# Appendix A

## BUILDING ON DIVERSITY: A FACULTY DEVELOPMENT PROGRAM FOR TEACHERS OF INTERNATIONAL MEDICAL GRADUATES

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International Medical Graduates (IMGs) form an important component of the Canadian physician workforce. Approximately 25% of practicing physicians in Canada and the United States are IMGs (Buske, 1997; Huang, 2000). International Medical Graduates refer to physicians whose basic medical degree was awarded by a medical school that is outside the jurisdiction of either the *Committee on Accreditation of Canadian Medical Schools* or the *US Liaison Committee on Medical Education* but is listed in the *World Directory of Medical Schools*, published by the World Health Organization. Canadian-born citizens with international medical degrees are IMGs. Citizens of other countries, with international medical degrees who are in Canada on work visas, are IMGs. And most importantly, immigrants to Canada seeking to re-establish their medical profession are also IMGs (Watt, Lake, Cabrnoch, & Leonard, 2003). IMGs can enter the Canadian health care system in different ways, and each "entry route" into practice poses different problems and challenges. Although IMGs are often viewed as a single homogeneous category, they are not (Varki, 1992). In fact, IMGs come from many different cultural and ethnic backgrounds, and they represent a diversity of views that can be both challenging and rewarding.

The goal of this report is to recommend a faculty development program for individuals involved in the education of IMGs (e.g. teachers, clinical supervisors, program directors and educational administrators) in an attempt to enhance the teaching and learning of IMGs and to facilitate their integration into the Canadian workforce. The recommendations set forth in this report are also designed to complement and support the Recommendations of the Canadian Taskforce on International Medical Graduate Licensure.

Faculty development has been defined as that broad range of activities institutions use to renew or assist faculty in their multiple roles (Centra, 1978). That is, faculty development is a planned program designed to *prepare* institutions and faculty members for their various roles (Bland, Schmitz, Stritter, Henry, & Aluise, 1990) and to *improve* an individual's knowledge and skills in the areas of teaching, research and administration (Sheets & Schwenk, 1990). The goal of faculty development is to teach faculty members the skills relevant to their institutional and faculty position, and to sustain their vitality, both now and in the future.

In recent years, faculty development has become an increasingly important component of medical education (Steinert, 2000). Faculty development activities have been designed to improve teacher effectiveness at all levels of the educational continuum (e.g. undergraduate, postgraduate and continuing medical education) and diverse programs have been offered to health care professionals at many levels (e.g. institutional, regional and national). In this context, faculty development will refer to those activities designed to help educators in all settings (e.g. hospital, community, university) work with IMGs in a more effective and satisfactory manner. Moreover, whereas the primary emphasis will be on teaching improvement, it is expected that any well-designed faculty development program will also have an impact on the institution or organization in which it is offered.

To develop a faculty development program for teachers of IMGs, the following steps were pursued:

- A comprehensive literature review was conducted in order to ascertain the existence of faculty development training programs for teachers of IMGs.
- Key stakeholders were consulted in order to determine the existence of faculty development training initiatives in Canada as well as teachers' needs for faculty development.

- A number of principles and recommendations, based on the literature review, the consultations with key stakeholders, and personal experience in faculty development, were developed to guide the design and delivery of a faculty development program.

## LITERATURE REVIEW

As mentioned above, the goal of the literature review was to ascertain the existence of faculty development training programs for teachers of International Medical Graduates (IMGs), the special needs of IMGs, and specific concerns of teachers of IMGs. To accomplish this task, a Medline search on IMGs and faculty development, from 1985 to the present, was conducted. The key search terms for the IMG literature included: IMGs and training, in-service training, educational measurement, Canada, and cultural diversity/prejudice. Separate searches on faculty development and cultural diversity raining were also conducted. (Copies of the Medline searches on IMGs and faculty development are available upon request.)

The literature review did not yield one article on IMGs and faculty development, nor did one faculty development article refer to the training of teachers of IMGs. The literature does, however, tell us about the educational needs of IMGs, the challenges that they face in the clinical setting, and different training programs that have been initiated specifically for IMGs. A brief summary of these findings, which will be used to guide the design and development of the Faculty Development Program, will be provided here. The literature on faculty development and cultural diversity training will be cited in the sections on "General Principles" and "Specific Recommendations".

