, were audio-recorded. These recordings were then transcribed to facilitate data analysis. An initial transcription simply aimed for word-for-word accuracy, along with notations for laughter and pauses, and any intonation or expressions deemed important to meaning. At a later date, the level of detail required was dictated by the level of focus on the data analyses, meaning that some particularly significant passages were transcribed in greater detail. For example, answers from any of the respondents that were particularly powerful or significant to the research questions would be given a more detailed examination that would include listening again to the audio file while reading the transcript to ensure that no important details were missing, such as extreme affect.

**Data Analysis**

This section will outline the processes used for both the thematic content analysis and use of poetic representation. At the conclusion of the section, Table 5 summarizes the
contributions of the thematic content analysis, poetic representation, and application of the Activity Theory model.

**Thematic content analysis.**

The thematic content analysis proceeded as an iterative process which moved back and forth between the activities listed below. This process can be characterized as a generic qualitative thematic analysis which incorporates some principles of grounded theory practice (Auerbach & Silverstein, 2003; Boyatzis, 1998; Charmaz, 2006; Miles & Huberman, 1994; Richards, 2005).

NVivo 6 was used throughout to support the data analysis activities and to facilitate accessing identified codes and participant profiles. NVivo 6 is qualitative data analysis software that helps to manage research data, such as documents, transcripts, and audio/video files, and allows the researcher to attach different levels of analytic codes to the raw data. NVivo allows for pre-determined codes to be pre-entered into the system before coding begins, and also for emergent codes to be entered as they arise. The data can then be coded with all of the available codes. As the project develops further, similar codes can easily be combined and codes no longer needed can be deleted. All codes can be structured and organized into a code tree that makes sense of their inter-relationships. All relevant biodata or other information can be entered into the casebook, and stored along with that of all other participants. If it is desired, the responses can then be searched and located according to these characteristics of the participants. Finally, for each code, the program keeps a complete record of who is coded under that code, and exactly what they said. If desired, the original transcript can be accessed with a double-click, the researcher can access the transcript to read the context of the comment.
After completing the Pre-Analysis activities, the three groups of activities that followed were Initiation, Exploratory, and Analytical.

**Pre-Analysis**

- Drafted conceptual framework
- Described my project to a colleague and ask them to draft a conceptual framework of my research
- Drew up format for an analysis log to track all analysis activities (Miles & Huberman, 1994)

**Initiation** Activities

- Pre-reading - Added any annotations from interview notes to transcript
- Initial line-by-line reading/amendment of each transcript along with audio file
- Added any insights from audio file, such as tone of voice, pauses
- Memoed on whole document (Richards, 2005) (i.e., wrote detailed responses to the interview and initial thoughts about potential analysis and emerging themes)
- Entered descriptive coding (biodata) from interview into NVivo

**Exploratory** Activities

- Intensive reading and re-reading of transcripts
- Initial coding using research questions, and some pre-determined categories selected from the literature, such as those related to key steps in the licensing process and concepts relevant to the theoretical framework, Vygotskian sociocultural theory and its descendant, Activity Theory, a “developmental theory” that facilitates focus beyond individual actions to larger, collective activity over time (Engeström, 2005, p. 307; Richards, 2005; Miles & Huberman, 1994)
• Identified any repeating ideas using grouping and comparison.
  (Auerbach & Silverstein, 2003); “Topic” coding (Richards, 2005)
• Applied Richards’ self-questioning technique: “That’s interesting!…WHY is that
  interesting?....WHY will this project benefit from that concept?” (Richards, 2005, p.
  71)

**Analytical Activities**

*WITHIN CASE*

• Constructed temporal data display for each participant (Miles & Huberman, 1994)
• Connected with a “coding group” to share ideas with, whether in person or online
• Identified themes which overarch the repeating ideas, and theoretical constructs
  which overarch themes (Auerbach & Silverstein, 2003)

*CROSS CASE*

• Experimented with various methods of data display that might assist with analysis,
  such as Stacking Comparable Cases, Role-ordered Matrix, Causal Flow Chart (Miles
  & Huberman, 1994), as well as various NVivo query tools that support analysis.

Thus, by moving through and around these activities, the data analysis proceeded.

The main activity throughout was repeated reading of the transcripts through NVivo.
Initially, a large number of codes emerged which were not apparently connected to each
other. Through repeated reading of transcript excerpts under these different codes,
similarities, patterns, and commonalities began to emerge. These commonalities were
labelled based on their common content and given a higher level of status in the coding tree,
modelled on pattern codes as applied by Miles and Huberman (1994). As the coding
progressed, these higher-level codes began to organize the large number of emergent codes
into coherent groups and categories. These categories were explored both within each individual case and also across cases using data display methods (Miles & Huberman, 1994). Through repeated review of the initial codes and higher-level codes, certain codes were expanded or collapsed, resulting in the final list in Appendix B.

**Poetic Representation.**

Poetic representation, also known as poetic transcription, is a method of data representation wherein the results, most often of a qualitative interview study, are represented in a poetic format. One of originators of this approach in the social sciences was Laurel Richardson (1990, 2002), who has long experimented with alternative methods for communicating about research. For Richardson, the benefits of poetic representation include the reflection it can inspire on the greater meaning of representation in research, the power of poetry to evoke emotion. Richardson (2002) argues that poetry is consciously constructed to evoke emotion through literary devices such as sound patterns, rhythms, imagery, and page layout. Even if the prosodic mind resists, the body responds to poetry. It is felt. To paraphrase Robert Frost, poetry is the shortest emotional path between two people. (p. 879, emphasis in original)

Along with its self-reflective and expressive value, poetic representation has offered researchers other related benefits. For some researchers, the very richness of their interview data, often filled with participants’ own poetic turns of phrase or powerful metaphors, seemed to call for a mode of expression beyond academic prose (Carr, 2003; Jones, 2010). For others, the importance that they place on the importance of the affect in their findings inspired them to use poetic representation (Prendergast et al., 2009). If researchers are concerned about offering readers direct access to participant voices (Kennedy, 2009; Prendergast et al, 2009) or approach research from a activist or social justice perspective
(MacNeil, 2000), then poetic representation may support their goals. Finally, if a researcher is seeking accessibility in the presentation of research findings (MacNeil, 2000) or a synthesis of the complexity of the findings into a whole (Jones, 2010; Prendergast et al, 2009), then poetic representation may be their method of choice.

In the current study, my application of poetic representation was similarly impacted by the nature of my data and my goals for its use. I had anticipated in my ethics protocols that talking about the licensing process might be difficult for some IMDs. Very early on in the interview process, however, I was struck by how much emotion was contained in the interviews. I felt strongly that this emotion was also a finding and reflected on how it best might be represented or dealt with. At the same time, my explorations of Vygotsky’s works had led to my discovery of the importance he placed on emotion in the psychological system of the individual. With this reinforcement, I set the goal of creating one or more poems in the thesis that would represent different emotions or emotional experiences in the licensing process.

Richardson (2002) suggested focusing on metaphors or other powerful images in the transcripts as a starting point. In this, she draws on Lakoff and Johnson’s (1980) Metaphors We Live By, a book written to address the gap they perceived in Western philosophy and linguistics regarding metaphors and meaning, a gap which they felt belies the primacy of metaphors in human meaning-making. As Lakoff and Johnson argue

Metaphors may create realities for us, especially social realities. A metaphor may thus be a guide for future action. Such actions will, of course, fit the metaphor. This will, in turn, reinforce the power of the metaphor to make experience coherent. In this sense metaphors can be self-fulfilling prophecies. (p. 156)
From this perspective, metaphors can function as a guide to future action, and reveal the orientation of an individual to a particular situation or reality, something useful when seeking further understanding of the experiences of the IMDs. In addition, Lakoff and Johnson (1980) argue, metaphor allows us to express aspects of our experience that we may not completely comprehend ourselves: “Metaphor is one of our most important tools for trying to comprehend partially what cannot be comprehended totally: our feelings, aesthetic experiences, moral practices, and spiritual awareness” (p. 193). Thus, metaphors are not simply images chosen from a menu to express an idea, but they are part of how we create reality, respond to reality and are a tool for trying to come to grips with that reality. For these compelling reasons, an analysis of the metaphors used by IMDs to describe their experiences in the licensing process was conducted, and provided me with a strong foundation from which to begin creating the poems.

My approach to the poetic writing process was modelled on the work of Prendergast et al. (2009), as I aimed to represent the findings in synthesis form, using quotes from more than one participant in the study to craft the poems. The thesis itself is conceived similarly to the work of Ellingson (2011), in which the poetic representation is presented alongside the traditional social scientific research presentation, as an enhancement and supplement to it. Finally, in order to specify the origins of each poem in terms of participants’ or my words (Glesne, 1997) and to clarify meaning of each particular poem and its relationship to the overall thesis, a brief frame appears before each poem. Each frame can be read before or after the poem, and it is my hope that these provide further insight into the application of poetic representation in the current study.
Table 5

Summary of Analytical Methods

<table>
<thead>
<tr>
<th>Type of Analysis</th>
<th>Modelled on</th>
<th>Contribution of this type of analysis</th>
<th>Result/s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thematic Content Analysis</td>
<td>Boyatzis, 1998; Miles &amp; Huberman, 1994; Richards, 2005;</td>
<td>-made sense of large quantity of data and identified similarities across cases</td>
<td>-coding scheme - answered the research questions</td>
</tr>
<tr>
<td>Poetic Transcription</td>
<td>Ellingson, 2011; Glesne, 1997; Richardson, 1990; 2002;</td>
<td>-represented affective aspects of the interviews</td>
<td>-three poems that synthesized key findings and affective aspects of interviews</td>
</tr>
<tr>
<td>Activity Theory Licensing Model</td>
<td>Engeström &amp; Sannino, 2010; Engeström, 2005</td>
<td>-system-level view of IMDs’ experience</td>
<td>-Model that included IMDs, immigration and licensing</td>
</tr>
</tbody>
</table>

The Quality of Qualitative Research

Many language learning researchers acknowledge the potential of qualitative research to increase knowledge in this field (Benson & Nunan, 2005; Kalaja & Leppänen, 1998; Lightbown & Spada, 2006; Pavlenko & Lantolf, 2000; Skehan, 1989; Spolsky, 2000). Still, the question of how to judge the value and validity of qualitative research is an important one. Due to the previous dominance of quantitative methods in language learning research, qualitative research is sometimes viewed with suspicion, including concern about “the highly subjective nature of the data” (Mackey & Gass, 2005, p. 204). As Lynch (1996) observes
“Validity is establishing what counts as evidence. We have seen that the criteria for doing this can differ depending on the research perspective being used” (p. 69). As Denzin and Lincoln (2005) acknowledge about the qualitative perspective, “qualitative researchers study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them” (p. 3). With a research perspective that is openly interpretive and focused on making sense of others’ meanings, what criteria can be applied to judge quality or what steps can be taken to ensure it?

There are many steps that a qualitative researcher can take to ensure that his or her research is rigorous and of high quality. One of the ways to achieve this is by making connections to other resources, such as ensuring an adequate foundation in the existing literature or by using triangulation to advantage (in order to “capture and report multiple perspectives, not to seek a singular truth” (Patton, 2002, p. 546)). Another way to ensure rigour is to make research procedures and design decisions transparent: the researcher can ensure that the study embodies “a systematic process systematically followed” (Patton, 2002, p. 546), and documented. Another area where transparency is important is in the presentation of the research results: Does the researcher provide adequately thick description that the reader may a) “Draw conclusions other than those presented”? (Benson & Nunan, p. 151) b) “See what s/he would have missed without the [researcher’s] observations”? (Eisner, 1991, p. 114) and c) Make his or her own inferences about the possibility of extrapolation of the findings to his or her own setting? (Patton, 2002, p. 584). The present thesis has attempted to address all of these during the research process and write up in some form. Finally, while the process of coding qualitative data is admittedly a subjective one, the process of having another researcher check the reliability of the coding system is a confirmation that what the
lead researcher is seeing can actually be seen by another coder, including the lead researcher across time (Miles & Huberman, 1994). What follows is a discussion of this procedure for the present thesis.

Coding reliability: Checking between coders and across time.

One way to check the reliability of the coding is by assessing the ability of another researcher to label the passages with the same thematic code previously identified by the primary researcher. For this study, inter-coder reliability was tested with a colleague in the department who was familiar with the study and applied linguistics in general. The process began with a three-hour training session on the coding scheme to define and clarify the key themes in the thematic content analysis. Various support documents were drawn up to facilitate the clarity of the codes, including a diagram of the licensing process for IMDs, a spreadsheet list of all codes in a hierarchical diagram, and a detailed list of explanations for all codes, including, when necessary, examples of what would be coded under each code (See Appendix B for this list). Half of each transcript was used as a training tool to familiarize the colleague with any relevant background information about each participant, and have her practice coding with my support.

Transcripts used for this session were selected randomly from a stratified sub-sample that was purposively chosen to cover the main interview types in the data: one with an IMD from the initial interview pool with high language proficiency, one with an IMD from the initial interview pool with lower level language proficiency, and one with a bridging program staff member. After both of us were satisfied that she was confident in applying the coding scheme, the colleague was given seven lengthy excerpts from the three interview transcripts to code using the coding system independently (Miles & Huberman, 1994). Altogether, the
excerpts represented 10% of the total data set. The coded transcripts were returned to me via email and the level of agreement with the researcher was then checked, and a percentage was arrived at that represented the level of agreement for that first attempt. The initial level of agreement overall was 68%, with the more serious level of disagreement located in just one transcript, that of the staff interview. After a further explanation of the coding scheme and a detailed discussion of the differences, we both reviewed the codes again and were able to reach a much higher level of agreement overall, 84%.

Another type of reliability relates to the reliability of the researcher him or herself to recode earlier transcripts in the study in the same way as previously coded. For the intracoder reliability, the lead researcher went back at the time when analysis was almost complete, and recoded a randomly selected transcript from the first four coded. The second coding was checked against the original coding and a percentage was arrived at that represented the level of agreement between the earlier and later attempt. This percentage was over 85% and most differences in the coding were not related to which codes were assigned, but to which segments of the participant’s words they were coded onto. Overall, the process of checking reliability was instructive, and I agree with Miles and Huberman (1994) that the process “aids definitional clarity” and “reaps real rewards” (p.64).

**Summary**

This chapter has provided an overview of the methods used to answer the three research questions of the current thesis. Recruitment of the participants, their profiles, and the sources of data were discussed, including both interview and observational data. A description of the data analysis activities provided a summary of how the thematic content analysis proceeded. In addition, the use and purposes of poetic transcription were discussed
and its role in the current study was outlined. Finally, the importance of ensuring quality in qualitative research was emphasized, along with some methods for doing so. The next chapters will present the major findings of the current thesis in relation to its three research questions.
Chapter Five: 
IMD Learning and Bridging Education

This chapter will focus on the learning of IMDs in two separate bridging support programs: one for residency interview preparation and one for English for medical purposes. The results will be presented according to the source of data, which include observational data from both programs, and interviews with IMDs who participated in the programs, as well as staff who taught in both programs.

While the primary goal of this research is to explore the experiences of IMDs going through the licensing process (Research questions 2 and 3), the first research question, What do IMDs learn in a bridging education program, according to the researcher, the IMDs themselves, and the bridging program staff?, played an important, developmental role in the research project. Although data regarding the bridging education and IMDs’ learning could have been collected exclusively through interviews with bridging program staff and IMDs themselves, it was decided to include observational data as well, for the purposes of triangulating and enhancing the researcher’s understanding of what the bridging program staff and IMDs were discussing in the interviews. It is worth noting at this stage that examining the learning in detail within each program was not feasible, due to time constraints and the fact that this was not the main focus of this research. Thus, the goal of this research question was further understanding of a small sample of existing bridging education programs; in addition, the observations would allow me to triangulate with those of the IMDs and staff whom I was interviewing who had participated in the same programs themselves. Gaining insight into what IMDs were learning in bridging education was, I felt, an excellent starting point for understanding their experiences in the licensing process overall.
For various reasons, not all participants in the study could respond to the current research question. Some of the participants were newly arrived in Canada and had not yet accessed any bridging education. Two of the participants had arrived in Canada so many years ago that there had not been any options available at that time. The participants who had taken part in at least one bridging education program were from the following countries: Pakistan (2), France, Bangladesh, Ukraine, Russia, India, and other. Of the 15 IMDs in the study, four had participated in the first bridging program featured in this chapter, the residency interview preparation program, and seven had participated in the second bridging program, an English for Specific Purposes (ESP) Medical Bridging Program, which focused on language and communication skills for IMDs in a medical context.

This chapter will proceed to summarize the observational data from both of these programs, and then provide an analysis of the interview data from IMDs who participated in each program, followed by interview data with staff who taught in each program.

**Interview Preparation Program Initial Group Orientation Session**

The session was held in a board room, with ample space for all participants. Fruit and crackers and cheese were available for everyone, as well as coffee. Before the session began, some people were chatting and others quietly waiting for the session to begin. Rows of chairs facing the front of the room were available for participants to seat themselves. I was welcomed warmly to my chair by a friendly woman who was an international doctor herself. The 15 attendees introduced themselves at the beginning of the session, and they were from a variety of countries, including India (four), Iran (four), China, Singapore, Nairobi, Hong Kong, Germany, Sri Lanka. The ages of the participants varied, with some being obviously in
their 40s or 50s, and some of them being younger, perhaps in their 30s. The facilitator was an animated woman in her 40’s who was an immigrant to Canada herself, although she was not a medical doctor, but a full time employee of the agency. She established the framework of the session, explaining that it was based on a combination of a review of academic research and discussions with physicians who conduct residency interviews to select residents.

Table 6

Group Session on Interview Preparation

<table>
<thead>
<tr>
<th>Category of Content</th>
<th>Brief Summary of Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRESS</td>
<td>- be comfortable, be yourself BUT no heavy perfume, wrinkled clothing, too much jewelry, wear hijab if you usually wear it, dress conservatively (business casual)</td>
</tr>
<tr>
<td>RESEARCH/PREPARATION</td>
<td>- 50 – 100 hours</td>
</tr>
<tr>
<td></td>
<td>- be ready to ask good questions about program; do not ask ANYTHING that’s already on their website; research all faculty for all programs</td>
</tr>
<tr>
<td>MANAGING ANXIETY</td>
<td>- breathing, muscle flexing and relaxing, positive thinking</td>
</tr>
<tr>
<td></td>
<td>- find location beforehand</td>
</tr>
<tr>
<td></td>
<td>- propanolol? (calming drug)</td>
</tr>
<tr>
<td>PROJECTING THE RIGHT QUALITIES</td>
<td>- don’t ask SALARY, HEAVY WORKLOAD</td>
</tr>
<tr>
<td></td>
<td>- IMD weaknesses: not proficient in English, less knowledge of Can health care system, interpersonal skills</td>
</tr>
<tr>
<td>MAIN QUESTION: Can they work with you? Do they like you?</td>
<td>- positive, balanced life, can deal with stress, ethical, have initiative, interprofessional communication, collegiality, know the specialty you are applying for, leader, problem solver, professionalism, self-directedness, know yourself, responsible, team player</td>
</tr>
</tbody>
</table>
**Interview Preparation: IMDs’ Reported Learning**

In describing the reported learning of the IMDs who participated in this study and who had taken interview preparation, it is important to note the ethical considerations that limit one aspect of this reporting. In Ontario, all IMDs and CMGs who participate in the Family Medicine interview process are required to sign a non-disclosure agreement in which they agree not to disclose any aspect of the interview to anyone, including the questions asked. Although I had made some attempts to see if an exception could be made for the current research, as I felt that the results would be helpful to both the IMDs and to those conducting the interviews, this was not possible. This means that this section can report only on learning that IMDs reported in connection to the bridging education itself, and *not on any experiences or successes they had in applying that knowledge in the actual interview itself.*

Sometimes, IMDs may have inadvertently referred to incidents that occurred in an actual residency interview. Out of respect for the non-disclosure agreements they signed, that data

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<table>
<thead>
<tr>
<th>Category of Content</th>
<th>Brief Summary of Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>POSSIBLE QUESTIONS</td>
<td>(almost 50 different possible questions shared, in all categories above)</td>
</tr>
<tr>
<td>FOCUSING ON THE POSITIVE</td>
<td>- was emphasized over and over in different ways by both facilitator and guest IMD speaker</td>
</tr>
<tr>
<td>ADVICE FOR ADDRESSING WEAKNESSES</td>
<td>- be ready to discuss any weakness in your application in a positive way</td>
</tr>
<tr>
<td></td>
<td>- English low? – speak less and more carefully</td>
</tr>
<tr>
<td></td>
<td>- Accent? – speak slowly</td>
</tr>
<tr>
<td>POSSIBLE INTERVIEW STYLES</td>
<td>- interviewer directed, interviewee directed, spontaneous – be FLEXIBLE and ready for anything!</td>
</tr>
</tbody>
</table>
will not be analysed, published or included in this research in any way. Of the 15 IMD participants in this study, four had participated in interview preparation. Of these four, three had been successful in the interview and had gained access to a residency position, and one (at the time of the research interviews) had not.

