INTERNATIONAL MEDICAL GRADUATE PHYSICIANS’ ALIENATING EDUCATIONAL EXPERIENCES

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ABSTRACT

This paper describes the experiences of IMG physicians as they pursue Canadian medical certification from the sociological perspective of alienation, as described by Melvin Seeman. The Canadian licensing examination processes, the communication difficulties faced by IMG physicians, their loss of status and their difficulties integrating into the Canadian medical community are identified as possible causes of powerlessness, self-estrangement, isolation and meaninglessness experienced by these physicians. The author’s observations as a teacher of IMG family medicine residents are validated by similar experiences of other medical educators. Recommendations are presented which will assist medical educators in mitigating these alienating experiences and in promoting full integration of IMG physicians into the broader Canadian medical community.

CANADIAN MEDICAL LICENSURE AND EDUCATION

Canada has a long history of relying upon physicians from other countries. Before Canadian medical schools were established, our first physicians were those who had immigrated from France, Great Britain, Ireland and Scotland. The first medical school in Canada was inaugurated at the Montreal Medical Institute in 1824, later becoming McGill Medical School in
1829. By the turn of the century, medical schools were established at the University of Toronto, Laval, Queen’s University, Dalhousie, University of Ottawa and the University of Manitoba (Waugh, 2010). However, the country was not still self-sufficient in producing physicians and continued to rely upon physicians emigrating from predominantly Commonwealth countries. As late as the 1970s, Canada relied on IMGs to supply between 30-35% of its medical personnel.

In the last decade of the 20th century, the federal and provincial governments significantly decreased enrolment at Canadian medical schools in an attempt to curtail burgeoning health care costs. As a result, the number of Canadian physicians again became inadequate to provide care to all Canadians. Accordingly, Canadian provincial departments of health and health care regions began to actively solicit physician immigration from the United Kingdom, France, Australia and South Africa. By nature of their place of training, these physicians found it relatively straightforward to obtain Canadian medical licenses and enter medical practice.

At the same time, Canada experienced increased immigration from many parts of the world. Large numbers of physicians from Latin America, South-East Asia, the Former Soviet Republic and India came to Canada as political or economic refugees. They experienced significant barriers in their quest to practice medicine in Canada as, at that time, the Canadian regulatory bodies had yet to establish methods to assess their medical credentials. It was only with the turn of this century that most IMG candidates became eligible to enter Canadian medical residency programs. The experiences of these physicians will be examined from the perspective of alienation.

ALIENATION
The concept of alienation has provided fertile grounds for sociological analysis. In its essence, alienation refers to the action of estranging, or a state of estrangement in feeling or affection. (Oxford English Dictionary, Alienation, 1989). Karl Marx defined alienation as a by-product of the exploitations and inequalities inherent within the class structures of society. The machines of industry owned by the bourgeoisie (capitalists) required the proletariat (working class) to provide cheap labour to produce goods for bourgeoisies’ profit. As the proletariat produced goods for the bourgeoisie, they became separated from the products of their labour. They no longer owned the goods they produced. They enslaved themselves as labourers for a wage. In doing so, they become estranged from the goods, the work involved, and indeed themselves. In this context, alienation is “a feeling of powerlessness and estrangement from other people and from oneself” (Kendall, Lothian Murray, & Linden, 2007). In Marx’s analysis, capitalism produced workers’ alienation at four different levels: alienation from the act of working, alienation from the products of work, alienation from other workers and alienation from human potential (Mancionis & Gerber, 2002).

Max Weber, another early sociologist, attributed alienation to bureaucratic structures that developed with the rationalization of society, which he attributed to the rapid industrialization of the Western World since the 16th century. According to Weber, alienation developed from “the stifling regulation and dehumanism that comes with expanding bureaucracy.” For Weber, modern society reduced the individual to “only a small cog in a ceaselessly moving mechanism that prescribes to him an endlessly fixed routine of march” (Mancionis and Gerber, 2002).