### *Perceived Needs of IMGs*

The literature has defined a number of educational needs of IMGs that include the following: deficits in medical knowledge and clinical skills (Kidd & Zulman, 1994; Conn, 1986; Conn & Cody, 1989; Kvern, 2001); a lack of proficiency in the English language (Fiscella & Frankel, 2000; Rothman & Cusimano, 2000; Kidd & Zulman 1994; Kvern, 2001); a lack of training in communication skills (Hall, Keely, Dojeiji, Byszewski, & Marks, 2004; Rolfe & Pearson, 1994; Kidd & Zulman, 1994); different study skills/techniques (Kidd & Zulman, 1994; Kvern, 2001); differing cultural perspectives (Cheng, 1974; Kvern, 2001); and significant life stresses (Kvern, 2001; Kidd & Zulman, 1994; Cole-Kelly, 1994; Bates & Andrew, 2001). Clearly, these needs must be addressed by teachers of IMGs and should, therefore, form part of a structured faculty development initiative.

### *Training Programs for IMG's*

Diverse training programs, specifically geared for IMGs within or outside pre-residency or pre-internship programs (Nasmith, 1993) have been described. Some of these include: orientation programs for IMGs (Crutcher, 2001; Rosner, Dantzker, Walerstein, & Cohen, 1993; Cole-Kelly, 1994); remedial courses on interviewing skills (Brooks, Robb, & Tabak, 1996); the use of standardized patients for language assessment (Friedman et al, 1991) and interviewing skills (Boulet et al, 1998; Cole-Kelly, 1994). Although these programs have not guided faculty development initiatives, their content and methodology offer promise for faculty development training programs as well.

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### *Recommendations for Teaching*

In an insightful article, Kvern (2001) described different ways of improving the teaching of IMGs. His suggestions included the need to: create a supportive training environment through the building of trust based on understanding; hold IMGs to the same clinical and professional standards of excellence as all other residents; anticipate the common areas and causes of weak performance without relying on IMGs to self-assess or recognize their weaknesses; recognize that medical school experiences, learning styles, comfort in groups, and cultural norms differ for IMGs; and be creative in planning core experiences and remedial activities, as needed. Other educators have written about specific preceptor responsibilities, ingredients for successful collaboration, and how to structure the learning experience (Crutcher, 2003). Clearly, all of these issues need to be addressed in a faculty development initiative for teachers of IMGs.

## NEEDS ASSESSMENT - CONSULTATIONS WITH KEY STAKEHOLDERS

As stated earlier, a number of key stakeholders (i.e. clinical teachers; Family Medicine Program Directors; Associate Deans for Postgraduate Education; and faculty developers) were consulted in order to assess the existence of current programs as well as perceived needs for a faculty development program.

These consultations included the following activities:

1. Preliminary discussions with individuals familiar with IMG-related issues.
2. A group consultation with faculty members involved in teaching IMGs at McGill University.
3. A group consultation with Associate Deans for Postgraduate Education and other interested individuals at the Association of Canadian Medical Colleges (ACMC) Meeting in April, 2003.
4. An e-mail survey of Faculty Developers at all 16 Canadian Schools of Medicine as well as individuals responsible for faculty development in the 16 Canadian Departments of Family Medicine.
5. An e-mail survey of all 16 Canadian Program Directors in Family Medicine.
6. Follow-up phone calls and e-mail exchanges with identified experts.

**Appendix A.1** includes a summary of the key findings for steps 1, 2, 3, 4, and 6. **Appendix A.2** provides a summary of the responses to step 5. **Appendix A.3** outlines the names of individuals consulted for both steps 1 and 6.