When asked about the usefulness of the interview preparation, three out of the four participants felt that it had been a positive learning experience; perhaps not surprisingly, these were the three who had gained access to a residency position. The participant who was less positive did feel it had been beneficial, but was upset that he had only been able to gain access to one mock interview at that time. With increased resources, the agency was now offering multiple mock interviews and the three successful candidates had all had the opportunity to attend the group session, as well as at least two mock interviews.

Overwhelmingly, the participants reported that the interview preparation benefited them in a tangible way: Upon increased understanding of the expectations of the interview, each reported changing how they would respond to certain questions. One participant reported that after feedback from his mock interviewer, he would change the common practice of reporting his applicant ranking at his medical school as a strength, which would be quite impressive in his own cultural context, to giving a more appropriate response that discussed his ability as a multi-tasker with a good work-life balance. Another participant was encouraged to change her examples of leadership success from ones before her immigration to others that had occurred after her immigration to Canada. Another participant’s increased understanding was applied across all her interview responses to behavioural questions, which shifted from simply narrating an incident without any emphasis on her role in dealing with conflict at the workplace to learning “the rules” of good responses, which she explains here:
“They don’t want to hear about the details of you know, how it happened or whatever. They want to know where you shine. And they want to know whether you were shining according to their expectations” (Interview 17, June 18, 2009). Finally, the participant who was not successful in accessing residency training related that he had benefited from contextual information from his mock interviewer, who had provided him with some information about aboriginal peoples in Manitoba, where he was to interview for a position, as well as preparing him to anticipate the question “Why do you want to relocate from Ontario to Manitoba?” He felt that he had gained some insights that he could apply to the future interview.

Thus, in summary, in a bridging education program designed to improve IMDs’ performance in a residency interview, all those who had participated in interview preparation felt that they had benefited from the training. Three of the participants, those who had gone on to access residency training, defined their learning in reference to what the interviewers wanted to hear and their resulting adjustment of their responses. One participant defined the core of his learning this way: “Getting a better feel of how the different questions are asked and what type of questions that are asked and how to modify your answers according to what they want to hear” (Interview 15, May 9, 2008). For another, it was learning the rules from her mock interviewer that made all the difference: [R: Researcher; P: Participant]

P: You just have to know what they want to hear about….You shouldn’t leave anything to their imagination or to their understanding to you know, so nothing should be implied.

R: Right, okay.

P: You should say it. For example when you are telling them about leadership, instead of just saying that we have this problem but we, you know, I sorted it out. You should say, so we had this problem, but because I believed in open
communication and I was flexible and I was so committed, so that’s why I did this, this, this.

R: Wonderful.

P: You see, it was the perfect combination of telling them, verbalizing your strengths and incorporating it into your story so that, so they can see that this is how you're practically applying your skills. (Interview 17, June 18, 2009)

Finally, for another participant, it was the realization of the culture of North American job interviews generally: She related that her mock interviewer had “told me to sell myself at what I’ve done. It was really helpful” (Interview 16, May 11, 2009). Thus, particularly the participants who were successful in accessing training found that the interview preparation had been a supportive tool in assisting them to understand what was expected in the residency interview, which is conducted like a North American-style job interview.

**Interview Preparation Program: Staff Reports of IMD Learning**

This section of the chapter discusses interviews with two staff members who helped to prepare IMDs for residency interviews. Both of these staff members had experience meeting with and talking to IMDs at all stages of the licensing process, as well as preparing them for residency interviews. In order to prepare IMDs for the residency interview, the first staff member reports relying on all of the mock questions that are prepared by the agency to help the IMDs practice their interview skills. For him, the greatest challenge that the IMDs face is that they have not had experience with this type of employment interview in their home countries. This lack of experience means that when they begin interview preparation, “a lot of their answers aren’t the greatest” (Interview 10, March 25, 2009).
This staff member recalls that for one strong candidate, however, it was his struggles with the system that led to his challenges in the interview: The difficulties he had faced in gaining access to training led to his bringing a negative “emotional attitude” into the mock interviews. Here, this staff member talks in the interview about trying to coach this candidate and others towards success:

I have no problem again, when I’m on the floor or talk to someone saying, “You know what, try to be a little more humble. Try to hold back. You can’t show that you have a chip on your shoulder. You do; they don’t want.” Again, the way I describe to people is, “Picture this as a jigsaw puzzle: They’re looking for the right piece of the puzzle – to fit. They’re looking for a good fit; they’re looking for the most suitable candidate.” (Interview 10, March 25, 2009)

When candidates aren’t successful, he wonders how the interview might have influenced the outcome: “Maybe something did come up with that interview that didn’t come up with us in mock interviews.” Thus, for this staff member, the interview preparation must help the IMDs gain familiarity with a new genre, the interview, while also helping them better understand what the expectations are for the display of attitude and emotion within that interview setting.

The second staff member at the same agency also acknowledges that the IMDs’ lack of familiarity with the interview causes them difficulties, but sees the interview process much more through a cultural lens: according to her, the IMDs must work in interview preparation to master the culture of self-promotion. She feels that particularly doctors, both abroad and here in Canada, are not often in the position where they need to self-promote: They are often at the top of their class and in a profession that is always in demand:

P: I think on a personal level there’s -- they’ve never had to deal with period. But culturally in the broader sense interviews are new to them. Marketing and self-promotion is something they’re not comfortable with -- they don’t know how to do it. They don’t know what it is there -- there’s a fine line between -- even for North Americans, you know, between bragging and talking about your accomplishments.
R: So, true…

P: But we know what it is…

R: We know that line…

P: We know…

R: Yes…

P: When we’re passing it and it’s really hard when it’s not your culture to get that. (Interview 13, May 5, 2009)

Thus, according to this staff member, the IMDs must not only gain familiarity with the genre of the employment interview during preparation, but also gain a sense of where the unspoken cultural lines are drawn around this new activity of “self-promotion.” For her, the benefits of preparation for the IMDs are almost more psychological. She feels that the interview preparation will help them relax and be themselves more in the interview, and that the familiarity with common questions asked will transfer well, even if they are asked a new question:

But the key is the preparation like an exam preparation makes you feel confident. So, if you go into an interview feeling, “You know what: I’ve done everything that I can do, I think. I don’t know what they’re going to ask me, but I know what I want to talk about.” (Interview 13, May 5, 2009)

Thus, while acknowledging the substantial challenges that IMDs face in gaining familiarity with the new interview genre, this staff member has seen the interview preparation benefit participants in their increased confidence and readiness to face the questions of the interviewers.

ESP Medical Bridging Program: Observational Data

According to its own leaflet, the ESP Medical Bridging Program is a 40 hour course that provides assessment and training in medical English, which is defined as “[t]he language
skills of listening, speaking, reading and writing in a professional medical context.”

In relation to ESL programming in Ontario, the program can thus be viewed as an English for Specific Purposes (Medical English-focused) program. The program is promoted as offering IMDs the opportunity to work with Standardized Patient (SP) educators, who portray patients in the context of a simulated doctor-patient interview. During the simulated encounter, a facilitator can stop the “action” to support the IMD’s success in the interview by clarifying what was needed or to encourage another path of exploration in the interview. It is worth noting that this methodology is not only used with IMDs, but throughout today’s medical education system for both medical students and licensed physicians.

It became clear that one of the strengths of the program was that, in addition to encounters with SPs, the IMDs also participated in a variety of activities that focused on the four skills, including “small group work, practice in oral presentations, writing chart notes, reading the medical literature, and use of web-based interactive cases.” At the time that it was being offered (at no cost to participants, due to funding from MCI) there was a waiting list of over 100 IMDs, which is an indicator of the shortage of available opportunities in Ontario for opportunities such as this. I received ethical approval to observe the program, and attended classes during the winter of 2009 that crossed more than one iteration of the course. The observational data reported here focuses on one iteration of the course, in order to represent the topics of discussion that typically would arise for one group of participants.

Through observation, it was possible to see the philosophy of the program in action. At times, it appeared that the agenda of the IMDs was more focused on preparing for the demanding examinations that they faced than on improving their skills in the doctor-patient

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8 The reference for this document is not provided, so as not to identify the program.
9 See above.
interview in a more general way, but the facilitators of this program were insistent that the Bridging Program was not an exam preparation course. When asked about exam preparation, the facilitators did comment that being effectively patient-centered could support success in an OSCE-style examination.

The responses of the facilitators when faced with challenges or questions regarding the methodology helped to clarify their position. At one point, they were asked by the IMD students if they could provide a vocabulary list of common body slang and other colloquial language that had come up in the SP encounters. The facilitator refused, and argued that the program wanted to encourage them to focus on deep learning, rather than rote memorization. If they moved to another region, the slang might change, so the program wanted to give them transferable skills: clarifying, listening, asking questions appropriately, gathering data, interpreting; these were skills that they would use in medical practice with colleagues and patients, and even in other areas of their lives. The goal, as stated, was to give them skills they could apply within the 40 hours of the course—“We’re drawing awareness, you are practicing: You’re making your own sense of it.” Thus, the main philosophy of the program was an emphasis on sense-making and integration for the IMD participants as they took part in the various activities, with a focus on what skills they develop in the 40 hours that they could take with them.

The patient-centered clinical method was at the heart of much of the content that I observed being demonstrated or discussed during the program. While it would be familiar to North Americans who have grown up in this medical system to have a physician leave the final decision up to them, as the patient, regarding treatment, many IMDs come from countries where the doctor is considered the main authority to which the patient should defer
Instruction that encouraged the IMDs to consider more patient-centered ways of practicing was communicated in three main ways: through content that expanded their view of the patient beyond “an illness on legs,” through repeated modeling of doctor-patient interviews that contrasted successful vs. unsuccessful questioning and interactional approaches, and through the IMDs’ opportunity to role play with SPs and receive feedback on their performance that was from a patient-centered perspective.

An example of content that facilitated a more patient-centered perspective was the triangle diagram (see Figure 5), which was presented and then brainstormed by the entire group for different factors related to a patient’s illness experience and contextual aspects of his/her life. An example of the contrastive doctor-patient interviews was a demonstration where a facilitator role-played a physician interviewing the same SP two different ways: once with mostly close-ended questions (i.e., that require a yes or no answer) and once with a more appropriate blend of open and close-ended questions. IMDs observed these role plays as a large group and then got into small groups to discuss the questioning techniques and the information gathered. One representative of each group then presented their findings. This led to a lively discussion of the questions themselves and further input from the facilitators on how to use questions to foster a therapeutic alliance with patients. One example of a structure they were recommended to avoid was the tag question, such as “You’re unhappy, aren’t you?” Facilitators were also careful not to over simplify what being patient-centered meant: It was not simply always using open-ended questions, but using a skillful balance of both, based partly on patient cues.
The wrap-up discussions at the end of the evening, after the IMDs had their encounters with the SPs, provided an opportunity to discuss challenges and successes they had encountered with the SPs. Very often these discussions opened up the forum for cultural and linguistic questions. Many IMDs brought up slang words that had come up in the course of the interview. Other topics that arose included the difference between Miss and Ms., the meaning of the words “partner,” “girlfriend,” “boyfriend,” and “friend.” One interesting cultural discussion focused on what questions the IMDs would never have asked in their home country. Sometimes, the IMDs would raise questions because they had learned a different way to approach the patients from a private OSCE prep school and were now confused about what was the “right way” to do things. One IMD shared with the group her challenge of trying an open-ended question that the patient had not known how to respond to, “Tell me more about your headaches.” In this way, the IMDs raised “burning questions” that had arisen out of their interviews with the SPs and also received further feedback on moving forward with their more patient-centered questioning techniques.

![Figure 5. Triangle diagram of the patient.](image)
ESP Medical Bridging Program: IMDs’ Reported Learning

Of the 15 total participants in the research, seven had participated in this Bridging Program, and these IMDs were from a variety of countries (including Belarus, France, Pakistan, Bangladesh, and Ukraine) and ranged in age from 28 to 49. Although the course incorporated the four skills of reading, writing, listening and speaking in English into the curriculum, it was interesting that, when asked what they learned from participating in the program, the participants tended to focus on their experiences with the Standardized Patient Educators (SPs) and how they benefited from those simulated doctor-patient interviews.

For example, one participant felt that the most valuable aspect of the course was the chance to get feedback on her communication skills from the SPs: “Because I never thought how people feels [sic] when I talk.” (Interview 14, May 8, 2009) She then described how she knew back in her home country when she talked in her first language how her patients felt and they often told her “Doctor just to talk to you it’s enough!” For this participant, the feedback from the SPs helped her translate that sense of competency into this new setting. For another participant, even though the feedback from the SPs was not always positive, she still felt that she benefited from it. In one particular session, she remembers being particularly frustrated:

Because the first eight minutes I wasn’t - I didn’t get the point. I didn’t get I was - I wanted to go somewhere and I, I wasn’t able to go there and it was frustrating for me. And at the end I got the feedback and I understood that I wasn’t asking the right questions, so, for me it was helpful. (Interview 16, May 11, 2009)

As summarized earlier, a particular focus of this program was “asking questions appropriately,” and this IMD learned from constructive feedback after a simulated interview regarding her approach to questioning and learned from that.
Another emphasis of the ESP Medical Bridging Program was on transferable skills, and it was interesting that three of the seven participants in the program specifically described the benefit of learning “clarifying” as a transferable skill. One participant acknowledged clarifying as a program focus, but also could now see in retrospect that it led to more learning:

Yes, one very important thing that I learned there was that if I don’t understand anything, I should ask about it….But this is something that they really drilled into us. They helped us overcome our hesitation to ask about those seemingly trivial things, but you know when you ask about it, you really learn a new thing. (Interview 17, June 18, 2009)

For another participant, clarifying with her SP meant that she had to overcome her own feeling of shame at not knowing certain words. In the course of describing her learning, she demonstrated two clarification strategies learned in the course verbatim:

It is really necessary to be clear about patients’ language…and what he or she wants to mean with this, this…So, then, I realized that there is nothing to be shamed. So, I…whatever I don’t understand I told him clearly that, “Can you rephrase it?” or, “Sorry, I couldn’t understand, can you explain it more?” (Interview 11, March 31, 2009)

For one participant, however, it was not only the skill of clarifying that was beneficial. To really feel she had benefited, she needed to return from the program’s blend of communication skills to re-integrate her medical focus as well in her final interview:

[At first] the priority for me was to know how to ask questions…To clarify, to check and everything, but I lost the medical parts of the interview, and at this interview I understood that I have to make the mix between the medical parts - - I’m still a physician -- and language part…So, this was interesting for me…So, I was aware of that and I hope -- I think that I will have the opportunity to experiment this. (Interview 16, May 11, 2009)

Thus, for this participant, even though this was a communication skills course and IMDs received no feedback on medical knowledge, she felt that she needed to put her interview
back together and mix the language with the medical content to feel she had learned successfully.

Language learning was also a benefit of the program that participants commented on. For one participant, he felt he learned some colloquial language from the SPs, especially slang referring to body parts. Interestingly, this participant also recognized that his difficulties in recognizing slang allowed him an opportunity to practice the skill of clarifying. For another participant, the encounters with the SPs provided reassurance about her English language skills, about which her confidence was low: “It was helpful to know that first he [the SP] understood me….That my English was not so bad” (Interview 16, May 11, 2009). Another participant mentioned three of the skills (writing, listening, and speaking) along with the concept of patient-centered care and using clarifying appropriately as the benefits of the course. Thus, the integrated skills-based approach of the program led to more participants focusing on the transferable skills that they had obtained through the program, rather than language acquisition itself.

Although not technically a transferable skill, but rather an understanding about the nature of the role of the doctor in Canadian practice, patient-centeredness is another key outcome that IMDs reported learning in the program. With many IMDs coming from more doctor-centered contexts (Steinert, 2006), the concept of patient-centeredness may not only be new, but can be uncomfortable. For one participant who already had experience in a more patient-centered setting, the program reinforced the idea that “every patient is different” and she felt that her knowledge as a professional “got refined and I could understand the concept of patient-doctor relationships in Canada” (Interview 9, March 5, 2009). For another IMD, patient centeredness meant watching for and responding to patient cues, something that he
found challenging in the role plays: “So for this, it was useful for me for sure because now I know this – cues, the patient’s cues that I was not aware about” (Interview 12, April 24, 2009). Finally, one participant did an excellent job of defining what patient-centered practice means to her, having taken the program:

I learned that I have to first know about the patient. Not only the patient, his or her family and how his or her disease influences the patient as well as family, as well as occupation. And, then, I have to go with the patient. That means I have to know that what this patient idea about all his sufferings, and, then I have to suggest him, and, then, it is on his or her…it is his or her duty to take the decision. And, I can tell you, it is not only his or her decision, because we will…we will reach in a common ground. And, then, we’ll go from there. Investigations, treatments, follow-up, everything. (Interview 11, March 31, 2009)

Thus, the concept of patient-centered practice was also an important outcome of the ESP Medical Bridging program for the IMDs, and it was inextricably linked to the communication necessary to learn the context of the patient and negotiate common ground.

**ESP Medical Bridging Program: Staff Reports of IMD Learning**

Like almost all of the staff working in this program, this staff member had extensive experience working with IMDs and other internationally educated health professionals as a Standardized Patient, and thus was knowledgeable about the learning needs of IMDs related to communication. Based on this staff member’s professional experience, IMDs could not benefit from learning medical or communication content if they did not have the English language proficiency to first understand what was being said:

What would -- what was being labeled as communication issues and other things I felt were grounded more in language issues. Because of patterns that I recognized, you know, from teaching [IMDs], right? So, or just recognizing that they would look so blankly. (Interview 24, Aug. 25, 2010)
Similar to the IMDs in the bridging program, this staff member highlighted the importance of the skill of clarification as an outcome of the program:

They’re taught to really ask when they don’t know. That’s a very big part…of, you know, clarification. Like, they’re really taught to clarify so certain aspects of language are addressed. (Interview 24, Aug. 25, 2010)

Interestingly, further reflection on IMDs’ learning in the program led back to the importance of language:

Like I think the nuances is what they learn from this kind of experiential -- these experiential programs. They learn more about the nuances. They learn more about how powerful it is to listen. Um, and we’re -- all of that is so valuable and so important. But I do think the language is kind of the bottom line. (Interview 24, Aug. 25, 2010)

Thus, the experiential approach used by this program was productive, in the opinion of this staff member. However, in order for IMDs to benefit from this kind of experiential learning, language proficiency was emphasized as the “bottom line.”