Marx, Weber, and others viewed alienation as the result of forces acting within society at large. Melvin Seeman however viewed alienation as acting at a more personal level,
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from the social psychological rather than structural standpoint (Seeman, 1959). He described alienation as having five dimensions: powerlessness, meaninglessness, normlessness, isolation, and self-estrangement. According to Seeman, powerlessness is “the expectancy...held by the individual that his own behaviour cannot determine the occurrence of the outcomes, or reinforcements, he seeks.” Meaninglessness occurs when “the individual is unclear as to what he ought to believe-- when the individual’s minimal standards for clarity in decision-making are not met” and is “characterized by a low expectancy that satisfactory predictions about future outcomes of behaviour can be made.” Normlessness occurs when there is “a high expectancy that socially unapproved behaviours are required to achieve given goals.” Isolation describes to the “detachment of the intellectual from popular cultural standards” who cannot value the objects of the modern society. Finally, self-estrangement is characterized by the disconnect between work performed and the intrinsic meaning this work provides to the worker. In this regard, self-estrangement is “the degree of dependence of the given behaviour upon anticipated future rewards” (Seeman, 1959). It is from Seeman’s perspective of alienation that the experiences of IMG residents will be examined.

IMG RESIDENTS’ EDUCATIONAL EXPERIENCES

Powerlessness

Medical graduates are categorized by the country in which they obtained their medical education. Canadian Medical Graduates (CMGs) are graduates of Canadian medical schools. International Medical Graduates (IMGs) then are graduates of medical schools outside of Canada or the United States. For the purposes of the Canadian Medical Education system, an IMG may
be a Canadian citizen or permanent resident who went abroad to study medicine, a Canadian or permanent resident who studied abroad before immigrating to Canada or a citizen of another country who is temporarily in Canada for training purposes (Curran, Hollett, Hann, & Bradbury, 2008).

It is quite a challenge to enter the Canadian Post-Graduate Medical Education system. For graduates of Canadian medical schools hoping to obtain a seat in a Canadian residency program, the major difficulty is in matching to one’s program of choice. Depending upon the relative desirability of a certain program, and the number of residency seats offered across the country, candidates may not necessarily match to their first choice of speciality. For graduates of Canadian medical schools however, it is almost certain that they will be matched to a residency program. In the most recent CaRMS (Canadian Resident Matching Service) match of 2009, 94.6% of 2432 applicants were successfully matched (Canadian Resident Matching Service, 2009). Of the remaining 131 candidates, many would have found places in one of the 126 unfilled seats across Canada, as the Post-Grad Deans of the Canadian Medical Schools make every effort to ensure that their graduates enter a residency program.

IMGs are eligible for residency positions within Canada once they have attained landed immigrant status or Canadian citizenship, and have successfully completed several levels of national assessment examinations. The process is time-consuming and expensive. The entry level Evaluating Exam costs $1,500. The Qualifying Examination Part 1 costs $720. Although not necessary for applying to a residency position, many candidates also sit the Part 2 examination, at a cost of $1,850, in hopes of enhancing their application so they might be seen as more qualified (Medical Council of Canada, 2009).
Additionally, those IMGs who did not train in a country where English or French was the language of their medical education must provide certification of proficiency in one of the two Canadian official languages. This requires, at the very least, successful completion of the Test of English as a Foreign Language or the comparable Quebec Test of French Proficiency ($185 or more), or several months or more of English or French language instruction. They must also send notarized copies of Medical Diplomas and official University transcripts to the Medical Council of Canada, the Physician Credentials Registry of Canada and the Canadian Residency Matching Service at their cost (between $350 and $600, depending upon the number of documents submitted) (Medical Council of Canada, 2009). Finally, they apply to CaRMS at a cost of $240. Those who are fortunate to be invited to interview criss-cross the country hoping to make a good impression, and to match into a residency program.

Because of unfamiliarity with English or French, or because of differing medical educational methods within their countries of origin, many candidates will repeat these exams. Many spend several years devoted to study and exam taking. During this time, they work to either support themselves and their families or depend upon other family members to support them.

Unfortunately, these IMG candidates are not nearly as assured of matching to a Canadian residency seat in the CaRMS match as their Canadian medical school counterparts. In 2009, 1387 IMGs applied for residency seats; 392 (28.2%) were accepted. In breaking down this figure by year of graduation, 73 of 119 (61.3%) current year graduates and 319 (25.1%) of previous year’s graduates were accepted.
Most IMGs are not eligible for the CaRMS match in their year of graduation. This category applies primarily to candidates who took their undergraduate training in Canada and have attended medical schools in Commonwealth (Great Britain, Scotland, Ireland and Australia) or European nations. They take the Evaluating Examination during the final year of medical school; many sit the Part 1 Examination after they have matched to a Canadian residency seat. Candidates from other countries begin the examination process after graduation and after immigrating to Canada. This process takes several years, which further handicaps successful applicants who are several years out of date by the time they are eligible to apply to the Canadian Resident Matching Service.