In summary, the above-outlined consultations have been invaluable in identifying issues of concern to teachers and program directors of IMGs, areas of need for faculty development, available programs for IMGs and current resources. Interestingly, however, no respondents reported on the existence of an organized faculty development program for teachers of IMG's, although we know that one school has initiated significant efforts in this area (University of Calgary) and a few schools have incorporated IMG-related issues into their faculty development sessions (e.g. Dalhousie University; University of Alberta). The individual consultations and e-mail surveys also helped to identify a number of individuals with a particular interest or

knowledge in this area. In fact, there appears to be a wealth of expertise across the country, including different pockets of activity related to IMG training as well as many "well kept secrets" regarding areas of cultural competence and cultural diversity training that exist in our medical schools. Hopefully, recognition of these diverse activities will lead to better coordination and sharing of information across the country.

## A FACULTY DEVELOPMENT PROGRAM FOR TEACHERS OF IMGS

As mentioned earlier, the following section has been guided by the review of the literature, consultations with key stakeholders, and personal experience in the area of faculty development. It will be divided into two main sections: "General Principles" and "Specific Recommendations". (**Appendix A.4** and **Appendix A.5** summarize these principles and recommendations.) In reading through the following section, please note that the term "teacher" and "supervisor" will be used interchangeably; the term "respondent" refers to individuals who participated in the consultation process. Individual quotes have been cited in order to reflect the depth and breadth of the respondents' perspectives.

### *General Principles*

1. *The content and process of a Faculty Development Program for teachers of IMGs is not fundamentally different than one for teachers of all postgraduate trainees. However, certain topics may be encountered more frequently - or become more pronounced - when working with IMGs.*

Crutcher (2001) has noted that the challenges teachers face in supporting an IMG in a learning role are not fundamentally different than the challenges we face in any learning encounter, as each trainee has their own unique blend of strengths and weaknesses, and the skillful teacher will help "all students see both their individual strengths but also the gaps that must be addressed". Most of the individuals consulted during the needs assessment agreed with this sentiment and observed that the need for faculty development for teachers of IMGs is not fundamentally different than that for teachers of all residents. However, some of the issues become more pronounced – or critical – at different moments in training. As one individual commented: "faculty development issues are essentially the 'same' for all teachers; however, some become more 'acute' when teaching IMGs."

Thus, although the following recommendations could easily apply to faculty development initiatives for teachers of all students and residents, they are written from the perspective of enhancing the learning – and practice – experience of IMGs.

2. *Faculty development refers to different approaches to helping faculty in their multiple roles. This includes faculty development, faculty **orientation** and faculty **support**.*

During one of the group consultations, the nuances of the term "faculty development" were discussed at length, and the individuals present highlighted the importance of differentiating between faculty development, faculty *support*, and faculty *orientation*. This distinction appears essential in this context and will, therefore, be used to frame the recommendations that follow.

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3. *Principles of effective faculty development must be applied in this context as in all others. That is, faculty development programs should incorporate principles of instructional design and educational relevance, and the outcome of all faculty development initiatives should be evaluated.*

Much has been written about the need to incorporate principles of instructional design and educational relevance into all faculty development initiatives as well as the importance of evaluating effectiveness (e.g. Reid, Stritter, & Arndt, 1997; Rubeck & Witzke, 1998; Skeff, Bergman, & Stratos, 1988; Wilkerson & Irby, 1998). For the purpose of this report, some of these key principles will be summarized briefly. Additional information is available upon request. For faculty development programs to be effective, they must: match the institution's culture; be responsive to individual and institutional needs; promote buy-in and joint ownership; offer diverse programs and activities; incorporate principles of adult learning and other applicable conceptual frameworks (Kaufman, Mann, & Jennett, 2000; Knowles, 1980); remain relevant and practical; work to overcome common problems; and demonstrate effectiveness (Steinert, Spooner, Kaufman, & Jones, 1996; Steinert, 2000). Clearly, the design of any faculty development initiative for teachers of IMGs must follow these principles and ensure that research informs practice.

4. *A "deficit-based approach" to understanding learner differences must be avoided.*

During the consultation process, Heather Armson observed that the literature on IMGs starts from a "deficit perspective". That is, the majority of articles and studies primarily highlight the IMG's deficits in knowledge base, clinical skills, and medical experience. It is imperative that we work to overcome this trend, and that we approach each IMG, prepared to acknowledge their strengths and address their weaknesses. As Armson has suggested, "we must carefully look at each IMG's strengths and encourage a spirit of 'appreciative inquiry' that acknowledges what is going well. We must honour and respect the IMG's previous experiences and learn from them."