**Summary**

When revisiting the first research question (“**What do IMDs learn in a bridging education program, according to the researcher, the IMDs themselves, and the bridging program staff?**”) for two separate bridging education programs that were observed by the researcher, in general, there is a fair degree of agreement regarding what IMDs are learning, although the different perspectives are worth noting. For the interview preparation program, the lack of IMDs’ familiarity with the genre of the employment interview was a common theme for both bridging staff and IMDs. However, while IMDs viewed at the interview preparation as learning what “they (i.e., the interviewers) want to hear,” the staff working in the interview preparation program saw the IMDs’ learning as either the improvement of
inappropriate responses or the acquisition of the appropriate cultural boundaries of the genre. My observation of the initial group session that is part of the interview preparation program saw evidence to support both viewpoints; the lecture provided some negative examples of “what NOT to say,” as well as numerous positive examples of the ideal self to project to interviewers, in terms of the qualities given (a small sample): leader, problem solver, professionalism, self-directedness, know yourself, responsible, team player. While an acknowledgement of the cross-cultural challenges of the North American “sell yourself culture” was not observed in this initial session, it is possible that this was dealt with in the individual mock interview sessions that were not observed.

With regard to the Bridging Program, there was, again, a fair degree of agreement across the groups. Although language was indeed one focus of this program, which included benchmarked tasks and a pre- and post-assessment, the methodology of using SPs in simulated encounters and the philosophy of the program to teach “transferable skills” led to less of an explicit language acquisition focus on the part of the program instructors and the IMDs themselves. When asked what they had learned in the program, IMDs tended to focus on these global skills, such as patient-centeredness, or even clarifying, rather than the vocabulary that they may have gained through clarifying during encounters. From the perspective of one of the staff of the program, this approach did lead to the acquisition of these kinds of transferable communication skills, such as clarification; however, having seen how important a certain level of English language proficiency was to success in simulated interviews, this staff interviewee argued that even more explicit focus on language might be beneficial. Thus, through my observation of two separate bridging programs for IMDs, along with the triangulation of perspectives of the bridging program staff and the IMDs themselves,
a clearer picture of the IMDs’ learning has emerged. This initial research question also
fulfilled its developmental role in the research by enhancing my understanding of the
challenges faced by IMDs as they seek to acquire the knowledge they need to gain entry into
the Ontario medical system.
Chapter Six:
The Residency Interview and the Licensing Process

This chapter will present results related to the second and third Research Questions related to the residency interview and the licensing process overall. In the first section, the barriers and enhancers to success in the residency interview are discussed from the perspective of the IMDs, bridging program educators, and one IMD who has conducted residency interviews. These are compared and discussed in the conclusion to this section. In the second section, the experiences of IMDs during the licensing process are highlighted, with two key themes coming to the foreground: language proficiency and Canadian medical knowledge. Then, the thematic findings regarding IMDs’ experience of the licensing process are expanded by the inclusion of an analysis of the metaphors used by IMDs to describe their experiences. This analysis was inspired by Richardson’s (2002) poetic transcription methodology, and the methods of Lakoff and Johnson’s (1980) book Metaphors We Live By. The metaphor analysis supported the inclusion of another dimension of IMDs’ experience (i.e., their affect in relation to the process and system), which in turn supported both the crafting of the poems included in the thesis.

When initially examining the licensing process, two things struck me as an applied linguist: Having worked with newcomers to Canada for several years, I could imagine how difficult it might be to perform well in a residency interview if (a) I did not have exposure to the genre and (b) if language proficiency was still a challenge for me. As well, it interested me to know more about how language proficiency impacted on all stages of the licensing process. How well did existing language training programs, such as LINC, serve the needs of this community? What steps did IMDs take to improve their language proficiency before
arrival to Canada and how well did those steps pay off for them when they arrived? And, finally, how did IMDs perceive the licensing process overall? In the course of answering these questions, I felt that the sociocultural dimensions of the IMDs’ experiences would become clearer. This chapter explores the answers to two research questions related to IMDs’ experiences during the licensing process, and as such, forms the core of the dissertation. In keeping with the value placed by Vygotskian sociocultural theory on the role of emotion, the analysis of the metaphors used by IMDs to describe their experiences in the licensing process will expand the understanding of their perceptions and contribute to the building of an activity system description that is true to their experiences.

Section One: Barriers and Enhancers to Residency Interview Success

This section of the chapter will explore the following research question through the analysis of the 15 interviews with IMD participants:

What are the barriers and enhancers to IMDs’ success in the residency interview, as perceived by the IMDs themselves, bridging program staff and an interviewer?

The first theme that emerged was the lack of experience that most IMDs faced with regard to any type of North American employment-style interview. Although not all of the IMDs had experienced a residency interview themselves, the vast majority were aware of its role in the selection process and had formed some theory of its importance in the process. They all also had opinions as to what might enhance success or be a barrier to success in the residency interview. The opinions of the two staff members who worked in bridging education related to interview preparation are also explored in this section.
Past Experience with Interviews

Very few IMDs interviewed reported having any previous experience with employment interviews in their home country and, when they did have some previous experience, they noted important differences between those interviews and the residency interview. For example, one younger IMD from Pakistan who grew up in the Middle East reported that “not really, I never…had such interviews over there” (Interview 15, May 9, 2008). For this IMD, whose age of only 24 years could also have been a factor in his lack of experience, the interview was a totally new genre. For an older Eastern European candidate, one did not get jobs in his home country of the Ukraine through interviews: “No, no not at all….No, there are no such interviews conducted in our country. Most of the positions gained from some connections…generally speaking, it’s all connections” (Interview 12, April 24, 2009). Another IMD from Asia reported an employment application process that did not include formal interviews: “Back home, before even I was graduated various hospitals wanted me to go and work there, so, I didn’t have to do any…even interviews. We would just go and talk to the director of the hospital and say, okay…you know…which department I would like to work…why…you know…” (Interview 9, March 5, 2009).

Other IMDs were not familiar with the application of the interview process to the selection of residency candidates: One participant from Bangladesh described that, in their system, “everybody is guaranteed a residency” (Interview 4, Nov. 6, 2008). Thus, those trained in his country knew that they would have a residency position, and the allocation of these spots was not determined by an interview, as it is in Canada even for the Canadian-born medical students moving into residency training. Thus, the different contexts of their home countries and countries of training mean that many IMDs have had no exposure to the
employment interview, either through work or through the selection process used for residency training positions.

Is it possible, however, that IMDs who had come from contexts where interviews were used would have a competitive edge over those who did not? This was an ongoing question that was explored over the course of the data collection. For another participant, who had experienced interviews both in her home country and in Europe, even familiarity with the interview in two other cultural contexts was not enough to help her confidence when she faced the interview here in Ontario:

P: In my home country a lot of things are informal…
R: Ah okay, okay, okay…
P: But in France yes, you have some formal yes…
R: So, that kind of interview was in a sense familiar to you…
P: Yes, and also, I’ve, I’ve had several job during my medical studies…
R: Ah yes, okay…
P: I worked…
R: Okay…
P: And for all the work I have done I always have done an interview…
R: I see okay…
P: I sent my resume and etc and also, the interview. So, for me it was yes…
R: You know, your process - familiar process…
P: Yes. It was dreadful here because I didn’t really know what they wanted…
R: Okay, okay…
P: I asked myself what they wanted and I listed things…
R: Yes…
P: And I went with that… (Interview 16, May 11, 2009)

It is interesting to note that her own interview preparation process gets at the crux of what many IMDs felt was the benefit of the bridging education that centered around interview preparation: to try to divine “what they wanted.” For another participant, interviews were used for employment purposes in her home country of Bangladesh, but the focus was decidedly different: “They mainly asked about the knowledge…medical knowledge” (Interview 11, March 31, 2009). This participant objected to the interview as a screening tool and, while she acknowledged the validity of examinations to test knowledge, she felt the licensing process was not “helpful” and questioned how much could be learned about a person within a 30-minute interview. Thus, employment and resident selection processes in other contexts varied, and, through examination of the data, it became clear that even those participants who had been interviewed previously in other cultural contexts did not feel that the knowledge they had gained from that experience was relevant, especially in relation to the formality of the residency interview. From a sociocultural perspective, this means that these IMDs lack the basic knowledge to mediate their participation in an interview, placing a great responsibility on them to recognize this gap and gain access to this knowledge after they arrive.

Interview Importance

Before exploring the IMDs’ perceptions of the enhancers in interview success, it is important to explore their perceptions of the importance of the interview in the overall selection process of residents. As described earlier, the residency interview is the final step in the selection process before the selections are made. The files submitted by candidates are
reviewed to screen which IMDs will be contacted for an interview, and then the interviews proceed. When describing the importance of the interview, the level of experience with the selection process had some influence on IMDs’ perceptions. As might be expected, those IMDs who were very new to the process or had never applied to the match did not feel confident describing the role of the interview based on their own experience. One newer IMD, however, who had been in Ontario less than one year, identified the interview as a key factor after her discussions with other IMDs who had been here longer:

Actually, there are so many doctors I have met and they’re quite depressive because they are waiting since three years, four years…and they have no jobs. Even if they have finished their exams they are waiting for the interview call. They have not been called for interview and even they have finished their interview, maybe they are not good in talking or communication. They have not been taken for residency program. (Interview 6, Feb. 19, 2010)

Although there have not been any studies to date specifically on IMDs and the residency interview, the interviews in this study contain anecdotal evidence that the licensing process does take a toll on the mental health of IMDs.

Almost all IMDs who do have experience applying to the CaRMS Match describe the interview as important, or very important. For some of these IMDs, it is the pain of an unsuccessful interview or more that forces them to acknowledge its importance in the selection process:

I think it is very important because I have been to two, three interviews and missed two so I know that maybe I didn’t do well in those two interviews and that’s the reason why I didn’t get in. So I know that it’s very important. The thing is I don’t know how much it ranks, how much it is important for them so I don’t know. They say they score each person and they share the scores and whatever so I don’t know about what happens there but it is very important. You have to do well in the interview…Even if you have the best CV and the best transcripts if you don’t do well in the interview, I guess you won’t be taken in. (Interview 5, Feb. 17, 2010, emphasis added)
This lack of knowledge regarding how much the interview actually counts in the selection process (see italicized text in previous quotation) reflects a common theme. A smaller number of IMDs responded that they could not rate the importance of the interview due to the lack of information available about its role in the selection process. One IMD was not able to determine how selections were made, as he felt each year he tried and was unsuccessful, he was getting farther and farther from actual practice, yet he was finally selected after three attempts, and six years after arriving to Canada:

P: I don't know the math behind it...because I was getting worse and worse, I think!

R: You were! (laughs) so these exam scores, or in terms of?

P: I mean if you're not practicing, the more years you're not practicing

R: Yes, yes right

P: So you're losing some of your knowledge

R: Yes

P: Ah, so that kind of showed me that there's no real algorithm of this interview and how we are - what is the selection criteria is not clear.

(Interview 1, Oct. 10, 2008)

Thus, without any other option, IMDs continued to participate in the interview process even though they were not clear on how the interview was or was not contributing to their success.

**IMDs: Enhancers of Residency Interview Success**

An enhancer that was prominent for both very new IMDs who faced more significant language challenges and for those who had been in Ontario for many years was language skills. In this sense, for many, the residency interview is seen as a de facto language assessment: Although all IMDs must submit TOEFL scores to enter the assessment process
(or meet other criteria to be exempted from this requirement), IMDs felt that interviewers would be assessing their ability to communicate effectively in English. One IMD, who had very recently arrived from China, and who faced more substantial language challenges, felt that language assessment was, in fact, the main purpose of the interview:

Oh, in my opinion, I think this interview, it try to test ahhhh ahhhh the ahhhh the candidates ahhh how what what the ability to communicate with the Canadian patients and ahhh to ahhhh test the ability ahhhhmmm how to ahhhhhh to ahhhh explain the mmmmmm situation of the patients for the patient to explain the disease or mmmmm. I think maybe the communication between the patient and the physician is the most important and to others, I’m not sure! (Interview 2, Oct. 23, 2008)

Most of the other participants in this study believed that assessing language was only part of a larger agenda for the interview. Here is one example from another IMD who had been in Canada for less than 6 months at the time of the interview:

I think [the interview can select the best doctor] because [the interviewers] will see the doctor, his personality. And if they will ask the question, the communication skill and what the, what the idea of the question he -- the way he’s answering the question. They can guess that he knows the Canadian system...Or he has had some orientation in the system. (Interview 6, Feb. 19, 2010)

Similarly, another IMD who had been in Canada for more than a decade reported that interviewers looked for personality, along with language ability:

And, they want to see how your communication is. I think they also looking at the - your language capability: whether you can, you know, talk to the patient. You understand what the patient ask and what your answers are…and how you approach. Are you a person who is...you know…what kind of person you are, your personality. (Interview 9, March 5, 2009)

In fact, language was one of the most commonly mentioned enhancers perceived by the IMDs to lead to success in the interview, although it was often connected with other enhancers.

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10 As the pauses in this interview were much more substantial than in any other, they are left in, as they give a better sense of the participant’s speech.
Another perceived enhancer of success in the interview was the ability of the IMD to win over the interviewer. One IMD defined his understanding about success in the interview by talking about a hypothetical IMD candidate who was, in fact, a very good doctor, but who needed polishing to be successful in the interview:

So you could be a very good doctor: so how we can improve your language, for example, how we can improve your mannerism, of you know, of how you present things, maybe, you know, how we can...these and I told everyone, it's all about the soft skills, not about the knowledge, the medical knowledge. (Interview 1, Oct. 10, 2008)

For another IMD, the necessity was to “impress” the interviewer, which could mitigate even being an older IMD: “I don’t know why, but I think if you impress your interviewer it doesn’t matter how old you will be” (Interview 14, May 8, 2009). When asked how she would impress her interviewer, this IMD replied, “I don’t know yet but I would like… Yes, I will be myself… I just don’t know how to prepare and don’t say anything more than they wanted to know” (Interview 14, May 8, 2009). Thus, this IMD’s lack of formal interview preparation and experience with interviews left her unsure of what was expected, but sure that one needed to impress and avoid saying more than necessary.

Definitions varied of what it meant to have the interviewers “like” an interviewee or be impressed by one. For one IMD, impressing the interviewer means that they like you: “If they don’t like you at the interview, you will never be invited, accepted to the program” (Interview 12, April 24, 2009). For another IMD, “liking” meant that you had to convince the interviewers that you were compatible with them and a good person to work with:

You have a good knowledge you’ve good marks that why [you were called to] the interview…but the purpose of interview -- what I felt was to see your compatibility with them. If you are compatible with them if you are the right guy for them that they can work with for the next two three years (Interview 15, May 9, 2008)
Thus, one of the enhancers of interview success perceived by the IMDs is to win over or be perceived by the interviewers as likeable, compatible, and impressive.

Not surprisingly, another enhancer of interview success was participating in bridging education program that supported the development of their interview skills. The previous chapter has given some sense of what IMDs feel they learned in an interview preparation programs, and they did value what they learned. One IMD felt that her mock interview advisor had been key to her success, as it was only through her that she had learned what was expected: “So she taught me the rules actually” (Interview 17, June 18, 2009). Once this IMD had gained access to this knowledge, it transformed her experience of the interview, which had not been successful on her first attempt:

Previously…when I went for the interview, it was a totally new concept for me in terms of like, you know, what they ask and what I have to say. And by [the next year], I felt that I had become a pro because now I knew the rules of the game. I felt very confident that, okay come on, bring it on, I’m ready to play the game. So this time you know, the interview really went very well. (Interview 17, June 18, 2009)

Another IMD was not as concerned about the content of her responses, but just felt that the experience of practicing in the mock interviews helped her gain confidence:

What they answer didn’t help me, I forgot everything. What helped me was this exposure only made me stronger, and made me…confident and, less nervous. That is what helped me. So, the answer to the question was I have my own…. I just wanted the exposure I wanted to be confident and I wanted the interview set-up -- you know, to get used to the interview panel. (Interview 9, March 5, 2009)

What is interesting here is how attending the same preparation program led to two contrasting perceptions of its value. For another mock interview participant, the real value of the experience was in learning to offer examples that left an impact on the interviewers. He recounts that his ideal outcome from the interview would be that
They [i.e., the interviewers] recall that Dr. X [meaning himself] gave me this example and that’s still in my mind. So, I mean tell such an example that is different and that strikes their mind and then they will be able to give you a different grade. So, that was really helpful for me. (Interview 15, May 9, 2008)

Thus, for all of these IMDs, participating in bridging education regarding interview preparation was an enhancer of success, but in different ways. It is worth noting that two of these candidates (the first and third examples) were successful in accessing training, which could have impacted on their perceptions of the value of the preparation.

In fact, another theme that arose out of the interviews with these two successful candidates was that of the necessity to have rich experience to draw on during the residency interview. Thus, for these two candidates, simply understanding the “rules of the game” was not enough: It was important to be prepared for the interview with appropriate professional content and knowledge. What does this mean? Earlier IMDs have already emphasized that, unlike some interviews in their home countries, residency interviews do not focus on medical content. Through the reflections of these two successful IMDs, their understanding of interview preparedness becomes clearer.

For one, a crucial aspect of preparation means having interesting medically-related volunteer experiences to draw on during the interview: This IMD had a clinical observership at a major hospital in which she was encouraged to take on a higher level of responsibility, such as presenting at grand rounds on clinical content areas to physicians who were currently practicing in the system. She calls these experiences “enriching” and feels that they made her answers in the interview “more colourful and more interesting”; not only that, but she also talked about having increased confidence in the interview: “I had more interesting things [to talk about] because I was out more in the field...so I had more material on hand, I would say,
and that gave me more confidence” (Interview 17, June 18, 2009). Thus, for this IMD, who had very high exam scores, the difference between an unsuccessful residency interview and a successful one was defined by her first learning the rules of the interview, but also by having enriching experiences based in the Canadian healthcare system to draw on when she spoke. This speaks to the importance of IMDs working their way into the system to have access to experience in the Canadian system through clinical observerships, but, as we shall see in the findings below, access to these is limited.

Preparation in terms of research about the various programs was key for another IMD who was successful in the interview. She described the month that she spent conducting research on the Family Medicine programs in Ontario, working full time hours on all aspects of the interview preparation. It is interesting to note that this amount of time is within the range recommended by the bridging program: 100-150 hours.

P: I really, really prepared and I took one month to prepare this interview…

R: Oh, wow just completely full time wow…

P: Yes, to know the people to know the program…

R: Ah research…

P: I’ve done a lot of research…

R: Okay…

P: Yes, to know the kind of questions that can be really relevant to ask them…

R: Yes…

P: To make a good conclusion. (Interview 16, May 11, 2009)

Thus, for this IMD, the enhancer of success was a substantial investment of time to ensure that she had an adequate knowledge base about the programs she was applying to in order to ask a question at the end that would impress her interviewer. This was a point raised during
the orientation session for the interview preparation: Due to lack of familiarity with the “hidden” expectation, many IMDs may take the question at face value and simply decline to ask a question, feeling that it is an acceptable choice, not realizing that they could then be viewed as lacking in either initiative or interest in the program, or both!

**IMDs: Summary of Enhancers of Interview Success**

Almost all IMDs interviewed felt that there were enhancers to success in the residency interview. The most commonly mentioned enhancer was language and communication skills, which was often described in relation to a physician’s need to communicate with patients. Most IMDs did not see this as the only focus of the interview, but rather saw it as a part of the assessment that also focused on other factors, such as personality and familiarity with the Canadian system. The three IMDs interviewed who had gained entry into the system through a residency interview all cited the interview preparation support that they had received as being worthwhile; they tended, however, to emphasize slightly different aspects of it, such as learning the “rules of the game,” using memorable examples, choosing Canadian examples, or learning to “sell yourself.” From a sociocultural perspective, this highlights the importance of having a more competent peer to support learning in one’s ZPD through scaffolding. The descriptions of the IMDs about how they learned the skills related to interview success strongly reflect this kind of one-on-one learning.

Another important enhancer was having worthwhile content to discuss in response to questions: This could be accomplished through medically-relevant volunteer work, according to one IMD, or by extensive research on the Family Medicine program, according to another.
Finally, a less concrete enhancer was winning over the interviewers, which IMDs defined in various ways, such as impressing or being liked by them, proving one’s compatibility or using soft skills. The overall tone used to describe enhancers was that they were achievable knowledge or skills. Out of 15 IMDs interviewed, only one felt that no formal interview preparation would support her success, although she also described having her interview responses checked by an IMD in the system, which she felt was adequate preparation.