Thus, it appears the reward for completing medical school abroad prior to coming to Canada is several years spent in hard study preparing for expensive evaluating examinations with only one in four odds of being matched to a Canadian residency position. Although the candidates are not entirely powerless during this process (as their scores on the assessment and qualifying exams are dependent upon the time and effort they apply) once the examinations are completed, IMG physicians are powerless to affect the outcome of the CaRMS process. Many are relegated to applying year after year, hoping they might finally strike it rich at “residency roulette.”

**Self-estrangement**

Communication Issues

Physicians must be able to communicate effectively with their patients. Communication forms the core of patient-centred medicine, for how can care be “grounded in the patient’s subjective experience of illness,...in which the patient and clinician must be collaborators,
sharing responsibility for defining goals and problems, making decisions, and carrying out treatment plans” (Suchman, 1994) without effective communication?

In their study of IMG-patient communication Zulla et al found that Canadian residency program directors ranked communication difficulties of IMGs as the most pressing need for improvement (Zulla, Baerlocher, & Verma, 2008) and Pilotto et al identified that improving communication skills should form a significant portion of IMG orientation programs in New Zealand (Pilotto, Duncan, & Anderson-Wurf, 2007).

Many IMG residents have learned English or French to take their licensing exams. Although they have passed language assessment tests as part of the application processes, they often have difficulties in communicating with their teachers and with their patients. They often struggle with the variations in language across Canada or they may not be familiar with certain colloquialisms or the informal language used by their patients. Dorgan et al found that IMG physician trainees "experienced communication barriers related to colloquial language use; these challenges seemed to be magnified by the regional dialects" (Dorgan, Lang, Floyd, & Kemp, 2009).

Our residents face similar challenges. Many speak multiple languages but this often leaves their spoken English heavily accented. This makes it difficult for their patients to understand them, which affects their ability to collect accurate patient histories or provide the patients with an explanation of their medical conditions. On many occasions, the author has needed to return to the examining room with the resident to clarify some feature of the history or to re-explain the proposed management plan. This leaves the residents with the perception that the supervising physicians do not trust their abilities.
Dorgan et al recount how one of their respondents felt about his difficulties communicating with his patients in the American Appalachians thusly: “[A]t first, it was just nasty. They [patients] just didn’t like me and I . . . didn’t like them because I could not communicate” (Dorgan, Lang, Floyd, & Kemp, 2009). In their study of communication issues experienced by IMG residents at the University of Ottawa, Hall et al found that the residents in their study “were very sensitive to misunderstandings due to language” which contributed to difficulties with their interactions with patients, allied health professionals and teaching faculty (Hall, Keely, Dojeiji, Byszewski, & Marks, 2004).

Loss of status

The social status of physicians varies widely around the world. In many societies, physicians enjoy high status. In many cultures, it would be unheard of for the patient to question the physician or to take an active role in his or her care. For many IMGs who arrive in Canada, the notion of patient centred care “grounded in the patient’s subjective experience of illness,...in which the patient and clinician must be collaborators, sharing responsibility for defining goals and problems, making decisions, and carrying out treatment plans” (from Understanding and Promoting Patient Centered Care as quoted in Suchman, 1994) is difficult to grasp. For IMGs who had previously practiced in their home countries, it is particularly difficult to have their care questioned.

Wong and Lohfeld described how IMG physicians experienced loss in their pursuit of further medical training in Canada. They identified loss of personal and professional identities, financial losses, loss of personal autonomy, status and professional devaluation. One of their respondent residents stated “You felt dehumanised, in a sense, as if you had lost something that
you had already achieved -that [your profession] had been taken away from you. You had to sort of work to get it back” (Wong & Lohfeld, 2008).

Specialty-trained IMG physicians often are unable to practice in their specialty area once in Canada. Their international credentials are may not be recognized which then requires them to retrain. Specialty residency positions are highly sought by all CaRMS applicants, and it proves very difficult for IMG physicians to gain entry. In 2009, 67.2% of IMG applicants to Canadian speciality residencies were unmatched. Often IMG specialist applicants unable to match to their own speciality apply to the family medicine seats across Canada. This may provide IMGs with a residency position, but not their program of first choice.