5. *All educators must recognize - and acknowledge - that each IMG is a unique individual.*

As stated in the introduction, we cannot assume homogeneity between IMGs, as each person comes from a different socio-cultural context, learning environment and individual background. As well, the definition of an IMG varies greatly, and the issues encountered will differ depending on the "definition" – and the individual.

6. *All educators must recognize - and acknowledge - that each teacher/supervisor is a unique individual, different from his/her colleagues.*

Just as we cannot assume homogeneity between IMGs, clinical teachers and supervisors differ significantly from each other, and as one respondent noted, we must consider teacher variables (e.g. teacher's gender, years of experience, cultural biases and prejudices) in the development of any faculty development program. A number of respondents also suggested that faculty members should possess certain "core competencies" (e.g. cultural sensitivity; experience with post-traumatic stress), and that they should be selected according to their mastery of these competencies. Whereas this may be a controversial suggestion, the importance of assessing teacher skills cannot be under-estimated in the design of any faculty development initiative.

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*7. Opportunities for training IMGs should be used to benefit all trainees.*

IMGs bring with them a wealth of knowledge, traditions and experiences. Providing them with opportunities to describe and explore their own undergraduate training and cultural expectations can enrich the experiences of all students and faculty members. As Bates and Andrew (2001) have said: “The inclusion of IMGs into postgraduate training can, through spirited dialogue, enhance the cultural basis of clinical practice in North America as well as the requirements of delivering culturally appropriate care to patients of differing ethnic origins. In fact, the difficulties sometimes experienced in the training of IMGs can shift postgraduate programs to a more learner-centered approach, where the roots of learning (and the difficulties of performance) are explored in the context of the learner.” It is imperative to remember that whatever we develop in this context will have a positive impact on all teachers and learners.

***Specific Recommendations***

The following recommendations are framed to guide the development of a faculty development initiative for educators involved with the training of IMGs and to complement the key recommendations of the Canadian Taskforce (e.g. establish a national assessment consortium; support the development and implementation of orientation programs for faculty working with IMGs). In summary, it is recommended that we:

1. *Develop an Orientation Program for Teachers of IMGs.*

During the consultation, a number of the respondents commented that teachers need to become more aware of the IMG’s previous medical school experiences, entry routes into practice in Canada, and challenges encountered along the way. It was therefore suggested that we develop an Orientation “Package” for teachers, available in hard copy or on the web, which would orient teachers to the challenges faced by IMGs. Teachers should also have access to *The Orientation Guide to Licensure, Medical Practice and Life in Canada*, proposed by the Orientation Committee of the IMG Taskforce, as this document will help teachers understand the challenges involved in immigrating to Canada and re-settling here; what information regarding life in Canada is being provided to IMGs; and what the process of entering medical practice will be.

At the same time, teachers need to “orient” IMGs to the Canadian health care system, and we should include an Orientation Package for IMGs as part of a faculty orientation program. Topics suggested during the needs assessment included: an understanding of Canadian health care delivery (including the hospital system); the Canadian “way” of working (e.g. inter-professional team work) and the North American “medical model” (which includes the concept of patient-centred care). As one respondent suggested, we might wish to consider the inclusion of former IMGs in the development of an orientation program for teachers and IMGs. *The Trainee and Preceptor Guide to the Alberta IMG Clinical Orientation Program* (Crutcher, 2003) could also be a helpful resource in this context.