**IMDs: Barriers to Residency Interview Success**

Some of the barriers to interview success identified by the IMDs participating in this study were related to the enhancers in that a lack of something important, such as language skills, became a barrier. Some of the other barriers were related to factors that could not now be controlled by the IMDs, such as the selection process itself, and time-related factors, such as age. Other barriers were related to the IMDs’ lack of experience with the interview as a genre, and the final barrier was the demonstration of a negative personality in the interview.

The first barrier, factors related to the selection process, involved both the IMDs’ perceptions of how the selection process works, as well as their understanding of the stakes of the interview itself. For example, one IMD reported that he quit interview preparation when he received his results on an examination and figured that the mark was so low that he would not be likely to be invited for an interview. Another IMD, who was successful in gaining entry into the system, identified a barrier to success in the interview as performing poorly in the interview while also having a weak application file (i.e., low exam scores). Thus, for this IMD, low exam scores would only be a barrier if the IMD did not shine in the interview. He described how this was based on his personal experience, as he gained entry
into the system having written only one of the exams, but he felt that he had had a strong interview. Although he recognized that poor interview performance could result in a candidate with a weak interview being excluded, he felt that the interview was a good selection tool, because it was the process that had allowed him entry into the system.

Not all IMDs agreed with him, however, and some identified the intense pressure that they were under in the interview as a barrier to success. For them, the extremely high stakes of the interview were considered a barrier in that the pressure often results in intense nervousness.

It's your future, it's your family members’ and everybody is relying on you and it only happens once and if you screw up...This is a huge nervousness and an anxiety, you know,...they have only once chance for one year...if you screw up this - so this would definitely impact your performance and how you present yourself. I think, you know, a lot of people got not accepted because they got just NERVOUS, maybe, or anxious, or they didn't know how to cope with it. (Interview 1, Oct. 10, 2008)

The combination of extremely high stakes with an unfamiliar genre means that IMDs are performing year to year in a selection process of which they have not internalized the operational rules: This would certainly provoke anxiety.

For another IMD, simply being an IMD was perceived as a barrier, due to the fact that they are now competing against Canadian-born students studying in foreign medical schools (e.g., in the Caribbean or Ireland), who are also called Canadians Studying Abroad (CSAs):

P: I know, Canada prefers the IMGs who are Canadian-born and brought up.

R: Oh, okay. So, that’s an issue.

P: They are superior than us. (Interview 11, March 31, 2009)

For this IMD, this preference for the Canadian-born students was the factor that was “most affecting” the newcomer doctors’ chances for success. Thus, for these IMDs, certain aspects
of the selection process itself, such as the once-a-year timing, the need for minimally sufficient scores, or the need to balance a weaker portfolio with a strong interview, and even simply being an IMD, can be barriers to success for IMDs.

Another barrier identified by IMDs is related to the passage of time. As reported even in the application materials on the CaRMS website, there is a strong preference for IMDs who have not been out of practice for more than four years (CaRMS, 2010c). How can these newcomers settle their families, learn English or improve their English, write all the necessary examinations, work a survival job when their money runs out, locate medically-related volunteer work, and master the art of the interview in that amount of time?

One IMD felt that it was ironic to be rejected twice by the system with high exam scores and then to be finally accepted on a third attempt, which was six years after arriving in Canada:

I hear, not necessarily first hand they were saying, "you are an old grad and you have been out of practice for quite a while" and that was a negative point on my interviews. I think the very last one why I got in, I think, you know I was lucky to be with two person who interviewed me who and it's their impression of, what - doesn't matter really how long this guy is out of practice, he's ambitious, he's focused on this, he's going to get it, and he shows consistency that he's going to get it. If we don't put him this year, he's going to come back, so that's the only speculation that I have, that's my impression. I don't know why I got in. (Interview 1, Oct. 10, 2008)

In addition, as the years attempting to gain licensure go on, there is another time-related concern that raises its head: looking and being old in the interview. As discussed earlier, IMDs already tend to be older when they arrive, with most tending to be between the ages of 35 and 44 (Szafran et al., 2005) and although there is no published guideline, it is widely accepted that there is a preference for younger grads, although there are exceptions. One 46-year-old IMD felt that this was the main reason he was rejected in interviews:
It’s probably -- what I believe is probably my age is the thing. Uh, that’s what I believe….that, like from hearing from the CaRMs director. So that if your [last active medical practice is] more than five years back. Uh, your chances are very slim. He just announce in a public a gathering so. To that probably I could relate. I don’t know any, any, any other thing. I am really in the, in the dark because I don’t know, nobody telling me. I approached Ministry of Health, I approached an Ontario Faculty of Medicine. Whatever, I approached everybody. (Interview 4, Nov. 6, 2008)

So, one barrier to success in the interviews (and ultimately, in the licensing process), is the clock that begins ticking once they arrive in Canada: Can they do everything they need to do to create a competitive application file before they are perceived as being too old or out of date?

Another barrier to success in the interviews is making a negative impression on the interviewers. There are two reasons identified by IMDs that might contribute to a negative impression: The first is their lack of familiarity with the interview genre, and the second is simply having a personality that would be perceived by interviewers as undesirable for their program. As discussed above, many IMDs report a lack of experience with formal employment interviews, due to different hiring systems in their home countries. Thus, when they answer a question, they are always wondering if the response is what the interviewers are looking for. As reported above, one IMD discussed the stress that this concern caused her, calling the feeling “dreadful,” despite the fact that she had much more experience in interviews than many IMDs who come to Canada. Another IMD saw a barrier to success not in the lack of experience with the interview itself, but in the personality of an IMD who would not be a good team member, which he felt the interview would definitely reveal:

What the program directors want to have: people in the program who will not complain, who will do what they’re told, and [study] appropriately and okay, be kind. They don’t want some unpleasant worker, I’m sorry – shit stirrer -- and they don’t want them in the program. And that’s the main purpose [of the interview], of course. (Interview 12, April 24, 2009)
**IMDs: Summary of Barriers to Interview Success**

Many of the barriers to interview success identified by the IMDs were factors beyond their control or difficult to control, such as their age, the recency of their medical practice, or simply being an IMD who must compete against Canadian-born graduates of foreign medical schools. Certainly, lack of experience with the interview was identified as a barrier, but this was one that those successful in the interview had all remedied by participating in bridging education that focused on interview preparation. Again, from a Vygotskian sociocultural perspective, the IMDs’ lack of experience in the interview reflects the fact that the interview is a screening tool that is part of the new culture into which they are trying to gain entry. How can they gain knowledge of this new tool? The main way is through social interaction (i.e., practice) in which they are scaffolded by more capable peers. Not only does their lack of knowledge of the genre itself present a challenge, but also the fact that they may come from different cultures which directly conflict with the “sell yourself” North American interview culture.

**Bridging Program Staff: Enhancers of Interview Success**

The two staff members who were familiar with the licensing process and who had worked in interview preparation -- although to varying extents -- were asked what they believed the enhancers to interview success were for IMDs in the residency interview. The first response was similar to the enhancer identified above by the IMDs themselves: winning over your interviewer. This staff member felt that if the IMD could come across as likeable (i.e., a good colleague to work with), then the interview could lead to acceptance into a residency position: “You get the impression meeting somebody in a twenty minute interview.
Well you know what? Smiling, friendly, nice, I think they’d be a good fit, [and they have] good scores. Let’s go: this person!” (Interview 10, March 25, 2009). Even if an IMD did have a heavy accent, if he or she had good language skills and could demonstrate a knowledge of the Canadian system, this staff member felt that these assets could lead to a training position: “I think you know if they can still communicate and they’ve got a good sense of the system, and they’re knowledgeable and they come with the skills and there’s no reason why they wouldn’t select someone [with a heavy accent]” (Interview 10, March 25, 2009). For another staff member, the greatest enhancer to interview success was interview preparation, but she raised the question of whether the best doctors were getting the residency positions when the interview was such an important part of the process:

I mean they may have interviewed well…I wondered if we prepared some people too well for the interview…See there’s always a risk at the interview is a skill some people are going to learn it…And we always say the best -- the best candidates don’t always get the position, the best interviewee gets the position right? (Interview 13, May 5, 2009)

Thus, both of these staff members see that there is a necessity to use the “skills” of the interview to win over the interviewer. Does mastery of the interview genre represent the best candidate, however? When the exposure to the genre in the cohort of IMDs has been so minimal beforehand, it becomes clear that participation in interview preparation provides a huge edge when competing against IMDs who have not learned the rules of the game and “what they want.”

**Bridging Program Staff: Barriers to Interview Success**

Staff members were also asked what factors would constitute barriers to success for IMDs in the interview. Not surprisingly, lack of experience with North American
employment style interviews was identified as one barrier, along with lack of experience in
the “sell yourself” style of self promotion required in interviews: “And self promotion, I
think, is a real -- is something they really need to work on. We could do seminars on self
promotion all year around” (Interview 13, May 5, 2009). The kind of local cultural
knowledge required to be successful in the interview leads to another more insidious barrier,
however: One staff member believes that there are many IMDs who feel confident in the
interview due to the fact that they are judging their responses according to their own cultural
framework and simply aren’t aware of what they don’t know:

There are a lot of people we’ve never seen…They don’t think they need it,
probably. I noticed that a lot of people tell us that they had interviewed
previously they thought they did fine until they came to the interview
prep…So, that might also, be -- we may not be capturing a large group who
think that they’re doing fine…Like the client I was telling you interviewed:
this was her third time…She said, “You know I really thought I was doing
okay. I thought I was answering them correctly.” (Interview 13, May 5, 2009)

Thus, another barrier to success in the residency interview, according to this staff member, is
that many IMDs are actually not aware of the “unwritten rules” of the interview and may
miss one or two chances at entry into the system before they become aware of how they may
have been harming their chances for success. This dynamic was also present in the IMD data,
where they emphasized the importance of the interview preparation to their success at
gaining entry into the system.

Another barrier identified was poor language proficiency, with one staff member
saying that she had never seen a case of the candidate being accepted with very low English
language proficiency. This reinforces the perception of IMDs that the interview is, indeed,
functioning as an informal language assessment, although it is not clear whether language is
being assessed explicitly or not.
Two other barriers identified were attitudinal, although focused in different directions. One staff member, similar to the IMD above, felt that the interviewers (faculty and residents) were simply trying to protect themselves from bad apples:

They're looking some in [the] interview: Are you a good fit for my team? And I speak frankly here: Basically, are you going to be a pain in the ass in my program? Do I think you’re going to need remediation? Are you one of these people that’s -- we’re constantly meeting, “Oh, how about tomorrow? Can I do this? Ah, can I have a shift tomorrow?” Are you bothersome? Are you annoying? I don’t want that. (Interview 10, March 25, 2009)

The other staff member felt that an inwardly directed negative attitude was a significant barrier to IMDs’ success in the residency interview. Although she acknowledged that the challenge of learning to sell oneself was not easy, she had seen how dwelling on these difficulties of learning the new interview genre had led to complicating problems:

If you have a “can’t do” attitude it is going to affect you. “I can’t -- don’t know how to do it I’ve never done it this self promotion. I don’t” –You keep saying that to yourself over and over and over again: it’s going to be really harmful. (Interview 13, May 5, 2009)

Thus, attitudinal barriers were also identified by staff members as hampering interview success: not only displaying a negative personality in the interview, but also impeding one’s own chances of success through negative thinking.

**IMD Interviewer: Enhancers and Barriers to Interview Success**

As mentioned previously, one IMD participant was successful in accessing training, and had participated in interviewing both IMD and Canadian-born candidates for residency at one point. For this IMD, the interview was something that he had seen from both sides, as he had also participated in the interview process as an interviewer, thus offering a unique perspective in this sample of IMDs. First, his opinion of his own interview was that of an
uncertain experience. After an interview which he felt went very well -- and he was in a professional position in which he had some experience with interviews in Ontario – he was unsuccessful with strong exam scores. What appears to have been frustrating was the inability to receive any feedback on how to improve:

I knew what they were looking for, so -- and I think I did pretty good, but surprisingly they said "you're not in!" ah, no idea, so....no feedback, no idea, no nothing, it's just ah, I said "Okay, I mean, you know what, I'm working, I have a good job, so ah, I'll keep doing it! [i.e., keep applying]" (Interview 23, Oct. 15, 2009)

Thus, in the difficult position of not knowing what he was doing wrong, he just decided to keep applying. When he was accepted, which was several years after arriving in Canada, he felt that the loss of knowledge due to his distance from practice should have meant he would be less and less likely to be successful, except he did finally get accepted: “So that kind of showed me that there's no real algorithm of this interview and how we are - what is the selection criteria is not clear” (Interview 23, Oct. 15, 2009). Thus, even in retrospect, the reason for his success in gaining entry into the system was not clear.

His experience as an interviewer did not change this impression; in fact, it has perhaps been intensified. He recounted a number of aspects of the interview that he felt fostered subjectivity, including the fact that the interviewers had never met and had little time to formulate a plan for the interviews. In addition, the nature of the questions asked (i.e., typical behavioural interview questions) were very subjective in that people’s perceptions of how well a situation was handled could vary. This led him to conclude that

it's only two people who are doing this, so ah, the inter rater reliability, it's just only between two people, so it's - but I assume if it was 10 people at the interview you would see, you know, all over the place, different numbers. (Interview 23, Oct. 15, 2009)
Thus, in his opinion, there is limited reliability in the interview ratings. In addition, while he acknowledges that the screening process is the best that the resources currently allow, he has seen situations where a candidate performs well in the interview, only to end up being an unpleasant surprise for him and his colleagues: “I've seen many surprises, I've said that, you know, this person went PERFECT in the interview and now they're an embarrassment! Oh my God!” (Interview 23, Oct. 15, 2009). Thus, for this IMD, the interview is a screening process that is highly subjective in nature and that is allowing false positives (i.e., less qualified doctors who appear to be good) into the system.

**Summary: The Interview**

Overall, when examining the perceptions and experiences of IMDs seeking licensure in Ontario regarding the residency interview, a number of key themes emerge. First, the interview is, in most cases, a completely new genre with unwritten culturally-influenced rules that are difficult to master without the support of a bridging program that focuses on interview preparation. In fact, when considering the enhancers of interview success, interview preparation was only surpassed by language and communication skills in frequency of mention. Other enhancers mentioned included having effective and medically relevant content to discuss in response to questions, and finally, the ability to win over one’s interviewer. Figure 6 that follows provides a visual summary of the enhancers and barriers identified by IMD and staff participants. The items in the central list, entitled “Shared,” were those that participants felt were key enhancers when present and key barriers when absent. It is interesting to note that there was unanimous agreement on these three items from both IMDs and bridging program staff.
Figure 6. Barriers and Enhancers of Interview Success.

Barriers to interview success contrasted with enhancers, as more of these tended to be aspects beyond the IMD’s control, such as age, recency of practice, personality, or even simply being an immigrant and having to compete for training positions against Canadian-born candidates educated at foreign medical schools. One key barrier was a lack of experience with the interview itself. While these are the enhancers and barriers identified by the IMDs themselves, there was a relatively high level of agreement with staff working in an interview preparation program.

Staff did emphasize attitudinal factors featured more prominently, and also raised the concern that IMDs’ lack of familiarity with the interview can sometimes work against them. By this, staff meant that the IMDs judge their interview responses through their own cultural...
framework and judge them to be suitable; without any feedback from those with knowledge of “what they are looking for,” these IMDs are not aware of the need to prepare further for the interview. Both staff and interviewer responses gave consideration to the subjective nature of the interview, as well. What is clear when analyzing these data from IMDs, their bridging program instructors and an interviewer is that, regardless of what they believe about the ability of the interview to select the best candidate and its fairness, all acknowledge its importance in the current selection process. Success in the interview may be dependent on the IMD’s ability to recognize that s/he is dealing with a new tool from a different culture and, thus, seek out scaffolding in how to negotiate it and what unspoken rules mediate the evaluation of interview success.

**Section Two: IMDs and The Licensing Process**

This section of the chapter will explore the following research question through the analysis of the 15 interviews with IMD participants:

**How is the licensing process understood by IMDs in the midst of the process, with special reference to language proficiency?**

Language proficiency was a priority to explore, given the lack of studies in this area, especially when this had been identified as a priority by the Canadian IMG Taskforce. Of particular interest was what steps IMDs with less exposure to English in their home countries were taking to improve their proficiency, both pre- and post-arrival. However, another theme emerged over the course of the analysis as the IMDs’ experiences in the licensing process were explored: the crucial need for Canadian experience to support their learning of a new medical system, and the unequal access to the clinical observerships that have often played this role for IMDs. Finally, once content themes related to licensing and language proficiency
have been discussed, the analysis will examine the metaphors used by IMDs to describe their experiences in the licensing process; these often very emotional images shed further light on the IMDs’ perceptions of their agency within their attempts to join the medical system. Because the residency interview is actually part of the medical licensing process, the metaphor analysis was included under this larger, more inclusive concept.

**Language Proficiency**

The IMDs’ experience with English language instruction varied widely, but followed recognizable patterns across countries and regions. IMDs of South Asian descent were most often exposed to English through immersion education (called English medium instruction there) from a young age. South Asian IMDs who did not take English immersion studied English as a subject from primary school onwards. In contrast, IMDs from Eastern Europe or the Middle East or Africa often did not study English until high school or even adulthood. This gap in experience with English widens even further when the language of medical education is considered: all South Asian IMDs, regardless of whether they had studied in English immersion schools, studied medicine exclusively in English. The impact of this experience cannot be overestimated. As one IMD from Pakistan put it, “But whenever we were discussing something, even at the bedside, we were always told to speak English. I think that was also instrumental in polishing one’s language skills” (Interview 17, June 18, 2009). Some IMDs who did not have extensive English language exposure in their regular education system studied at private English schools, such as the IMD from Iran. This IMD identified two factors that led to his studying English from a young age: the value his parents put on multilingualism, and also his own interest in eventually emigrating from his country:
First of all, again the value that our family put into the language was, you know, already a good background, and the second, I knew that I want to move out, and just go to a country, I didn't know where to go - no plan at that time. I said if I know English, probably half of countries in the world could probably be my destination, so that's the reason. (Interview 1, Oct. 10, 2008)

This IMD also studied and read North American texts in English during his medical studies, even though this was not expected or required. He represents the one exceptional case in the IMDs interviewed who, without the benefits of immersion or medical education in English, arrived in Canada with an English proficiency level high enough to move into medically-related professional work soon after his arrival.

Please see Table 7 that follows for a summary of the English learning experiences of all IMDs interviewed.