Family Medicine does not exist as a discipline in many parts of the world. In these areas, the medical system is divided between specialists (similar to our Canadian, British and American specialists) and general practitioners who work in small rural clinics (in India, for example) or polyclinics (in Russia and countries formerly part of the USSR). These clinics generally provide the most basic levels of care. If patients need any investigations or medications beyond those provided, they are referred to a specialist. For some physicians previously recognized as specialists in their home countries, it is very difficult to accept becoming “only a GP” in Canada.

Remennick and Shtartkshall assert that the IMG’s ability to maintain “a positive self-image as a professional” is essential to the successful integration into a host medical system (Remennick & Shtarkshall, 1997). The experiences of the IMG residents through their training, their difficulties with communication and their loss of status undermine any positive professional self-image; they examplify Seeman’s principle of self-estrangement. Their experiences
demonstrate to the IMGs how they have become “less that one might ideally be if the circumstances in society were otherwise” (Seeman, 1959).

Isolation

A medical residency is a challenging endeavour. It is common for residents to work a 50 or 60-hour workweek; on many occasions they may work longer. They are on call every third or fourth night and often remain in hospital for 24-30 hours at a stretch. Residents are expected to present at medical or teaching rounds, research their patients’ medical problems, remain current with the medical literature and study for their certification examinations. It has been noted that there is a positive association between resident participation in study groups and success on the Canadian College of Family Physicians Certification examination. In the Family Medicine Program at the University of Manitoba, residents are strongly encouraged to form study groups early in their residency program. Due to the many professional and educational demands upon them, the residents have only a limited amount of personal time.

For those residents who are studying away from home, these demands create the potential for isolation. As previously described, those IMGs who have successfully entered a Canadian residency program have often devoted many years to studying for and taking entrance examinations. This may limit their ability to establish support in their home communities. As well, many residents relocate across Canada to enter their residency programs, which also makes them vulnerable to further isolation.

Many residents attempt to remain connected with their family and friends back home (either in their countries of origin or across Canada). Telephones, internet connections and web-cams certainly make communication easier, but for many residents it is important to visit family
whenever possible. For example, one of our residents has family in Eastern Canada. He tries to fly home at least monthly to visit. These trips away have severely cut into the time he can devote to study.

Many residents, both IMG and Canadian trained, experience time shortages because of domestic demands. However, IMG residents are often more likely to lack extended family in Canada, particularly if they have relocated for educational purposes. With small children at home, and often a fatigued partner, it is very difficult for the residents to find the time to study. When the resident is torn between the needs of the family and the demands of the residency, their personal time suffers. Many residents have voiced distress at their inability to study effectively at home; frequently they cannot get away to join in the resident study groups. This lack of personal time places them at risk of not completing their residencies successfully.

Seeman described isolation in the context of the individual who assigns “low reward value to goals or beliefs that are typically highly valued in the given society” (Seeman, 1959). At first glance, the isolation of these residents would seem to be due to their social isolation or separation from family. However, by spending time with family at the expense of time spent on attaining the education goals of their residency program, they are demonstrating that they value their personal goals above those of the program. In this fashion, they are isolated as Seeman described.

**Meaninglessness**

In Seeman’s model, meaninglessness occurs “when the individual is unclear as to what he ought to believe –when the individual’s minimal standards for clarity in decision-making are not met” (1959, p. 786). Often the IMG residents struggle to understand what is
expected of them in their new roles as Canadian medical trainees. Wong and Lohfeld found that IMG residents undergo a period of disorientation after entering a residency. Their IMG residents described feelings of confusion in their roles in the medical hierarchy and confusion in understanding the context of practice in the Canadian healthcare system. One of their interviewees noted that “[t]he transition from practising Third World medicine to practising First World medicine is one of the biggest jumps that I have made in terms of my practice career” (Wong & Lohfeld, 2008).

IMGs in Canadian residencies enter a world that differs in many ways from that in which they trained. The hospital structures (wards, diagnostic and laboratory services and personnel) may in no way resemble the hospitals which they have previously experienced. Depending upon their place of origin, they may not have experience with complex laboratories services or highly technical radiologic modalities (particularly Magnetic Resolution Imaging/MRI or Positron Emission Tomography/PET). Medical informatics such as computerized orders and electronic medical records may also be unfamiliar.