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2. *Incorporate at least six key content areas into a Faculty Development Program for teachers of IMGs.*

Whereas all faculty development topics are clearly relevant to teachers of IMGs, the following topics seem to be most pertinent, based on the literature review and stakeholder consultations. However, all faculty development topics related to teaching (e.g. effective clinical teaching; interactive lecturing; small group facilitation; teaching in the ambulatory setting) administration, and organizational development are important to teachers and supervisors of IMGs and should be considered, even though they will not be described in detail here. The key content areas are as follows:

### A. Assessing Learner Needs and Establishing Mutual Goals and Expectations

*"Preceptors must clarify their common expectations on a routine basis so that we don't end up in trouble for not doing things that we didn't know we were supposed to do".*

The above quote reflects the sentiments of an IMG (Armson, 2003). However, all of the teachers and program directors involved in the consultation addressed the importance of assessing learner needs and establishing clear goals and expectations. Although a learner-centred approach is critical in all situations, the need for assessing needs and expectations becomes even more pronounced in this context because of issues related to personal loss, previous medical training and cultural differences.

#### *Personal Loss*

*"Teaching physicians who have been in practice formerly and now have to learn to work with patients with expectations and backgrounds so very different to what they have previously encountered is, indeed, a challenge."*

IMGs have often faced life-altering experiences before arriving in Canada (Kvern, 2001) and they are required to make personal adjustments that often lead to a sense of loss: loss of self-esteem, loss of country, loss of accessibility to a natural network of support, and loss of lifestyle (Cole-Kelly, 1994). It is imperative that teachers be aware of – and acknowledge – these losses. IMGs also face many obstacles to gaining entry into Canada, and once in Canada continue to face many barriers (Association of International Physicians and Surgeons of Ontario [AIPSO], 2003). For example, many have to work long hours at menial jobs while trying to study and pass the required examinations (Rutherford, 2002). As another individual commented, most IMGs are already physicians, and often end up in a training program "by default". This adds a level of complexity to the teaching and learning process, and teachers must be cognizant of these issues in order to create an environment for learning. As another individual commented, "imagine the difficulty of moving from practice to residency and back!"

#### *Previous Medical Training*

*"Our previous training usually focused on textbooks and lectures, whereas the Canadian system has more of an emphasis on practice-based applications and clinical practice guidelines."*

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The systems of medical education throughout the world vary from country to country, primarily with respect to duration, curriculum content, standards, quality, and evaluation methods (Gary et al, 1997). In fact, some graduates are required to specialize at an early stage of training and they miss out on rotations such as pediatrics, obstetrics, gynecology and psychiatry. It is therefore critical that teachers carefully assess previous learning experiences and approaches, as the homogeneity of US/Canadian medical school curricula cannot be assumed.

To facilitate understanding of the IMG's previous education and training, one respondent suggested that we ask IMGs to create a "portfolio" that will allow them to showcase their previous accomplishments and to give their teachers and colleagues a clearer understanding of who they are and where they come from. The diversity in backgrounds also dictates that teachers need to learn to "tailor" a program to individual needs.

### *Cultural Differences*

*"We must understand gaps produced by cultural differences so that we can address these gaps. In this respect, we must help IMGs articulate their previous teaching and learning experiences."*

Much has been written about the cultural differences of IMGs – both from an educator's and an IMG's perspective. (e.g. Cheng, 1974; Dinyari, 2000; Fiscella, Roman-Diaz, Lue, Botelho, & Frankel, 1997; Kvern, 2001; Majumdar, Keystone, & Cuttress, 1999) Most IMGs come from non-English speaking cultures, and consequently, they are often confronted by a series of trans-cultural challenges that include not only language, but also lifestyle, sex-role differences, discrimination and change in status (Fiscella et al, 1997). Cultural differences also include issues related to gender, hierarchy and power (Hall et al, 2004). For example, many IMGs come from cultures and training programs where deference to authority is expected, and at the same time, admitting to a lack of knowledge in any area may be personally and culturally very difficult (Kvern, 2001). Cheng (1974) has eloquently described differences in role identity and attitudes toward authority figures that can cause problems in working within the North American medical context. He suggests that cultural norms may cause IMGs to appear "too inhibited, passive and rigid", and that by minimizing the influence of culture, we may misinterpret behaviour. A case in point: questioning a professor's opinion may be unthinkable in some cultures. In North America, however, silence – meant to be deferential – may be interpreted as lack of knowledge, lack of interest, or lack of confidence. Constant agreement by a resident may be interpreted as sycophantic (Kvern, 2001). Thus, awareness of the cultural meaning of behaviour is essential.