Table 7

*English Learning Experiences of Research Participants*

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>English Medium Education? (Yes/No)</th>
<th>English studied from what grade/time</th>
<th>Medical Education in English? (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iran</td>
<td>No</td>
<td>Grade school in private schools</td>
<td>No</td>
</tr>
<tr>
<td>China</td>
<td>No</td>
<td>High school</td>
<td>No, but limited instruction in English medical terminology</td>
</tr>
<tr>
<td>India</td>
<td>Yes</td>
<td>Age five</td>
<td>Yes</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>No</td>
<td>Grade school as subject</td>
<td>Yes</td>
</tr>
<tr>
<td>India</td>
<td>Yes</td>
<td>Kindergarten</td>
<td>Yes</td>
</tr>
<tr>
<td>Country of Origin</td>
<td>English Medium Education? (Yes/No)</td>
<td>English studied from what grade/time</td>
<td>Medical Education in English? (Yes/No)</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------</td>
<td>-------------------------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Yes</td>
<td>Grade One</td>
<td>Yes</td>
</tr>
<tr>
<td>India</td>
<td>Yes</td>
<td>Age three</td>
<td>Yes</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>No</td>
<td>Grade school</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>Yes</td>
<td>Grade school</td>
<td>Yes</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>No</td>
<td>Grade school</td>
<td>Yes&lt;sup&gt;11&lt;/sup&gt;</td>
</tr>
<tr>
<td>Ukraine</td>
<td>No</td>
<td>High school</td>
<td>No, but limited instruction in English medical terminology</td>
</tr>
<tr>
<td>Belarus</td>
<td>No</td>
<td>Adulthood – 2 years before immigration</td>
<td>No</td>
</tr>
<tr>
<td>France</td>
<td>No</td>
<td>High school</td>
<td>No</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Yes</td>
<td>Grade school</td>
<td>Yes</td>
</tr>
<tr>
<td>Pakistan</td>
<td>Yes</td>
<td>Grade school</td>
<td>Yes</td>
</tr>
</tbody>
</table>

We saw above the strategies that one IMD used to learn English in a country in which the educational systems did not support English acquisition the same way as in South Asia. What kind of strategies were adopted by IMDs from other countries in which exposure to English was more limited? One IMD from Ukraine described his study of English in high school:

<sup>11</sup> Although the medical education was in English in South Asian countries, such as India, Pakistan, and Bangladesh, the degree to which these IMDs spoke English with their patients varied. Some were encouraged by the medical faculty to speak English at all times, and the patients of some of these IMDs could not speak English.
It was kind of a joke. The school level of English was so low, and we barely, generally what we can do is read something, from call it text. And we couldn’t speak English at all. We couldn’t understand it at all. I mean a real English speaker, we couldn’t understand them at all. We couldn’t express ourselves. But we could read, we could. (Interview 12, April 24, 2009)

When he applied for immigration, this IMD decided to give up his job and move to a major city, where he could study English full-time from schools with native speakers from the US, UK, and Australia as teachers. Graduating at the end of the year with an advanced certificate in English, he felt that he was prepared to come to Canada:

At that time I was satisfied, but when I came here, the issues of language barrier came out and I realized that I was not so ready – but it was not so severe. When I found a job, it was one month after coming here. (Interview 12, April 24, 2009)

Interestingly, the job he found was working in a “brew it yourself” wine shop, and the manager hired him in part because of his medical qualifications. In the end, he felt the job helped him overcome the remaining language barrier that he faced:

I found an ad in the newspaper, came to him and “Oh okay, you will do. Because you’re a surgeon, you are familiar with the sterile concept...And you will do fine.” And I started work, working with him. And I met a lot of people, Russian speaking, English speaking. [That’s] when I get rid of my barrier, my language barrier. (Interview 12, April 24, 2009)

Thus, for this particular IMD, intensive study before arrival and immediate immersion in a Canadian workplace environment were two factors that he identified as supporting his language acquisition.

A contrasting example is provided by another specialist doctor from Eastern Europe who did not have the benefit of English instruction in high school. When she applied for immigration, she began learning English at a private school in her city, but was not satisfied with what she was learning:
Then I start to think, “Oh, gosh I can’t study properly because it’s not the same you have to talk to real people who speak English!” I start to think about job somewhere in English speaking country. (Interview 14, May 8, 2009)

In order to improve her English in preparation to move to Canada, she took a job in England as a personal support worker in a nursing home. She noted that the employers did not really want doctors for the job, so she had to convince them that she was willing:

And I explained her that I’m going to immigrate to Canada I want -- I have -- I need this job. She asked me so many times, “You understand what you will do? You understand?” I understood absolutely completely….It was very hard job physically. (Interview 14, May 8, 2009)

She worked this job for four years, eventually inviting her husband, also a physician, to join her and work there as well. It took, she said, eight months for her listening ability to consolidate, which she describes here: “My ear opened after eight months” (Interview 14, May 8, 2009). Thus, we can see in these two examples that IMDs who had limited exposure to English in their home countries took sometimes extraordinary steps to acquire English, with one giving up his job to move to another city to study English in his home country prior to immigration and another working several years in an English-speaking country to learn English.

How helpful did those IMDs who had had limited or less English instruction prior to immigration find the existing language learning resources, such as Language Instruction for Newcomers to Canada (LINC)? Of the eight who had not had English medium instruction earlier in life, five reported studying with the LINC program for at least a short period, and three did not. Of the three who had not taken any LINC classes, the IMD who was working in the wine-making store described above reported that he preferred “self-study,” and did not take any other courses on arrival, and the IMD from Iran who had studied intensively reported that he moved relatively quickly into work in the healthcare field. For these two,
work was either the preferred method to remove the language barrier, or else the language barrier was minimal on arrival. The third IMD in this situation, reported that he still felt that he could “improve my accent, I could be more fluent,” (Interview 4, November 6, 2008), although he never took any language classes to address this, reporting that his TOEFL score had been 640 out of a total possible 677 on the Paper-Based Test (PBT).

Of the five IMDs who did take LINC, four of them only took classes for a very short period of time before quitting. Two IMDs were quite explicit that the more immediate pressures of trying to obtain licensure as a physician stopped them from proceeding any further with language study. Of these two, the first said it was the need to study for the licensing examinations and the other said that it was the need to start some medically-related volunteer work. A third IMD did not directly connect her decision to the pressures of pursuing licensing, although she quit LINC after two months to join a program for alternative employment routes for IMDs: Even though she fully intended to pursue her licence, she felt that it would be necessary to obtain some related employment, especially in research, along the way. Another IMD tried LINC, but was dissatisfied with the classes and felt that she would be better off studying on her own; she was displeased to have a Bulgarian-born instructor, and chose to only take a few TOEFL preparation classes instead of LINC, as she could not begin the licensing process without it. Only one IMD was taking any LINC classes for any significant period of time: He was from Bangladesh and was assessed as Canadian Language Benchmark 6 on reading and writing and Benchmark 7 on speaking and listening, which would place him in Stage II, Intermediate proficiency out of the total of 12 Benchmarks. Four years after he arrived, he was still studying in LINC, but was quite dissatisfied with the classes, because they contain so many multi-level students in the one
class. Thus, in most cases, IMDs chose to forgo language training, even when it was free and easily accessible, in order to pursue goals more closely related to medical licensing.

In contrast, those IMDs who arrived with higher proficiency experienced a relatively smoother transition. Learning English was not a concern for them; one reported having to take the TOEFL for licensing in another province and getting a high score of 114 out of 120 without even studying, much less taking a preparation class. He reported that when he went for interviews for volunteer work, the interviewers explicitly compared his level of English to that of other IMDs that they had met before:

So, I mean the major thing that they told me was my English is very good I don’t have to -- I mean, many people -- IMGs -- that they meet, they have major problems communicating -- major problems expressing themselves. So, I don’t have that problem. (Interview 15, May 9, 2008)

Another IMD, also from Pakistan, found her linguistic transition “very, very smooth” (Interview 17, June 18, 2009). One IMD from Iran who arrived with relatively high English, felt he only needed the exposure to the spoken English here, and that he learned by being obliged to speak English all the time. An IMD from a South Asian country reported that the only challenge she faced with English was writing academic papers for her Master of Education program, something many native speakers find difficult.

Finally, another common theme was the challenge of the accent here, which was reported to cause some challenges on arrival, such as reported by this participant from Bangladesh: “Yes, I faced challenges because the accent is different, so, it was new for me, and it was hard to catch the words” (Interview 11, March 31, 2009). However, the challenges of accent were acknowledged to be much less than learning the language by these IMDs. For example, one observed: “But it’s not that big a challenge. I mean when you know the basics and you just have to do that fine tuning of yourself. So, it’s not that big a challenge rather
than if you’re starting from the basics then that’s a bigger challenge” (Interview 15, May 9, 2008). Thus, IMDs who arrive with more advanced proficiency may face subtler challenges related to accent or graduate level academic writing, but do not struggle with concerns such as passing the TOEFL standards set by the Ontario government to initiate licensing.

Passing the TOEFL is definitely a concern for those IMDs who arrive with lower English language proficiency, however. As discussed in the introduction to this dissertation, an IMD cannot even initiate an application into the licensing process in Ontario without a TOEFL iBT score of 93 total out of 120, with a minimum of 24 required on the speaking section. Although one IMD’s total score was more than adequate, he had a problem: “TOEFL, in general, it was more than required. They wanted 93, I had more than 100, but my speaking was less than 24” (Interview 12, April 24, 2009). On the recommendation of an advisor at a government agency, he appealed the speaking score and was fortunately awarded the score of 24 that he needed to proceed. The TOEFL was a barrier to moving forward for another IMD: She had concerns about American vs. British spellings, with which she was more familiar, and particularly the writing section of the test. In the end, she decided not to write the TOEFL and has since decided not to pursue licensing any longer, which was a difficult decision.

Indeed, for those who face challenges with language, it can impact on how they feel about themselves and clearly on their ability to succeed in the licensing process. For one IMD who did arrange an observership in a major hospital based on her French language

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12 Although the speaking section of the TOEFL iBT has six speaking tasks which are scored from 0 to 4. These scores are combined and scaled to a speaking score out of 30. The total iBT score is 120, with 30 for each skill (reading, writing, speaking, and listening). (ETS, 2011)
skills, she found her lack of confidence in English impacted profoundly on her ability to bond with patients:

I think that I get a problem when I was at Downtown Hospital: I wasn’t confident I thought that my English wasn’t good enough and I think that this affects my relation with the patient… I didn’t dare to talk. So, maybe sometime I get some kind of challenging relations with people but it wasn’t because of the sexual or homosexual. It was, I think the language that was for me the challenge…. I really think that my English is not good enough, and this stop me to do things you know and maybe some people can feel it, Because I’m -- I just stopped talking and be very reserved. (Interview 16, May 11, 2009)

From a Vygotskian sociocultural perspective, this IMD’s self-consciousness about her speaking ability was preventing her from accessing the very thing she needed to improve it: interaction. Another IMD who arrived in Canada within the past year and who recognizes she still has far to go in her language learning observes that, when it comes to getting a medical licence, “Language is the number one problem” (Interview 2, Oct. 23, 2008). A staff member who works with IMDs and advises them on how to proceed seconds this:

I mean if you get someone; like let’s face it again, I’ve had some clients some in -- one of them Russian or…and, and they barely talk. You’re probably never going to practice unless you get a lot of English help. Because some of them are just, some of them are so poor with the English language that there’s no chance they’re going to be selected. And you take it to; give them – “Right now, I can already tell you: unless you go away for two years and really improve your English, you’re not going to practice.” It’s very difficult for those people and I tell them “You really have to work on communication skills.” (Interview 10, March 25, 2009)

Thus, from both an IMD and bridging staff perspective, an IMD’s level of English on arrival can make or break his or her chances at getting licensed and impacts on the IMD’s confidence and ability to make the best of opportunities such as clinical observerships that can be key to licensing success.
Canadian Medical Experience: Access to Knowledge

The Catch-22 of Canadian experience is well documented in the immigration studies literature: How can you get a job in your field in Canada if you do not have the required Canadian experience? Thus, the vicious cycle continues. Factors at play include the devaluing of international credentials and education, and/or the inability to properly assess their value (Bambrah, 2005; Hearndon, 2007; Office of the Fairness Commissioner, 2010; Owen & Lowe, 2008; Wayland, 2006a, 2006b; Wilson, 2009; Zikic, Lemoine, Phan, Kelly, Fang, Preston, & Tufts, 2011). However, in medical licensing, where retraining through apprenticeship-style residency training is the dominant model, the Canadian experience catch-22 operates in a particular way that impacts more than one aspect of the licensing process. First, the series of examinations the IMDs are required to take increases in Canadian cultural and ethical content as the difficulty increases: from the initial Evaluating Exam, which is considered to be purely medical and sciences content to the QE1, which includes some ethical content to the CE1, administered by CEHPEA, which includes simulated doctor-patient interviews with 12 patients and encompasses culturally sensitive communication and counselling and doctor-patient interactions. The QE1 and CE1 are mandatory for those IMDs who want to be assessed by CEHPEA, so this is the first area where Canadian experience and access to knowledge arises: How can an IMD who has practiced in a different cultural setting access this knowledge that is needed to be successful on these examinations?

The IMDs are eager to obtain this knowledge, but available resources are limited. As discussed previously in Chapter Two, the Communication and Cultural Competence Program
(CCC)\(^{13}\) offers videos of sample doctor-patient interviews that contain key ethical content and accompanying reflective exercises, but this cannot completely replace a face-to-face course, with feedback on performance. IMDs are often forced to select private offerings, which are exorbitantly priced, to meet their needs for this content:

As we don’t have any other way to learn about this the context of the hidden things and how to conduct these examination here, so we have to go- we have to choose either or of these [private courses]” (Interview 8, March 3, 2009)

Preparing for the exams without knowledge of the context is daunting, and more than half of the 15 IMDs interviewed talked about the difficulty of knowing what the “correct” Canadian answers are. For this reason, many IMDs felt that the evaluation is not a fair assessment of their medical knowledge:

I always have a lot of doubt about the, about this a clinical exam. I don’t like that because as far as my understanding is a, you have to say uniquely Canadian, few things is beyond medical science to get a score. You don’t know which one and what they want…. If they tell us, my score – obviously, everybody’s score -- will probably dramatically improve because I didn’t study medicine here, I studied in British system. (Interview 4, Nov. 6, 2008)

Studying in a different system means a different way of approaching the patient. As this IMD has observed, he is familiar with the British system, as many South Asian IMDs are. What would happen, he wondered, if a Canadian doctor were put in his position?

If I take best Canadian student and place into him or her to British way of examination without any orientation, what would happen to that person? (Interview 4, Nov. 6, 2008)

Thus, many IMDs are concerned about access to the knowledge of the Canadian context needed in order to perform well on examinations with significant Canadian cultural and ethical content, as well as with knowledge of the style of examination itself.

\(^{13}\) http://www.img-ccc.ca/about.html
One of the main ways which IMDs might access this knowledge is through clinical observerships, which are opportunities to observe a licensed physician in practice in order to learn about the culture of Canadian practice. Most certainly, obtaining a clinical observership would assist an IMD in preparing for the cultural content in the higher level examinations. In addition, the competition for training positions also requires references, and it is widely believed that Canadian references are preferred to ones from the home country. However, the challenge faced by IMDs is that access to the clinical observerships is unequal at best: Many struggle to gain access to them, and this impacts unequally on their ability to compete in the licensing process.

Of the 15 IMD participants in this study, approximately half, seven, were not able to access even one clinical observership. A clinical observership is being distinguished here from hospital volunteer work which often does not involve work that is related to the expertise of the IMD. Of the seven who could not access clinical observerships, three were able to access some kind of volunteer work that was medically related, such as hospital research, but these positions were often such a stretch from the clinical medical practice that the IMDs needed to improve their knowledge that they questioned the value of such volunteerism: One IMD was asked to file records in the basement of the hospital, and quit after two weeks. Another ended up working in the hospital library, after initially being told that it would be relevant and helpful to him:

So initially these was a little bit of misleading that you can go there and do some volunteer work there that is a good help for you. But I feel one way, no, that this library work will not help in getting in medical science. (Interview 8, March 3, 2009)

Even though he was disappointed in the opportunity this hospital volunteer work offered him, he felt that he should still honour the one year commitment that the hospital had required
when he signed up. Thankfully, his volunteer work at another hospital had proven more
fruitful, and he was able to participate in some research that allowed him to observe
interviews with patients in an area related to his area of medical expertise.

How does one go about obtaining a clinical observership? Being ready for rejection is
a helpful mindset, as many of the eight IMDs who obtained clinical observerships did so
simply by knocking on many doors or by sending many emails before they succeeded. One
IMD recounts her pleas with a local doctor:

I live nearby. I am willing to do anything you want me to do in your
office…you want me to clean your desk, I will! [Laughs] You want me to file,
charting…everything: answer the phone, everything and she was very happy.
(Interview 9, March 5, 2009)

There was something uncomfortable about hearing that a medical doctor who had practiced
in three different countries had to beg in this manner for the opportunity to observe a doctor
here. However, not only doctors face these kinds of challenges. Internationally educated
midwives also have difficulties gaining access to clinical observerships. One describes her
experience trying to find a midwife who would allow her to observe: “I literally begged to
see what they did. And it wasn’t because I wanted to monitor them…It was to share the same
love, the same experience” (Nestel, 2004).

In the end, however, this observership that the IMD above located developed into a
very positive one over a four-month period, as she could write down her own diagnosis and
treatment plan while the doctor interviewed the patient and receive some feedback on it,
which was very valuable experience:

And later on I had some exposure with the patient because she would just take
history and do procedures with me, and she would - I was able to write on my
paper and show her that “Did I write it [ok] – What do you think?” (Interview
9, March 5, 2009)
Although this story of an IMD knocking on the door of a local doctor to ask for an observership ended well with a productive learning experience, many do not.

Again, one of the key issues with regards to this crucial learning opportunity is that access is unequal. One IMD interviewed reported that she went to several doctors to request an observership, without any success, and that she felt that this lack of exposure to the Canadian setting harmed her exam success: “so the first OSCE was tough for me because everything was new to me” (Interview 5, February 17, 2009). It was surprising to me that she had such difficulty finding a doctor to agree to an observership, given that she was working as a paid research assistant on a hospital-based research project in medicine. I felt that those connections would have easily facilitated her access to a clinical observership, but this was not the case. Another IMD observed that obtaining an observership was almost random luck for others, but that now that her husband was in the system, her connections guaranteed her access:

You just keep giving your resume to each and every doctor, and then ask them to call you, or you just take out the list and start calling them. Maybe somebody calls you, somebody doesn’t and then… I got because since now my husband is in the system. So I have access to the people and, to be very frank, it’s easy for me, but it was not easy for my husband. (Interview 3, Oct. 29, 2008)

How crucial is the access to these clinical observerships? One IMD who was successful in gaining entry into the system identified this as a key challenge now faced by other IMDs:

There’s one thing that I really feel bad about, and it’s not about me, I feel that I was lucky and that I had the opportunity to do the observerships that I needed in order to build my portfolio. But as I speak other IMGs, I feel now at this point you know, it’s getting [more] difficult and difficult for them to get an observership. (Interview 17, June 18, 2009)

Should something so important to success in the licensing examinations be left to chance, or to the power of connections? The challenges faced by IMDs trying to achieve the needed
scores on the licensing examinations and the clinical observerships that support those scores raise important questions about access to knowledge.

**Metaphors of Licensing Experience**

As described in the methods chapter, the foci of this analytic approach are thematic content analysis and poetic representation. While the previous chapter and this chapter, up until this point, have explored the major themes that emerged from the data analysis, this section will now explore an aspect of how the story is told by participants: the metaphors they use to describe their experiences with and relationship to the licensing process. Lakoff and Johnson (1980) argue that “Metaphors have entailments through which they highlight and make coherent certain aspects of our experience. A given metaphor may be the only way to highlight and coherently organize exactly those aspects of our experience” (p. 156). For this study, I have selected the metaphors that the IMDs used to describe their experience in the licensing process, as I found these metaphors to be particularly revealing of both how they feel about the licensing process and their perception of empowerment, or lack thereof, in relation to it. In fact, there appeared to be a synergy in this respect, as the most striking and powerful metaphors used by the IMDs were all depicting their feelings about the licensing process. As these metaphors also supported the answering of research question 3, this was another reason for decision to exclusively focus on them.