Hall et al identified multiple system issues which IMG physician-trainees themselves found difficult: understanding the roles of allied health personnel (nurses, social workers, occupational and physiotherapists, home care co-ordinators); the egalitarian Canadian healthcare system versus hierarchical systems; difficulties in understanding the expectations of Canadian patients and their families; uncertainty in how to complete forms and discharge planning (Hall, Keely, Dojeiji, Byszewski, & Marks, 2004). Similarly, Pilotto et al described how IMG residents experience uncertainty in their dealings with their physician teachers. “The position of teacher is held in great esteem by Asian cultures and the student is not encouraged to question or challenge” (Pilotto, Duncan, & Anderson-Wurf, 2007). Even the fundamental principles of note
taking and charting may be foreign. In Canada, the SOAP (Subjective, Objective, Assessment, Plan) format is preferred. Many IMGs have never charted in this format, and struggle to adapt. Each challenging situation reinforces the novice status of the IMGs as medical learners.

Medical residencies are similar to apprenticeships in that the learners work alongside their physician “masters.” Learners acquire increasing levels of responsibility as they prove themselves increasingly capable. Residents’ progress is assessed regularly. These assessments are meant to be formative in nature, to provide the residents with an understanding of their strengths and weaknesses. This feedback is intended to help them so they can focus their studies to master the knowledge and skills required of them.

Graduates of North American medical schools have received much assessment and feedback during their undergraduate training. They recognize this as an expected part of their medical education, and indeed often seek further feedback from supervising physicians.

In many parts of the world, however, medical students have little clinical responsibility during their undergraduate training; it is expected they will learn by following and observing senior physicians. In such jurisdictions, there are limited opportunities for medical learners to perform clinical or procedural skills or to apply their medical knowledge. Consequently, these medical students have not received formative feedback on their clinical performances.

Many IMG residents cannot trust that they will be allowed to continue should difficulties arise. As Fiscella et al report, IMGs may fear that “I may be punished if I make a small mistake being foreigner” (Fiscella, Roman-Diaz, Bee-Horng, Botelho, & Frankel, 1997). The experiences of these residents exemplify meaningless as described by Seeman.

**Normlessness**
Seeman described normlessness as a “high expectancy that socially unapproved behaviors are required to achieve given goals” (1959, p. 788). This does not readily apply to IMG residents as they have struggled to gain a residency seat and believe that they might be expelled for the slightest infraction. Certainly deviancy from accepted norms can and does occur in any population. The recent example of the IMG resident who fled Winnipeg after being charged with sexual assault of a pediatric patient would exemplify normlessness (McIntyre & Giroday, 2009). This however is exceedingly rare, as in the author’s 30 years of involvement with the Manitoba medical community, she cannot recall a similar incident involving an IMG.

**CONCLUSIONS**

IMG physicians face many hurdles in their quest to practice medicine in Canada. As described earlier, these experiences induce a sense of powerlessness, self-estrangement, isolation and meaninglessness. How then can educators mitigate their alienation?

Pilotto et al have made recommendations to help IMG residents and their supervisors (Pilotto, Duncan, & Anderson-Wurf, 2007).

Clinicians need to:

1. Understand the language and communication problems associated with learning and patient care and recognise the associated concerns for IMGs.
2. Explore IMGs’ understanding of cultural boundaries.
3. Develop IMGs’ skills in communicating with patients (skills that include subtle and pragmatic aspects of language interaction).
4. Understand the impact that the teaching system from which IMGs come has on the communication process.
5. Deal with IMGs’ expectation of didactic teaching.

6. Differentiate IMG cultural silence from lack of interest or underconfidence.

7. Recognize the unspoken requirements of IMGs.

8. Guard against negative feedback being perceived as criticism.

They also recommend that IMGs require:

1. The ability to communicate with a range of people.

2. The ability to choose the appropriate terminology, register and amount of information for different audiences.

3. An element of empathy.

4. The skills to interact with nursing staff, and a clear understanding of the role of support staff in clinical care.

5. An understanding of practice protocols with ongoing monitoring of whether information is being interpreted accurately.

6. The ability to deal with an equitable doctor-patient relationship.

7. The ability to maintain a positive image of themselves as professionals.

(Pilotto, Duncan, & Anderson-Wurf, 2007)

Clinicians and educators need to recognize the difficulties IMG physicians face both during the examination and application processes and throughout their training. They also need to recognize the communication barriers which IMGs must overcome, as well as their learning needs specific to their understanding of the medical systems in which they now are members. By implementing Pilotto’s recommendations, the alienating impact of their experiences may be
ameliorated allowing IMG physicians to fully engage with the broader Canadian medical community.

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