Cultural differences can also create communication problems with patients. Graduates of North American schools share a common cultural background, or at least, have been exposed to the culturally accepted norms for providing medical services (Majumdar et al, 1999). However, as IMGs have not necessarily had this experience or training, they may not be familiar with the criteria for professional behaviour in a Canadian setting. They may also feel rejected by their patients or colleagues and/or frustrated by the challenges of caring across linguistic and cultural barriers (Fiscella et al, 1997).

Diagnostic and treatment options presented by IMGs will also be strongly influenced by their home country's cultural values. For example, patient cues about homosexuality, marital distress, substance abuse, premarital sex and pregnancy may be ignored. The use of alcohol as a coping mechanism may be a foreign concept and viewed as sacrilegious by many IMGs

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(Cheng, 1974). Unfamiliarity with culturally acceptable ways of presenting an illness in Canada means that IMGs mat be at risk of making assumptions or missing important clues in determining etiology and diagnosing their patients' illnesses.

As can be seen from these examples, cultural differences come to play in the doctor-patient relationship as well as the teacher-learner interaction, and teachers must work to understand the role of culture in understanding attitudes and behaviours. To explore these issues, teachers should be encouraged to use a methodology similar to that used by Fiscella and colleagues (1997) by asking learners to provide narrative accounts of a "particularly meaningful or challenging patient care experience in which their culture, language, or values either positively or negatively affected their ability to provide care". The impact of cultural differences on relationships with other members of the health care team must also be openly recognized and discussed.

### B. Evaluating Clinical Knowledge and Skills

*"We need an ability to assess level of training/experience; what is documented on paper is not at all helpful in most cases."*

A number of studies have shown that a high percentage of graduates of foreign medical schools have an inadequate knowledge base and repertoire of clinical skills when compared with graduates of US schools (Conn, 1986; Conn & Cody, 1989). Although many of these gaps are identified through a formal examination process (e.g. MCC examinations), it remains essential for clinical teachers to be able to identify both clinical strengths and weaknesses and to develop remedial programs to address potential deficits.

As Kidd and Zulman (1994) have pointed out, many overseas-trained doctors are highly skilled clinicians with the ability to make a major contribution to medical practice in any country. Others, however, lack the basic clinical skills of history-taking, physical examination, diagnosis and management necessary to practice medicine safely and effectively. Some have never learnt these skills; others have lost skills through extended periods of absence from medical practice (Conn, 1986; Conn & Cody, 1989). Moreover, as Kvern (2001) has pointed out, the curriculum content of medical schools differs markedly from country to country. Some programs lack comprehensive basic science training. Others require their students to specialize at an early stage of training, and clinical experiences may vary significantly. For example, in some schools female medical students only examine women and children, whereas men seldom have the opportunity to perform gynecologic examinations. As IMGs may miss out on important clinical experiences, teachers need to carefully evaluate the IMG's basic science knowledge, history-taking and physical examination skills, clinical reasoning, ability to interpret physical signs, and diagnostic and management skills.

Teachers must also be aware that IMGs, who may lack experience in specific clinical areas, may display uncooperative behaviours or attitudes, may be perceived as disinterested or a poor team player, or may just not be able to cope (Kvern, 2001). The ability to admit lack of knowledge may also be personally and culturally very difficult. It is for this reason that teachers must clarify previous clinical experiences and assess knowledge and skills in a systematic and rigorous fashion. Clearly, understanding the role of culture in knowledge, behaviour, and attitudes is key to the assessment process.

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In summary, we must teach teachers to evaluate carefully, to go beyond what is apparent, to observe systematically, and to use multiple methods of evaluation while providing a safe environment for learning. We must also familiarize teachers with innovative assessment methods. For example, standardized patients have been used effectively to evaluate the spoken English proficiency of IMGs (Friedman et al, 1991). However, this methodology can also be used to assess a wide range of clinical skills (e.g. interviewing, history-taking, and physical examination skills), and teachers must be cognizant of its potential use and feasibility.

Assessment is clearly one of the fundamental issues of importance. As one teacher noted, “we need to find the courage to evaluate honestly”.