**Transparency**

The first of these metaphors is transparency. This adjective/image is commonly used to criticize processes which do not publicly reveal the criteria being used to select candidates (e.g., for residency positions). IMDs are trying and failing year after year without any
feedback about why they are unsuccessful: Without any firm, published standards to aim for, they call for transparency. As one IMD observes, the process is “not clear, not transparent” (Interview 1, Oct. 10, 2008). This IMD connects the very culture of medicine to the difficulty IMDs have in dealing with not knowing why they are not successful:

> You can see this is a great source of frustration for doctors. We are all trained very logically, based on certain rules and things, so when we cannot get any feedback on what I need to do, it is very hard to make any improvement, knowing that we [are] in need of doctors [here in Canada]. (Interview 1, Oct. 10, 2008)

For another IMD, the frustration comes from not knowing what to improve while she writes the exams; all the while, the time since she last practiced medicine is growing longer year by year:

> Actually, the main challenge is, I don’t know what is my deficiency. Because, it would be better if they would tell me that, you are not matched because you have lackings, or you have not that kind of knowledge in this, this and this area, so, improving in this area, they could tell us the things. It would be better for us so we could see where is our deficiency, and, we could try to improve us. Because when I did my research in Bangladesh I wrote Canadian exams. I thought that, if I pass all these exams, I’ll be definitely in the system. But when I came here I did all my exams. Now, I don’t know. Ask them: taking me there will be gap of practice. One interviewer said you have a gap in your recency of practice. So, I don’t know what to say about this. And, they don’t give us any reason, and, I think this is not also a transparent process. (Interview 11, March 31, 2009)

The image of transparency repeatedly appears in the interviews of three IMDs, something that they feel the licensing process in Ontario is lacking. In terms of agency, transparency represents a situation where one wants to act, but cannot, because one cannot see. Decisions are made about them and IMDs want to improve, but they don not know what to improve.

> Other metaphors used by IMDs to describe their experience of the licensing process are equally powerful. Even more intense than the image of the opacity of the process is that
of darkness. This IMD talks about trying to get into the system in a metaphor that combines target shooting (with the target being getting licensed) and darkness:

> You were completely in the dark, and we were just shooting in the dark, you know: one day, maybe, one day I get in. (Interview 1, Oct. 10, 2008)

This image is compelling in how it captures the frustration of the IMDs: Where is their target? What is it? They cannot see to aim properly. If they could only see, they could hit that bull’s-eye. There is action in the image, as the IMDs are shooting: They are trying, but they are hampered by a system that is not transparent. In fact, there seems to be an element of danger to the image…a kind of randomness in the group taking aim in the darkness collectively that could endanger, if not themselves, then, perhaps others. All of these images share a common theme: that of what Lakoff and Johnson call “understanding is seeing” (p. 48). The IMDs’ metaphors express a connection between understanding the licensing process and being able to see it. Because they do not understand it, their images emphasize the lack of transparency of the system, and even the darkness they are shrouded in while they shoot (i.e. reach their target of getting into the system).

Interestingly, another IMD chose an image that included a weapon, like the previous one that describes “shooting,” but this one is quite different in its impact. She describes the challenges the IMDs face in trying to attain licensure as “fighting without weapons” (Interview 17, June 18, 2009). Here, she talks about the pain she feels when she thinks of the suffering of the IMDs:

> That really, you know, pains me, that. They’re kind of you know like - it’s like fighting without weapons. They don’t have weapons and yeah, they have taken their weapons from them and we are asking them to fight so – how are you going to do that? That’s - that’s very bad. (Interview 17, June 18, 2009)
Here, the image of the battle is much more hostile than the previous one, where the system was a kind of disembodied force that had seemingly surrounded the IMDs with darkness as they shot at their target. Now, the IMDs not only have no weapons, but those weapons have been taken by the foe. They are asked to fight, but in this image, their chances of success seem slim, and their lives appear to be at risk. The images this IMD chooses to represent the experience of IMDs seeking licensure show a daunting and overwhelming experience fraught with danger, and even the threat of death. According to Lakoff and Johnson (1980), this constitutes a specific kind of personification of the licensing process: “licensing process as adversary.” When one personifies a complex and abstract system into an adversary, they argue, it can help to make sense of the experience. Here, they discuss this dynamic in relation to “inflation as adversary”: “When we are suffering substantial economic losses due to complex economic and political factors that no one really understands, the INFLATION AS AN ADVERSARY [sic] metaphor at least gives us a coherent account of why we’re suffering these losses” (Lakoff & Johnson, 1980, p. 34). Thus, the metaphor the IMD chooses to describe the experiences with the licensing process is a way to make sense of the system and to personify what she perceives as its cruelty: an opponent who takes the weapons from the IMDs and still demands that they fight. What is also interesting to note is that, despite the fact that this IMD was successful in gaining entry into the system, as well as the IMD who used the “shooting in the dark” image, their eventual success did not soften the images they used to describe the licensing process.

Other images reflect the experiences of the IMDs in different ways that reflect different perspectives on the problem. For example, one IMD uses the image of a closed door
to represent his experience with being unable to receive feedback on his performance in the
licensing process:

But, but I, I didn’t have anything after that because the door was closed to me
and I don’t know the reason. See, if I knew the reason, I, if I knew what is the
challenge for me, if somebody told me, I could have tried to overcome
that….The, the biggest thing for me is, people who are selecting residents are
not telling how they select residents. (Interview 4, Nov. 6, 2008)

Here, similar to the image of shooting in the dark, the IMD had agency and willingness to
improve, but no feedback. To him, it felt like a closed door to the place he most wanted to
go. Another IMD who was older chose an image that focused on the difficulties that a more
experience IMD would face. In fact, her son was a newly graduated doctor in their home
country, and she felt that he would be successful:

Young doctors, my son, they can give, get that residency program, like four
year residency, three year residency whatever. But for the experienced
doctors, is very difficult to go to the again back to that residency. Like it is a
start from the zero. (Interview 6, Feb. 19, 2010)

For her, being an experienced and older IMD meant a particular challenge: Could she go
back to first year post-graduate training and train alongside young twenty-something medical
school graduates? Her image of the licensing process is about going back to zero: zero status,
knowledge, starting again at the age of 50. This is clearly more difficult for someone who has
more to give up. This was reflected in the findings of Wong and Lohfield (2007) who
identified younger IMDs with less experience as having an easier time integrating into the
system.

A final metaphor is an interesting shift to a more spiritual tone: this IMD reflects on
his experience in the licensing process as partly in his control (what is in his hand) and partly
outside of his control (the rest) and uses this image to give advice to other IMDs on how to
approach the challenges: “whatever was in my hand I did that. Do whatever is in your hand
and leave the rest to God” (Interview 15, May 9, 2008). This kind of hopeful approach mirrors his optimistic attitude about life in general. When he told the story of getting into the system (he was also successful in doing this), he recalled that he only had one interview and that he had to make it count. This image of using/doing whatever is available is a suiting image for his success, and still one which acknowledges that there are many things over which we do not have control.

This exploration of the metaphors and images that IMDs use to describe their experiences in the licensing process has added insights into how they understand their relationship to the system. Almost all metaphors and images used by the IMDs to describe their experiences were negative, and included connotations of a lack of control or a struggle to maintain control under difficult circumstances. Even the positive image, of doing whatever was in your hand, acknowledged that the rest is out of your control. Although the thematic content analysis was able to provide key themes that related to challenges in the licensing process, such as language proficiency, or preparing for examinations, the metaphor analysis contributed something qualitatively different: emotion and relation to the experience of being in the licensing process. By examining the dynamics behind these metaphors that Lakoff and Johnson’s (1980) analysis offers, such as “understanding is seeing” and “licensing process as adversary,” further insight was gained into the relationship being depicted by the IMDs with the licensing process. These findings, especially the emotions I imagined to be behind the metaphors, supported the development of the poems (particularly “Doctor Shortage” and “Tell Us About Yourself”) and also contributed to the overall Activity Theory model, which will be presented in Chapter 7.
Summary

Through the exploration of two research questions, one regarding enhancers and barriers to success in the residency interview, and the other regarding IMDs’ experience of the licensing process, with a particular focus on language proficiency, a clearer image of medical licensing as an activity system has emerged. The answers to these two research questions helped to clarify the aspects of Vygotskian sociocultural theory that were relevant to the IMDs’ situation. Overall, the nature of learning from a Vygotskian sociocultural perspective and the concept of mediation emerged as key concepts: Without experience in residency interviews and the Canadian system and medical culture and without the crucial clinical observerships to make sense of the system through the eyes of a licensed MD, how can the IMDs mediate their transition into the new system?

The analysis of the metaphors used by the IMDs to explore their experience of the licensing system led to a powerful collection of images, including “shooting in the dark,” “fighting without weapons” and “closed door.” These images revealed the emotions experienced by IMDs and their orientation to the task as they sought to reclaim their status as MDs in a new country. Without the appropriate learning supports and feedback on their performance, unsuccessful IMDs truly are “shooting in the dark” to guess how best to prepare themselves for next year’s match.
Poem Two:
A Frame for “Tell Us About Yourself”

“Tell Us About Yourself” reflects the focus of this thesis on the residency interview as a selection tool. While the previous chapter presented the findings related to enhancers and barriers to success in the residency interview, the thematic content analysis could only partially capture the emotions expressed by the IMDs in relation to this high-stakes gatekeeping encounter. How would it feel to have your once-a-year chance to return to medical practice hinge on a screening tool that was so unfamiliar? The interview as performance is evoked here through the italicized lines, which are all “classic” interview questions. The juxtaposition of the classic interview questions with the emotive, unscripted responses of the IMDs is intended to highlight their quandry and the emotions that they feel when facing such a daunting task. Towards the end, the poem shifts to another major theme related to the interview and licensing process overall: the lack of feedback and transparency.

In “Tell Us About Yourself,” the italicized lines of the “interviewer” were used to structure the poem and move the story along. The unitalicized lines are all verbatim excerpts from the transcripts. Only the third excerpt, which follows “What is your greatest strength?” was slightly altered to make the voice consistent across the lines. The poem ends without the IMDs answering the final question. The real ending is thus left open for the reader to decide: Do they have something left to add, but remain silent out of frustration or resistance? Have they left for another country, as many IMDs do? What else might this silence mean?
Poem Two:
Tell Us About Yourself

Please, have a seat.

What they want in the interview,
That is the biggest worry:
It’s the most important thing.

Tell us about yourself

It was dreadful here, because I didn’t really know
What they wanted.
What is the selection criteria, is not clear:
It's all about the soft skills, not about the knowledge,
The medical knowledge.

What is your greatest strength?

I don’t know what they want, exactly.
They want you to be relaxed or they want you to be nervous.
If you are relaxed, they may think you are a cool doctor,
Which is not good.
If you are too nervous, then they may think
“Oh my God, how is he going to deal with emergency situations!”
If you’re over-confident, then
“He’s over-confident, and I don’t know how he’s going to deal with his colleagues!”
If you’re not confident, then,
“Oh my God, he’s going to be bullied by his colleagues!”
I don’t know what they want exactly.

What is your greatest weakness?

When I went for the interview, it was a totally new concept for me
In terms of what they ask and what I have to say.

Where do you see yourself in five years?

"You're not in!"
No idea, no feedback, no idea, no nothing.
If you’re not practicing -- the more years you’re not practicing,
You’re losing some of your knowledge

Is there anything else you would like to add?
Chapter Seven: 
The Activity of Medical Licensing

This chapter will now focus on the licensing process as an activity and the ways in which Vygotskian-inspired Activity Theory can support the further illumination of these experiences. The activity theoretical analysis is the culmination of all other aspects of the study; as such, it functions as a synthesis of all results. In order to best illuminate the activity of medical licensing in Ontario, the options for the Activity Theory model will be discussed in detail, as well as the important aspects and “contradictions” of the activity from the IMDs’ perspective. This chapter will culminate in a new Activity Theory model which attempts to capture the history of the IMDs’ activity and the origins of the contradictions their activity system faces on their arrival to Canada.

First, I will discuss the model “The Activity of Medical Licensing in Ontario,” which is Engeström’s Activity System model applied to this context (see Figure 7 that follows). While this functioned as an initial model in the early stages of the research process, it became apparent over the course of analysis how inadequate a single model of the activity would be to represent the complexity of the relations between IMDs and the licensing bodies. One of the main reasons for this is that the IMDs are not members of the community in the activity: They are trying to gain access to membership. As such, the activity represented below really depicts the selection and screening processes applied to IMDs when they seek licensure. What is of note regarding this model is a dynamic, the importance of which will become clearer a bit later on: Virtually all tools used to screen and license Canadian-born graduates are identical to those used to screen and license IMDs: the examinations (except the CE1 examination), the match application package, the North American employment-style
residency interview. Thus, while this model did function as a useful heuristic to identify the various players in the process and the tools that mediate that process, it was unable to further elucidate the activity of the IMDs precisely because they exist on the boundaries of the activity, as objects of the medical licensing system, with only a small proportion gaining entry.

Figure 7. The activity of medical licensing in Ontario.14

How, then, to best represent the experiences of the IMDs? As seen in Chapter 3, one of the suggestions of third generation Activity Theory is the representation of multiple interacting activity systems (Engeström, 2008). A possible representation of this is found in Figure 8 that follows. This interacting model makes it possible to highlight concepts and dynamics not possible in the previous single one. For example, what is the source of the rules

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14 Special thanks to Ivan Webb at University of Tasmania for this template.
that the IMDs seeking licensure operate under? They are subject to the rules of the licensing bodies, and the interacting systems depict this through the dashed lines. As well, it is clear that the overlapping area of the objects of these interacting systems is not large: The experiences of IMDs seeking licensure represented above confirm that they face multiple challenges and long years of struggle to gain entry into the system. Reflecting on exactly what is contained in the overlapping objects is helpful: Licensing bodies in Ontario are mandated to allocate a certain number of IMD positions each year, with many more IMDs than positions: the small red circle is the “Potentially Shared Object” of the two activity systems and represents the quota of IMDs selected. The object, however, varies according to the particular activity system: For licensing bodies, the object is to ensure that the most capable IMDs are selected, for IMDs the collective object is to have the most IMDs selected as possible, and for an individual IMD’s activity system, this would represent being selected him- or herself.

Figure 8. The activity systems of IMDs and medical licensing.
However, the static nature of this representation of these two interacting activity systems remains, in many ways, a dissatisfying display. One of the facets of Activity Theory that Yrjo Engeström highlights is its historicity (Engeström, 2001): The fact that all activity systems are embedded in a historical context that is necessary to understand to grasp their current meaning. This is another aspect of these two activity systems that is not visible in the model above, and over the course of the data analysis, it became apparent how crucial historicity was to the understanding of the IMDs’ activity system and its relationship to that of medical licensing. In order to work towards a more dynamic representation of these two activity systems, this discussion will now shift to the historicity of the activity system of the IMDs. Unquestionably, their activity system is influenced by the context of their immigration and their reasons for doing so. The interviews with the IMDs revealed important themes related to their reasons for choosing Canada, their understanding of the licensing process pre-arrival, and their reasons for persisting in the licensing process, despite its challenges.

First of all, the IMDs’ reasons for choosing Canada. Overwhelmingly, IMDs who are parents, which includes all of the 15 IMDs interviewed except for one (the youngest who is unmarried), see Canada as a better future for their children, especially with reference to education. The fact that immigrants can become full citizens in Canada was mentioned by more than one IMD, especially those who had studied medicine or practiced medicine in other countries before coming to Canada. For example, one IMD recognized that, despite the fact that he was training in a prestigious speciality in a European country, he would never be fully accepted there and would face a kind of glass ceiling in medicine, above which he would never rise because he was an immigrant. He felt that Canada, with its diversity and as a “country of immigrants” would be more accepting and allow him to reach his highest
ambitions. Repeatedly, the theme of Canada as a “land of opportunity” was raised by IMDs from many different countries. This historical back drop to the IMDs’ licensing experiences is crucial to know, due to its contrast with the reality they face when they arrive.

A second major point connected to this argument is IMDs’ pre-arrival understanding of what was required to be licensed in Canada. Of the IMDs participating in this study, in addition to practicing in their home countries, three had also practiced in other countries before coming to Canada. One IMD from the Middle East had learned a completely new language in order to compete to enter training in Europe. Two other South Asian IMDs had emigrated to South Africa and Abu Dhabi, respectively and had both practiced there. Particularly for these IMDs, the challenges to get licensed were baffling. As the one IMD who had practiced in South Africa observed:

I wanted a good place to educate [my children], right? I also believe[d] that I will be able to practice. So, I came [in 1998]. No, I mean…I will go through the process and be able to practice….I knew that if you go to other country you have to go through the process for license. (Interview 9, March 5, 2009)

The expectation of being licensed after fulfilling certain criteria was common not only to those IMDs who had practiced in other countries, however. Many IMDs commented on the fact that they had passed all the same examinations as the Canadian-born doctors, and wondered why they would not be accepted into the system. This expectation strongly reflected their perception of the activity which they believed they were participating in.

Finally, a third point related to the historicity of the activity system of these IMDs is their rationale for persisting in a process that, based on the metaphors presented and analyzed above, is a bewildering process lacking in transparency. Of the 15 IMDs interviewed, 13 talked about their motivations for pursuing licensing under such difficult conditions. Of the two who did not discuss this, one had stopped trying after many years of no success, and the
other, although he talked at great length about his ongoing efforts, did not directly address his reasons for continuing his efforts to practice medicine in Canada. For those who did discuss this, there were a number of striking themes. The first of these was an opposition established in several of their discussions of the fate of not being licensed vs. the need to keep trying. The images of not getting licensed included images of joblessness, not fitting into society, and working in a grocery store in a job totally unsuited to one’s abilities. For one IMD who, many years earlier, was about to sign a contract with her husband to buy a business, the thought that she might not ever practice medicine again felt like a “death sentence” (Interview 17, June 18, 2009). It was this realization that continued to inspire her throughout several years of struggle to enter the system. So, on the one hand, the thought of not being licensed was unpalatable and unthinkable. On the other hand, many IMDs talked about their passion for medicine, their considerable investment of time and effort in becoming a doctor, and their patients and how these motivated them to continue trying. For example, this IMD, after describing her enjoyment of the hospital as a workplace, talks about how she liked to “work with the patients to help them relieve their pain, their disease, to help them” (Interview 2, Oct. 23, 2008). The contrast of these two images, of the consignment to never practicing medicine again and the pull of their passion for their chosen profession provides a moving image of the two extremes between which the IMDs found themselves.

Finally, two of the IMDs, in describing their motivation to continue pursuing their licence make a powerful linguistic statement about their identity:

P1: Like it was my dream to be a doctor, and I am a doctor and I want to continue with that. (Interview 5, February 17, 2009)

P2: I’ll not…I’ll not give up my profession. I am a doctor. I will be a doctor. (Interview 11, March 31, 2009)
The inextricable link between identity and profession becomes clear in these examples, in which the IMDs assert themselves linguistically. Despite the fact that they are not being recognized in this country, they are doctors, and there is a future for them in their identity as a doctor. Having seen the push/pull motivations and the powerful identification of IMDs with their profession, the importance of these motivators to their activity system as influences becomes clearer.

In fact, when examining the activity system of the IMDs in detail, it becomes clear just how different their activity is from that of the licensing bodies. Having examined their activity system in the context of their immigration motives and beliefs about their chances to practice medicine in Canada, it becomes clear that IMDs come to Canada because they are attracted to the fact that they can become full citizens here. Their respect for the education system and their desire to see that their children have the best education possible are other motivators of their move. However, many believe that they will practice medicine in Canada if they go through the licensing process. Once they arrive, they realize that their chances may be slim, despite having passed all the same examinations as Canadian graduates. Some may seriously consider the idea of giving up their profession, as four did in this sample of participants. However, of these four, two decided that they would pursue licensing when they realized how they would feel without trying. Indeed, as seen above, the IMDs’ identification with their profession is so strong that one even equates a loss of her profession with the loss of her very life. When considered together, these factors and motivations within the IMDs’ lives create what I define as an Integration Motive for their activity system: While they recognize that they are changing countries and medical systems, the extremely high stakes for their identity and their considerable investment in their profession mean that they plan, in
most cases, to practice medicine in Canada, even when they recognize the extended nature of
the efforts required to achieve this.

As described in the introduction, some of these assumptions are based on the policies
of the very immigration system that selected them: At the time of writing, Specialist
Physicians (#3111) and Family Physicians and General Practitioners (#3112) remain on the
Citizenship and Immigration Canada website within the list of only 29 professions that may
apply for immigration to Canada as skilled workers.\textsuperscript{15} It might not be such an irrational
assumption that one’s skills would be put to use when they are the basis for acceptance to a
country with an identified doctor shortage. The integration motive is strongly felt by the
IMDs before they immigrate and also upon arrival. However, when they arrive, their
integration motive faces severe challenges.