### C. PROVIDING EFFECTIVE FEEDBACK

*“Feedback skills are critical, especially when dealing with struggling residents. We must be aware that feedback will be perceived in quite different ways by different cultures. For instance, any praise may be taken very literally and may negate the impact of negative feedback; conversely, certain cultures do not accept criticism well and saving face is all important. This is particularly true of female preceptors and male residents.”*

Whereas feedback is a fundamental skill in every teaching situation, the notion of “feedback” takes on a different meaning when working with IMGs. As Armson (2002) has pointed out, IMGs often do not have the expectation that feedback will include both strengths and gaps, and at first, IMGs often appear quite defensive, when in fact, receiving feedback is not part of their previous learning experiences. Kvern (2001) has also commented that IMGs may be more familiar with indirect feedback, and when direct feedback is given, this may be interpreted as “criticism and disappointment, leading to anxiety, loss of self-esteem and decreasing performance”. As several individuals in the needs assessment also commented, IMGs need to be helped to say that “they don’t know” and to speak their minds more openly.

### D. PROMOTING PATIENT-CENTRED CARE

*“How do Canadian-trained physicians train IMGs when attitudes and approach to patient care can be so different? How do you teach patient-centredness to people who have been trained in a doctor-centered milieu? How do you acquaint IMG residents with the concept of equality between teacher and resident that we mostly espouse when they may come from a situation where you never question the instructor?”*

A number of respondents commented that it is in the area of patient-centred care where cultural differences regarding how medicine is practiced become most pronounced. Many IMGs need help in acclimatizing to the North American “medical model”. This includes an emphasis on patient-centred care and the concept of partnership rather than paternalism. A faculty development initiative must help teachers find ways in which to teach a patient-centred approach in an effective way. Attention to psychosocial issues – and ethical decision making – falls here as well. As Hall and colleagues (2004) have observed, a patient-centered model of care is unfamiliar to many IMGs as it is much more common for many of them to discuss diagnosis and treatment plans with male family members rather than directly with the patient. Many also lack the ability to take a psychosocial history, negotiate with patients and express

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empathy (Brooks et al, 1996). Strategies for teaching patient-centred care, using a variety of teaching and learning modalities, would be of benefit to all teachers of IMGs.

### E. TEACHING COMMUNICATION SKILLS

*"Preceptors assume that if we don't speak, it is because we don't know or don't care, when in fact, we are trying to be respectful in ways congruent with our previous medical cultures".*

Many IMGs come from countries where epidemic disease, physician shortages and disparities in education leave little time for communication with patients. As well, communication skills may not have been a primary concern in medical training (Fiscella & Frankel, 2000), and English is a second language for most (Kvern, 2001). Limited language skills can easily cause concerns about the accuracy of the information exchanged, and concentration on the verbal message may cause much of the non-verbal communication to be ignored (Fiscella & Frankel, 2000).

In an interesting study, Hall and colleagues (2004) used qualitative research methods to determine IMGs' needs for communication skills training from four perspectives: that of the IMGs themselves, program directors, allied health care professionals and experts in communication skills. Not surprisingly, IMGs listed the opportunity to practice communication skills as the most important element to include in an educational program. This included the need to negotiate treatment plans with patients, break "bad news" and discuss end-of-life issues with patients and families. Patient-centred interviewing skills, non-verbal communication, and English language skills were also rated highly. When describing the need for help with English, the use of idioms, nuances, humour and vernacular terms were identified as a key priority. Moreover, IMGs most frequently noted the use of unfamiliar terms and phrases, while program directors and teachers commented on the need for instruction in non-verbal communication skills (e.g. use of body language), the use of medical terminology, and managing telephone conversations.

Clearly, teachers and supervisors need instruction in language assessment (Watt et al, 2003) as well as the teaching of communication skills. However, training in communication skills for IMGs should be "in vivo", skill-based and clinically relevant. All educators need to be aware of available communication skills training programs (Makoul, 2001; Hulsman, Ros, Winnubst, & Bensing, 1999), cultural aspects of communication styles and patterns, and ways of ensuring relevance and practicality in teaching the subtleties of verbal and non-verbal communication.