The contradiction between the IMD’s integration motive occurs because the medical
licensing system is operating from a selection motive. Immigration now creates a surplus of
IMDs and the task of the system is to screen them and select the “best” ones for training and
entry into the Canadian system. Many IMDs are able to pass all of the licensing examinations
that Canadian medical graduates write, as some in this study had, and yet they are not able to
access a training position. Note that, in decades past, the low level of immigration of highly
educated immigrants, such as doctors, meant that the system was relatively open to IMDs
(Cesa, 2004). However, as the profile of immigrants shifted, the demand for positions
increased and the number of IMDs competing for positions also increased, along with the
need to confirm the credentials of IMDs coming from countries with systems less familiar
than the previous IMDs, who were mainly from Europe (Cesa, 2004). Many IMDs clearly

\textsuperscript{15} \url{http://www.cic.gc.ca/english/immigrate/skilled/apply-who-instructions.asp#list}.\n
felt that being approved for immigration on the basis of their medical expertise implied a commitment to support their licensure, and yet they encountered a system that only focused on selecting a few for training from the many arrivals. As Engeström (2005) argues, contradictions such as this one within interacting Activity Systems are important to acknowledge: the motives of the IMDs were established in part through their understanding of the Canadian immigration system. On arrival, their integration motive contradicts the selection motive of the Medical Licensing Bodies. Tensions and contradictions such as this are sources of “change and development” (Engeström, 2005, p. 64) within Activity Systems.

One of the most powerful ways to demonstrate the contrast between the activity systems of the IMDs and the licensing bodies is made clear is through the suggestions made by IMDs to improve the licensing system. Their multiple concerns with the licensing system have been covered in detail above: the lack of transparency, the lack of feedback, and their concerns about how to access the cultural content needed to succeed in the examinations that they need to write to join the system. When IMDs were asked how best to improve the system, their suggestions all involved shifting the current “selection” system to a more “integration”-oriented one. These suggestions varied; none of them involved doing away with the examinations completely, but rather having the system make a commitment to individuals to support their entry into the system through education and feedback. Examples of this included supervised practice for IMDs who pass all the examinations, or access to volunteer and research positions to support their licensing activities. A suggestion made by several of the IMDs involved a more substantial bridging education program that would also function to screen the IMDs and provide feedback on strengths and weaknesses that the IMD could then go off to work on and improve. While a bridging program such as this is a more
substantial commitment, one other suggestion was as simple as sharing more samples of examination questions with Canadian content to help IMDs learn the system:

    And when they give the answers they should explain why they, they want those kind of answers because sometimes it’s quite -- you know sometimes you can find two answers that can be the right one and explain. I know I think that the international physicians want to know to understand the system…The thinking of it because there is I think that for a Canadian they don’t need too much to study because when you understand, everything it is elementary. (Interview 16, May 11, 2009)

What all of the suggestions made by the IMDs to improve the licensing system have in common is that they are shifting a currently non-transparent selection-oriented system to an open integration-oriented system.

    The relational model (Figure 9) that follows is an attempt to capture the disconnect between the activity systems of the IMDs, Canadian immigration and Medical Licensing, while at the same time highlighting the learning needs of the IMDs. In comparison with the Activity System models presented above, which are static snapshots of collective activity at one moment, this relational model represents the interaction between three activity systems (the IMDs’, and those of Canadian immigration and medical licensing) over the stages of the IMDs’ arrival in Canada and highlights the sources of contradictions identified by Engeström as being key to future development of activities. The contradiction between the activity systems of the IMDs and Medical Licensing is the motive. IMDs have an integration motive, which led them to assume that Canada would support their licensure. On arrival, however, they find that the mediation they need to internalize the accepted practices in the Canadian setting is difficult to access. Many IMDs are unable to even arrange to observe a licensed Canadian doctor in practice, or participate in sustained bridging education with members of the medical profession.
The limited number of residency positions available each year means that the motive of the licensing bodies contradicts the integration motive of the IMDs: they must maintain a selective motive in which they allocate the limited training positions to the “best” candidates. However, the licensing bodies continue to use tools that are strongly mediated through the Canadian context: Are these the best tools to select international candidates? Another contradiction that arises is the question as to whether the “best” candidates can be selected when there is unequal access to appropriate support during the competition process. One resolution of this contradiction of motives is, when IMDs realize the number of years which may be required to practice in Canada, if at all, they may begin applying to the United States or leave Canada for another country. By viewing the three activity systems (IMDs, Medical Licensing and Canadian Immigration) in relation to each other, larger questions also arise about the relationship between the activity of Canadian immigration and the Licensing Bodies: Ultimately, is it ethical for Canada to attract IMDs from countries that often have their own doctor shortages if we know that most of them will not be licensed?
Figure 9. Activity Systems of IMDs and Immigration and Licensing Bodies.
Summary

Sociocultural concepts such as mediation, internalization, the zone of proximal development, and emotion and consciousness have all provided effective support to the analysis of the interview data in this study. However, an Activity Theoretical analysis contributes another level to this analysis: a view from a larger perspective of the individual IMDs within the systems of immigration and medical licensing. Activity Systems are collective activities with multiple actors. In order to complete this Activity Theory analysis, data from all aspects of the study were combined to construct the system. By taking a system-level view, the Activity Theory analysis and model in Figure 9 have facilitated the identification of a number of contradictions in the system that could drive change.

The supply of IMDs in the Canadian system has increased, and created a resultant shift in the medical licensing system to a selection motive. However, the tools and processes that the system is using to select the “best” IMDs are all taken, without adaptation, from the selection process for Canadian-educated graduates. Will this transplanted process select the best IMDs? Data from the medical literature and this study suggest that this is not the case. Meanwhile, based on their experience in the immigration system, IMDs arrive with an integration motive, however access to the learning opportunities that they need to succeed in the examinations and training competition is unequal. Some of these contradictions have ethical implications, such as Canada’s immigration policies regarding IMDs and our reputation as a global citizen; similarly, IMDs’ requests for a transparent and effective selection process should not be forgotten. An Activity Theory analysis has helped to reveal some of these important considerations.
Chapter Eight:  
Discussion and Implications

Using a Vygotskian sociocultural lens, this study examined the experiences of a group of diverse International Medical Doctors seeking licensure in Ontario. The main data used to answer the three research questions were interviews with 15 diverse IMDs and three bridging program staff/educators. Overall, the findings indicate that, in many cases, IMDs demonstrate awareness of their knowledge needs on arrival to Canada in relation both to medical/cultural knowledge and language proficiency, but they struggle to access the meditational means needed to “translate” their medical knowledge into this new context, particularly with regard to the examinations required for licensing.

In what follows, I will review these results in detail under the following three main headings: IMDs’ Knowledge Needs and the Canadian Context, and Policy Implications: Licensing and Access to Mediating Knowledge and Language Proficiency and IMDs’ Licensing Experience. Finally, I will make some recommendations for further study. The dissertation ends with a final reflective poem.

**IMDs’ Knowledge Needs and the Canadian Context**

What knowledge needs have IMDs identified that, if met, they believe would support their transition into the Canadian context? From a Vygotskian sociocultural perspective, although the needs might be in different areas, the identified knowledge needs of IMDs are all meditational means to support their professional transition. First, IMDs found the licensing examinations difficult without appropriate support: Some were concerned about the unfamiliar format of the OSCE examinations and others were concerned about the lack of supporting preparation material to facilitate their understanding of the rationale behind the
correct answers on multiple choice questions with Canadian ethical and cultural content. Without an explanation of why a certain culturally-bound response was preferred over others, the IMDs felt that they were at a loss to mediate their responses with the correct cultural framework. When they used their own cultural framework to choose the answers, they were sometimes unable to identify the correct response. The ideal experience that they felt would support their acquisition of the “hidden” knowledge required to succeed during the licensing experience, a clinical observership, was difficult to obtain and dependent on factors such as “who you know” in the system.

It is important to note that, even with a substantial number of clinical observerships under her belt, one IMD participant in this study acknowledged that she did not truly understand why the doctor she was observing did certain things in practice until she had the opportunity to take part in the ESP Medical Bridging Program. Thus, bridging education can play a crucial role in supporting IMDs’ internalization of what they see in the clinical practice of physicians here in Canada. As reported above, when asked what they found most helpful about the bridging program, many of the IMD participants commented on their learning with the standardized patients and the insights they gained about doctor-patient communication in the Canadian setting. In this sense, the ESP Medical Bridging Program provided some of what IMDs were requesting in the paragraph above: authentic communication practice and exposure to SPs, which are used in the OSCE-style CE1 (now NAC) assessment examination. However, the Bridging Program has since been cut, and there is no equivalent government-funded bridging education in Toronto with face to face classes that offers the opportunity to interact with SPs.
Another area where bridging education did appear to be successful was in supporting IMDs in gaining understanding to the “hidden rules” within the genre of the North American-style job interview, although they continued to struggle with the lack of clarity around the selection criteria. One question raised by the findings is how the interview preparation program can reach IMDs who are not aware of the importance of interview preparation: Program staff reported numerous cases where IMDs came for training after two or three failed interview attempts and realized only after receiving the scaffolding of a trainer how inappropriate their previous responses were.

While the residency interview has long been used as a selection tool with Canadian-born residents in Canada, and American-born residents in the United States, its adoption for the selection of IMDs adds further complicating factors to the selection mix that were identified in the findings: the lack of experience of almost all IMDs with the North American-style job interview, and the cross-cultural challenges that they face in performing in such a high stakes context. These themes were also identified in Wong and Lohfield’s (2008) study, where IMDs recalled the trials of the licensing process, with its lack of clarity and feedback, along with the realization that if they behaved in residency in accordance with their own cultural values (e.g., modesty and humility), they would be viewed negatively. The interview is a tool taken from the selection process for Canadian-born students and applied to IMDs, who must access appropriate coaching to learn the unspoken rules of this genre. While the bridging support has allowed those IMDs who access the interview preparation to be more ready for the North American-style residency interview, this study raises important questions about its suitability as a screening tool for IMDs. As one staff member emphasized,
“the best interviewee gets the position” and the question remains if the best interviewee is ultimately the best doctor.

**Policy Implications: Licensing and Access to Mediating Knowledge**

The findings of this study in relation to the difficulties faced by IMDs seeking licensure in Ontario have a number of policy implications. The difficulties IMDs face in obtaining the mediational tools (e.g., exam preparation supports, clinical observerships, and interview preparation) they need in order to succeed in the licensing process suggest that there is an immediate need to increase supports in the area of bridging education and examination preparation, beyond the expensive private schools that have no connection to the government or licensing bodies. This was also a theme related to Internationally Educated Nurses in Hearndon’s (2007) study. In addition, the currently unequal access to clinical observerships is particularly troubling when the reference letters from these are considered a key aspect of the competition for residency positions (Ginsburg, Schreiber, & Regehr, 2004). Just how important the reference letters are in the process, however, is not known, and this lack of clarity within the process itself regarding the value of the reference letters, exam scores, and the residency interview caused IMDs in the study enormous stress and concern. The powerful metaphors used by the IMDs to describe their experiences during licensing (e.g., “shooting in the dark,” “fighting without weapons”) reflect their feelings about its fairness. Given that the stakes the IMDs face are much higher in the annual selection process than for the Canadian graduates, who are almost all matched, it is worth considering taking steps to improve the transparency of the selection process through more explicit criteria.

As the findings from the Activity Theory analysis have shown, there are tensions and contradictions between the motives of the activities of the IMDs (integration motive) and the
motives of the Medical Licensing system (selection motive). The following policy recommendations address many of the challenges faced by the participants in this study. Because the results of the Activity Theory model revealed that IMDs had experienced a disconnect between immigration policies and the licensing process, some of these recommendations could harmonize the overall system. Because analysis of the interview data questioned the efficacy of a selection process developed for Canadian-educated graduates being applied to diverse international candidates, some of these recommendations suggest alternatives.

**Harmonizing Immigration and Licensing for Qualified IMDs**

If “Specialist Physicians” and “General Practitioners and Family Physicians” remain on the list of eligible occupations for immigration applications under the Skilled Worker Class, the Canadian government needs to improve its commitment to license those physicians who immigrate here. Right now, Canada will consider applications from up to 1,000 specialists and 1,000 Family Physicians per year (CIC, 2010), but the total number of IMDs admitted into training through CaRMs last year was only 380 across Canada (CaRMS, 2010a; 2010b). Canada needs to consider the ethical implications of an immigration policy that selects doctors on the basis of their credentials when their chances of getting licensed are approximately one in four each year in the CaRMs match. For those doctors who are accepted for immigration to Canada, funding should be earmarked for specialized supports that represent Canada’s commitment to licensing IMDs who immigrate here and meet the knowledge requirements to practice safely in this setting. An increased commitment is one way to ensure consistency between immigration and licensing programs with regards to
IMDs; otherwise, it is recommended to review the practice of accepting IMDs as Skilled Workers on the basis of their medical credentials.

**Bridging Education**

Bridging education has a crucial contribution to make in supporting IMDs’ transition into residency training, especially in scaffolding IMDs’ communication skills and cultural competency in this new practice setting. One IMD in this study who had accessed clinical observerships acknowledged that she did not understand some of the practices she observed in the clinics and hospitals until she received support from the ESP Medical Language Bridging Program. Virtually all IMDs in this study requested more substantial bridging education be made available to support their efforts at licensure. Especially in areas where a high concentration of IMDs settle, the government should ensure the accessibility of meaningful bridging education opportunities for IMDs. This is part of a full commitment on Canada’s part to the IMDs who immigrate here as skilled workers.

**Review Role of Clinical Observerships in Selection Process**

The results of this study show that access to clinical observerships is unregulated and inconsistent, with many IMDs unable to access this kind of exposure to the system. At the current moment, access to these is dependent on factors such as whom the IMD knows in the system, or the luck of the draw. IMDs in this study felt that access to clinical observerships would improve their success in the licensing examinations and also in the match. What impact do clinical observerships have on IMDs’ chances of success in the match? It is currently not clear how much weight a reference from an often brief Canadian observership
is given, for example, in relation to a professional reference from an IMD’s home country. Clearly, a review needs to be undertaken of the selection process to increase understanding and transparency of the role of clinical observerships in IMDs’ interview and match success. Given that access is currently inconsistent, if clinical observerships are, indeed, impacting the ability of IMDs to access a residency training position, that should give pause for concern.

Clinical Observerships as Part of the Application Portfolio

Vygotskian sociocultural theory emphasizes the role of social interaction and context in learning, and sees assessment of future development as integral to the learning process. For this reason, clinical observerships offer an ideal opportunity to not only facilitate IMDs’ acquisition of the relevant language and cultural skills in the proper setting, but also to assess their potential for integration into the system. Dynamic Assessment uses Vygotsky’s dialectical approach to teaching and learning to provide a means of “more accurately assessing an individual’s potential for future development by embedding instruction in the assessment process” (Lantolf & Poehner, 2009, p. 13). If there is a will to invest in these observerships, then they could be used as a Dynamic Assessment tool and included in an IMD’s application portfolio for the CaRMS Match. Observerships would only be granted to IMDs whose exam scores show promising levels of knowledge. These observerships could be supervised by specially trained Family Physicians who use Vygotsky’s educational concepts of scaffolding and the Zone of Proximal Development to assess not just the current performance of the individual IMD, but the future potential. This construct, I believe, could better represent those IMDs who are more culturally adaptable and best suited to residency positions. Standardized training on assessment for the MD mentors in these observerships,
along with the universal access to these opportunities would increase the fairness for all
IMDs, and offer them an opportunity to learn in practice, which is the source of sociocultural
learning. It is acknowledged that a program like this has resource implications. A pilot study
could be used to establish whether this model contributes to the ability to predict success in
residency training, and perhaps, the licensing examinations.

**Transparency of the Selection Process**

The transparency of the selection process must be increased so that IMDs can
understand more clearly how their file and performance are being judged. The IMDs in the
this study objected to the current process on a number of counts. First of all, the actual
selection criteria and the weighting of elements in the file (e.g., the reference letters, exam
scores, personal letter, and the interview) are not released. IMDs’ metaphors, such as
“shooting in the dark” reflect their feeling that they are applying without any sense of what
the target is, and therefore, how to aim for the target. When the stakes are so high for the
annual match, and missing your chance means one more year out of practice, IMDs deserve
more clarity around how the training positions are being awarded.

A second, and related, objection is that this annual process concludes without any
feedback on performance. Do I need to improve my spoken English? Were my answers to the
interview questions seen to be culturally inappropriate in some way? My exam scores are
very high, and I thought my interview went well: what happened? These are some of the
questions that IMDs asked themselves when they found out that they were not matched. It
must be acknowledged that Canadian graduates do not receive feedback on their application
package, either; however, almost all Canadian graduates are matched, so their stakes are not
the same as those of the IMDs. Increasing transparency in the process could include releasing rubrics used to assess interviews, reference letters, and personal letters. The assessment in the file could be released to the IMD so that he or she could work on improving elements of it for the next year. The approach is currently used with the examinations (e.g., CE1 and QE2), which provide a summary of performance and support the candidate in identifying areas of weakness for future improvement.

**Interview Alternatives**

The findings of the current thesis question the validity of the interview as a selection tool due to IMDs’ lack of previous exposure to the genre and its culturally bounded nature. Research in the resident selection literature recognizes that there are validity issues with the interview as a selection tool, even for Canadian- or American-educated graduates. A valid evidence base on how IMDs are selected is crucial both for fairness and for future improvements to the system. In fact, a recent finding by the Quebec Human Rights Commission recommended the validation of the selection process, due to a challenge by IMDs who were not selected in Quebec when they had passed all necessary examinations, even when spots remained empty. The Commission recommended “that the universities, to this end, set up a validation process for the criteria and selection tools so as to ensure that applications of IMG physicians are assessed objectively according to the qualities and skills required to access the postdoctoral training program” (Commission, 2011).

Alternatives exist, such as the Mini Multiple Interview, originally developed at McMaster University. As discussed above, this format has been applied to IMDs in Alberta with some promising results (Hofmeister, Lockyer, & Crutcher, 2009). As well, there is a
new online interview tool being developed at McMaster University for medical student selection, the Computer-based Multiple Sample Evaluation of Noncognitive Skills (CMSENS) that shows potential (Dore, Reiter, Eva, Drueger, Scriven, Siu, Hilsden, Thomas, & Norman, 2009).

Scaffolding Knowledge Needed for Examinations

IMDs in this study had requested more supports to allow them to understand the reasoning behind correct answers based in Canadian medical practice culture. At the current time, minimal resources exist that support the acquisition of knowledge in an examination preparation context. The small number of sample questions available do not explain the reasoning for the correct answer, and thus lack the scaffolding necessary to allow IMDs to comprehend the decision-making processes of the Canadian context fully. Thus, despite their strong desire to acquire the means to independently mediate their own selection of the correct answer, IMDs can struggle to identify what the correct answer is, because their medical knowledge is still mediated by their context of training. Although the Communication and Cultural Competence (CCC) website does an excellent job of introducing the C2LEO objectives needed for success in the QE1 examination (and ultimately, in Canadian practice), Sociocultural Theory acknowledges the importance of context in learning and would argue for examination specific supports. Perhaps a supplementary module could be developed that would demonstrate how the knowledge gained through the CCC might appear in the examinations and provide a scaffolded walk through a number of examples.
Dedicated Spaces for IMDs in the IMG Pool

A 2010 CaRMS study of Canadians Studying Abroad in foreign medical schools estimated the total number at approximately 3,500. IMDs must compete against these CSAs for the limited residency positions, and the perception of some participants in this study is that they are the preferred choice of program directors. Given that CaRMS matched only 380 IMDs and CSAs total in 2010 for residency position, it is hard to imagine how Canada can absorb 3,500 CSAs into the system – over 90% of them intend to return here for residency training -- without disadvantaging the chances of many IMDs to ever access training (CaRMS, 2010d). For this reason, it is worthwhile for the Ontario medical licensing authorities consider protecting a number of positions out of the “IMG” pool for immigrant IMDs only, in order to ensure their ongoing access to training. This action would affirm Canada’s commitment to IMDs who immigrate here as Skilled Workers on the basis of their medical credentials.

Language Proficiency and IMDs’ Licensing Experience

The experiences of IMDs who arrived with lower levels of English language proficiency were a particular focus of this study. The participants in this study who arrived with less than fluent English were smaller in number in the sample of IMDs interviewed. One possible reason to account for this is that the top two countries of origin for General Practitioners are India and Pakistan, which account for over 20% of all GPs to arrive in Canada, and all participants in this study from those two countries reported having English-medium education from their earliest schooling and studied medicine in English, as well (TIEDI, 2009b). The three participants who could be characterized as having lower English language proficiency were from Belarus, the Ukraine, and China, and had limited exposure to
English in school, and, particularly, few opportunities to speak English. Despite the fact that the first two of these participants had made significant sacrifices pre-arrival to improve their English, including a year off of medical practice to study full-time and working as a personal support worker in an English-speaking country for four years, they both struggled to meet the minimum TOEFL standard to apply for licensure. This raises the question of how these IMDs could have been better supported, both before and after their arrival in Canada.

Clearly, there are currently differential outcomes for IMDs arriving with lower language proficiency, despite the fact that they recognized their weakness pre-arrival and took significant steps to improve before immigration. The National Task Force on the Licensure of IMGs acknowledged that the required TOEFL standard does not capture the communication skills needed to be successful in a residency program (Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, 2004). One of the possibilities that could be explored is to use an OSCE-style clinical examination to also assess language proficiency (Maudsley, 2008; Watt et al., 2003). The new National Assessment Collaboration (NAC) OSCE examination came out of recommendations from the National Task Force on the Licensure of IMGs. Each station will measure up to seven out of these nine constructs: “history taking, physical examination, organizational skills, communication skills, language fluency, differential diagnosis, data interpretation, investigations and management” (MCC, 2011). How is the construct of language fluency being defined for the purposes of this examination? Thus far, only one round of the NAC OSCE has been offered (March 18, 2011), so it is too early to know what kind of impact this could have on the licensing process, especially when IMDs would likely
still be required to provide some proof of proficiency through a standardized test earlier in the process.

IMDs who arrived with lower English proficiency were often dissatisfied with the LINC language training program, which is a generic instructional program for newcomers that is widely available. Some wanted a more demanding program, or a program that was more focused on the acquisition of medically-related language and communication skills. This finding is supported by the similar requests of the IENs who participated in Hearndon’s study (2007). In addition, the IMG Taskforce also recognized that a program in this area was needed back in 2004 (Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources, 2004). However, with the ESP Medical Bridging Program having its funding cut, IMDs have few options available for in-person classes that cover content specific to physicians, and nothing of a more extended length in the Ontario. Certainly, the literature regarding selection of IMDs, and also once they enter training, references the challenges related to language repeatedly, so language is not a problem that disappears once training begins (e.g., Chur-Hansen, Elliott, Kvern, 2001; Fiscella, Roman-Diaz, Lue, Botelho, & Frankel, 1997; Rothman & Cusimano, 2000, 2001; Steinert, 2006; van Zanten, Boulet, McKinley, & Whelan, 2003). In this sense, the findings of this study strongly confirm what the IMD literature is saying about the needs of IMDs once they enter training. What is concerning is that language proficiency appears to be creating unequal outcomes for IMDs who seek to practice in Ontario.

What kind of policy changes could address the current situation? IMDs who are planning to immigrate to Canada and whose English language proficiency is lower need to be aware of the challenges that they will face. The Canadian government has already taken a
significant step in the right direction through the formation of the Canadian Immigration Integration Network, which provides pre-arrival counselling and support to immigrants in the “final” stages of the immigration process. What is not clear, however, is whether the “final” stages of immigration would still allow for enough time to undertake the steps necessary to improve outcomes regarding language proficiency.

The following policy recommendations address many of the challenges faced by the participants in this research who had lower levels of English language proficiency prior to immigration to Canada:

- Increase the prominence and importance of language proficiency in the immigration process for IMDs. This must include up-front information for IMDs who are considering immigration to Canada that a lower level of English proficiency on arrival could jeopardize their chances of ever being licensed.

- Adapt the immigration process for IMDs to allow a time range of arrival for IMDs who are at risk due to language proficiency, allowing them to perhaps arrive in Canada a bit later after they have obtained a certain threshold of language proficiency. Online language assessment and training could also be offered from Canada for those who might have difficulty accessing it in their home country, or as a supplement to local training.

- Even with these procedures in place, however, it is clear that occupation-specific language support is needed for IMDs after they arrive; medically-related language supports would help improve their success in the licensing examinations, and also in residency training. Given that some IMDs in this study gave up generic language support.

training in preference for the demands of the licensing process, it is worth considering how to make language training for this group as relevant and accessible as possible.

**Further Study**

Even as it answers questions, research also discovers questions for further study. In this case, the small number of participants in this study with lower English language proficiency raised further questions about what happens to IMDs like them on arrival and what more could be done to support them. I recognize that, for the most part, my participants were individuals who felt comfortable talking in English, which is why they volunteered for an opportunity to be interviewed in English. While I speak one South Asian language, Bangla (Bengali), I did not feel confident enough in my fluency to undertake interviews at this level of complexity. Pursuing research with IMDs who arrive with lower levels of language proficiency may need a different approach to recruiting than this study took, perhaps through various cultural community resources or groups and possibly a bilingual researcher or research assistants to conduct interviews in the language that the participants would be most comfortable with. This is important work that needs careful attention in the future.

While virtually all IMDs requested more extensive bridging education to support their transition into the Canadian medical system, the evidence base on bridging programs is limited. Research that explores all aspects of IMD learning in the context of bridging education (e.g., communication skills, language proficiency, professionalism, clinical knowledge, etc.) would add to the literature, especially studies that are able to follow IMDs longitudinally into training and explore the long term impacts of bridging education. Given the recent studies on IMDs’ difficulties with licensing examinations in Quebec and British Columbia here in Canada, these new studies would be all the more important.
This study has also raised questions about aspects of the selection process. Certainly, research related to validation of the selection process would be highly beneficial, especially regarding the current employment-style residency interview and the role of clinical observerships and related reference letters in selection outcomes. If the residency interview is maintained as a selection tool, there are many studies regarding the interview that would be of interest, and that would be relevant to the general newcomer population trying to master the North American-style employment interview. One pertinent question is if training of the interviewers in cross-culturally sensitive interviewing techniques would contribute to the selection of candidates who are more effective in the residency. In comparison, how effective are employment interview alternatives, such as the MMI or CMSENS at selecting residents? The large proportion of IMDs who are unable to access training year after year also raises the question of the outcomes of those who are unable to practice medicine again here in Canada: What are they doing? Are there some career choices in which they are more satisfied than others? Of those who leave Canada for other countries in order to get licensed, what are their outcomes? I hope that this study can inspire further research into the experiences of IMDs seeking licensure, and thus the gap in the literature will continue to shrink.
Poem Three:
A Frame for “Claw of the Lynx”

“Claw of the Lynx” is based on a story told by Vygotsky in his work *The History of the Development of Higher Mental Functions*, as a tribute to his influence on this thesis. While this story was used in the Theoretical Framework chapter to offer an example of the kind of psychological tool that Vygotsky chose to study and theorize about, here, it takes on a different role. Over the course of the interviews, many IMDs would comment on the need to effect change in the system, and sometimes would offer a suggestion or task that I could take on to help, such as sharing certain information with other IMDs in the future. As I was reading Vygotsky, this story jumped out at me, as it reminded me of the exhortations of the IMDs:

V. K. Arsen’ev, a well-known researcher of the Ussuriysk region, tells how in an Udeg village in which he stopped during the journey, the local inhabitants asked him, on his return to Vladivostok, to tell the Russian authorities that the merchant Li Tanku was oppressing them. The next day, the inhabitants came out to accompany the traveler to the outskirts. A gray-haired old man came from the crowd, says Arsen’ev, and gave him the claw of a lynx and told him to put it in his pocket so that he would not forget their petition about Li Tanku. The man himself introduced an artificial stimulus into the situation, actively affecting the processes of remembering. (1997, pp. 50-51)

Thus, the “Claw of the Lynx” is my own metaphorical reminder to myself to remember the reason for this study and the requests of the IMDs.

In “Claw of the Lynx,” the second stanza is built from one instance of these requests from the IMD. The poem reflects on the fact that the “end” of the research (i.e., the achievement of the PhD) is only the “beginning” in the journey to create change in the system.
Poem Three:
Claw of the Lynx

“Don’t forget us,”
Pressing the claw into my hand.
My journey continues:
This is not the end,
Only the beginning.

What can stories do?
“And I hope that your research does pave some way
Into getting more IMGs into the system…
You know if it can bring about a change in the thinking
Or it can dispel some myths about IMGs,
That would be really wonderful.”

Oh, Canada
Native land only of the indigenous peoples:
A country of immigrants,
A landscape of stories
Some proud and others
Less proud.

“Don’t forget us,”
A landscape where some hopes and dreams
Lie buried.
“I am a doctor. I will be a doctor again.”

What can stories do?
The claw replies,
“This is not the end,
Only the beginning.”
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Appendix A:

Interview Protocols

1. Interview Guide for Initial Interviews with International Medical Doctors
   (approximately 1-2 hours)

   Background Information (before Canada)
   - What kind of doctor are you?
   - How long did you practice in your country of origin? Did you practice in any other countries before coming to Canada?
   - I would like to get a sense of your medical practice before you came here: Can you tell me a story that illustrates who you are as a doctor or what kind of work you were doing?
   - What is your experience of English? Did you study and/or practice medicine in English before coming to Canada?
   - Can you tell me a bit about why you decided to come to Canada?

   Time in Canada (licensing process)
   - How long have you been in Canada?
   - Can you tell me what you have been doing towards getting your licence to practice here in Canada?
   - How has this process been for you?
   - What or who has been helpful along the way?
   - What are some of the challenges you have been facing?

   Bridging Education
   - Have you been involved in any of the newer programs designed to support IMDs as they seek their Ontario license, such as Health Force Ontario, the online Communication and Cultural Competence program, the new communication pilot, or another program?
   - Can you tell me more about your contact with each program, if any, that you have been involved in?
-How was it helpful?

-How was it less than helpful?

-How would you describe what you have learned from each program?

-Can you tell me a story that illustrates what you have been learning?

-Can you comment on the medical context where you were previously practicing and here in Canada: What are some of the important differences and similarities? How did you learn about these?

Residency Interview

- Have you ever had a residency interview here in Canada? In the States?

- If yes, how did you prepare for the interview?

- How well do you feel you were able to represent yourself in the interview?

2. Interview Guide for Follow up Interviews with International Medical Doctors for Case Studies

These mainly exploratory interviews will examine the IMDs’ experience who were successful in the 2009 match, and any insights that they have into what is working well, and what is challenging for them in their training.

As such, the core questions of the initial interview will form the starting point for this inquiry.

3. Interview Guide for Initial Interview with Bridging Education Instructors (approximately 1-2 hours)

Background Information (professional education and experience)

- How did you come to your current position working with IMDs?

- What kind of experience or education led you to work in this area?

- What are some of the insights you have gained working with IMDs?
Bridging Education

-Tell me a bit about the program that you are currently working for.

-What content is taught and why?

-How successful is the program at teaching this content? Why is that?

-Is there anything ‘missing’ from the program that you think would be useful for IMDs?

Insights about indicators of success/failure of IMDs

-What qualities or abilities seem to indicate future success for an IMD, if any?

-Can you tell me a story about an IMD you have that represents these qualities?

-What qualities or abilities seem to indicate a lack of success for an IMD, if any?

-Can you tell me a story about an IMD you have that represents these qualities?

Residency Interview

-How do you understand the role of the residency interview in the licensing process here in Ontario?

-How well does the residency interview play this role?

-Have you been involved in preparing IMDs for the interview/s in the past?

-If yes, please tell me about how you went about doing this?

-What content did you include and why?

5. Interview Guide for Interviews with those who have experience as Interviewers (approximately 1 hour)

Background Information (before Canada)

-What kind of doctor are you?
- How long did you practice in your country of origin? Did you practice in any other countries before coming to Canada?

- I would like to get a sense of your medical practice before you came here: Can you tell me a story that illustrates who you are as a doctor or what kind of work you were doing?

- What is your experience of English? Did you study and/or practice medicine in English before coming to Canada?

- Can you tell me a bit about why you decided to come to Canada?

_Time in Canada (licensing process)_

- How long have you been in Canada?

- Can you tell me what you have been doing towards getting your licence to practice here in Canada?

- How has this process been for you?

- What or who has been helpful along the way?

- What are some of the challenges you have been facing?

_Bridging Education_

- Have you been involved in any of the newer programs designed to support IMDs as they seek their Ontario license, such as Health Force Ontario, the online Communication and Cultural Competence program, the new communication pilot, or another program?

- Can you tell me more about your contact with each program, if any, that you have been involved in?

- How was it helpful?

- How was it less than helpful?

- How would you describe what you have learned from each program?

- Can you tell me a story that illustrates what you have been learning?

- Can you comment on some the medical context where you were previously practicing and here in Canada: What are some of the important differences and similarities? How did you learn about these?
Residency Interview

- Have you ever had a residency interview here in Canada? In the States?
- If yes, how did you prepare for the interview?
- How well do you feel you were able to represent yourself in the interview?

Insights about indicators of success/failure of IMDs

- What qualities or abilities seem to indicate future success for an IMD, if any?
- Can you tell me a story about an IMD you have that represents these qualities?
- What qualities or abilities seem to indicate a lack of success for an IMD, if any?
- Can you tell me a story about an IMD you know that represents these qualities?

Residency Interview

- How do you understand the role of the residency interview in the licensing process here in Ontario?
- How well does the residency interview play this role?
- Have you been involved in interviewing IMDs in the past?
- If yes, please tell me about how you went about doing this?
- Is there any training for residents who participate in the interview process?
- If yes, what does it consist of?
Appendix B:  
Qualitative Codes

1. BACKGROUND AND HISTORY

1.1. Practice story: They tell a story about a memorable patient or case from their former practice.

2. IMMIGRATION

2.1. Reasons for Coming to Canada – Why did they come to Canada? What was their motivation?

2.2. Criticism of Immigration – Any negative comments about the immigration process, the information they received, the wait times, etc.

2.3. Coming to Canada Challenges – Anything difficult about arranging immigration to Canada, and also on first arrival. Getting credentials recognized would be one example that would fit under here.

3. ENGLISH

3.1. Language Instruction for Newcomers (LINC) – Any experiences dealing directly with LINC programs

3.2. English Studies in Canada (not LINC) – Any other references to learning English in other programs in Canada, except for Bridging Program X (see below).

3.3. Licensing English Challenges – Any connections to difficulties in licensing and language proficiency

3.4. Language Learning with Standardized Patients – This refers to language learning connected to their experiences in the Medical Literacy Program.

3.5. English Studies – School and Medical School – Any references to learning English in their home country, whether as a child or in Medical School
3.6. English on Arrival – Specifically about their experiences using English when they first arrived in Canada

4. LICENSING

4.1. THE RESIDENCY INTERVIEW

4.1a Interview Preparation – Whether from a staff or an IMD, anything related to preparation for the interview – most often referring to support offered at one agency.

4.1b Interview Past Experience – Did they have any experience with job-type interviews in their home country before coming to Canada?

4.1c Interview Importance – How important do they think the interview is in the residency selection process?

4.1d Interview Experience – Do they have any experience with interviews in Canada (most often these are residency interviews)?

4.1e Interview Efficacy/Purpose – What is the purpose of the interview in the selection process? How well does it work to achieve that?

4.2. SUGGESTIONS TO IMPROVE LICENSING – Anything that they suggest to improve the current licensing system.

4.2a The Claw of the Lynx – Moments in the interview where participants reminded me of the need to act to improve the situation of IMDs by sharing information, addressing stereotypes, or other.

4.3. METAPHORS AND IMAGES DESCRIBING LICENSING EXPERIENCE – These are figure of speech that the participants use to describe their experiences: could be a
metaphor (comparing the process to being in darkness is common) or a simile (“it’s like swimming upstream”)

4.4. LICENSING SUPPORTS

4.4a Private IMD School – Some IMDs pay to go to private IMD schools that have short term courses on examination preparation, particularly the OSCE exams with simulated patients, and also some interview preparation

4.4b Orientation to the Canadian Health Care System – This is a very specific government-funded course available online and in person; not many participants took it.

4.4c Motivation to Pursue Licensing – Why have they continued to pursue their licence when it is so difficult? What motivation helps them persevere?

4.4d ESP Medical Language Bridging Program – This is a course that focuses on English in the medical context, including the four skills.

4.4e Health Force Ontario – A government-funded agency that supports internationally educated health care professionals, many of whom are doctors.

4.4f Health-Related Employment – Getting any kind of job in the health care field is often seen as a big support to an application for residency training.

4.4g Other Supports – Is there anything else that a participant has identified as being useful/supportive during the licensing process?
4.5. LICENSING CHALLENGES

4.5a Transparency – many literally say “the system is not transparent,” but some talk about how “we don’t know” why the IMDs are selected and also talk about the fact that the selection criteria are not released publicly.

4.5b Spouse is MD - if your spouse is also a doctor, then it can be difficult for both to get licensed.

4.5c Specialist IMDs – Because the government provides most of the spaces for IMDs in Family Medicine, which is less popular with Canadian graduates, specialists face particular challenges getting licensed in their original area of expertise.

4.5d OSCE Challenges – The OSCE exam uses standardized patients portraying detailed cases in an exam setting, where a physician examiner observes.

4.5e Older IMDs – Older IMDs are more socialized in the culture of practice of their home country; learning the language and writing exams that are more suited to recent graduates are more challenging for them.

4.5f Health-Related Employment – It can be quite difficult to get employment in the health care field that would be considered relevant to a residency application.

4.5g Examinations – Any challenges related to writing the exams, understanding the questions, knowing what is the “right” answer, getting resources to help understand the Canadian setting etc.

4.5h Ethics Challenges – This is related to examinations above, but is focused particularly on understanding what is ethically “correct” to do in a Canadian setting. There are now some online resources for this, but little available face to face.
4.5i Differences in Systems – Anything related to how medicine is practiced in the home country, but also how residents/doctors are trained in the home country.

4.5j Canadians Studying Abroad – Comments about the Canadians Studying Abroad in foreign medical schools who couldn’t get into Canadian schools. Often, they are preferred over immigrant IMDs for training positions.

4.5k Canadian Experience – The usual Catch 22 – here, the main theme is in relation to how difficult it is to access clinical observerships which are perceived as needed to get references to be competitive for a training position.

4.5l Abuse of IMDs as volunteers – Some IMDs report that they were mislead about volunteer positions, told that they would be able to get good references for training applications, but the volunteer job, for example, ends up being filing in the basement of the hospital.

4.5m Other Challenges of the Licensing Process – This is a catch all code, covering ANY OTHER challenges related to licensing. Some of the main themes to appear here include health problems, depression, a spouse’s unemployment, the responsibilities of having a family, children, etc.

4.6. CONSIDERING OTHER COUNTRY – The IMD talks about leaving for the US or Australia, usually.

4.7. CLINICAL OBSERVERSHIPS – Anything related to clinical observerships, where the IMD watches a licensed MD practice, but usually does not touch the patient. Related to these are externships, which have a higher level of responsibility, but the IMD must PAY for them: this is in the United States.

4.8. ATTRIBUTIONS FOR SUCCESS AND FAILURE OF IMDs
4.8a Unsuccessful IMDs – What are the qualities of an IMD who is not successful in accessing training?

4.8b Successful IMDs - What are the qualities of an IMD who IS successful in accessing training?