### F. DEVELOPING A COLLABORATIVE TEACHER-LEARNER RELATIONSHIP AND DESIGNING INDIVIDUALLY TAILORED LEARNING PROGRAM

"*We must carefully assess skills and foster an individualized approach. Teaching and learning should be problem-based."*

The previous sections have outlined the educational needs of IMGs and some of the teaching challenges faced by teachers and supervisors. It is apparent that a collaborative, non-threatening relationship that engenders trust and confidence must be developed in order for learning to occur. Cultural differences and similarities must also be recognized and identified, and at times, must be overcome to promote collaboration. In addition, the heterogeneity of IMGs has been highlighted, as has the need for individually tailored programs to overcome some of

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the identified gaps in knowledge or skills. Remedial programs that may consist of independent reading, tutorial programs, increased observation and feedback, or self-directed learning modules (Steinert & Levitt, 1993) are also needed to address identified deficits. As a participant at a recent workshop on *The "Problem" Resident: Whose Problem Is It?* observed when discussing an IMG, "one size does not fit all".

3. *Include Cultural Diversity Training Programs into a faculty development program for teachers and supervisors of IMGs.*

*"In a wider context, how do we educate our teachers to be better practitioners and more culturally sensitive to their patients of other cultures?"*

Despite good intentions, IMGs report a sense of discrimination and bias against them (Nasir, 1994). As Rutherford (2002) has reported, one IMG wrote that even with the tremendous change in Canada's demographics, hidden discrimination in the name of public safety, fear of the unknown, country of graduation, lack of trust and arrogance is alive and well at all levels. (Dinyari, 2000) Another IMG wrote that "there is not even a rudimentary differentiation made between the various foreign medical schools; they are uniformly considered suspect and inadequate, regardless of their quality" (Porzecanski, 2000). We must, therefore, recognize our own cultural biases and prejudices and work to overcome them.

Faculty must be aware of how IMG residents are being treated within the residency. IMGs could easily become scapegoats in a program that is insecure in the hospital or is struggling with internal unresolved conflicts. Pinderhughes (1989) speaks of the social projection process that operates in systems where the conflicts and tensions of a system get relieved by focusing on one group or individual in the system. It is important that faculty be alert to this potential problem. In addition, faculty can encourage residents to embrace and be proud of their cultural heritage and traditions through inquiry, through respect for important events and traditions, and through encouraging residents to seek and participate in local community activities (Cole-Kelly, 1994). It appears that faculty advocating for residents to maintain their cultural ties can help residents stay connected with sources of support and security.

Teachers and supervisors should also reflect, in formal and informal ways, on the program's sensitivity to IMGs. For example, is the department or organization aware of the IMG's religious and cultural requirements? Does it make adjustments for a Muslim resident who may be unwilling to work nights during Ramadan month or excuse an Egyptian resident from work on Egyptian Christmas (Cole-Kelly, 1994)?

A number of cultural diversity training programs have been designed and implemented for IMGs (e.g. McClain, 1996; Majumdar et al, 1999). The major content areas that have been addressed have included: perceptions about foreigners; gender roles; culture shock; personal losses; and behaviour and non-verbal communication. The major training methods have included small group seminars, live observation, videotape reviews and simulated patients (Majumdar et al, 1999). Interestingly, it would seem that just as cultural diversity programs can help IMGs integrate into American society (McClain, 1996), teachers could profit from education about cultural awareness as well.

A variety of programs focusing on "cultural competence" for students and residents have been described (e.g. Dogra, 2001; Dowell, Crampton, & Parkin, 2001; Godkin & Savageau, 2001; Kai,

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Spencer, Wilkes, & Gill, 1999; Kagawa-Singer & Kassim-Lakha, 2003; Robins, Fantone, Hermann, Alexander, & Zweifler, 1998; Wear, 2003; Zweifler & Gonzalez, 1998). These programs are rich in content and utilize a variety of modalities to achieve their objectives. However, few such programs exist for faculty (Beagan, 2003; Tang et al, 2003). Interesting resource materials are also available to aid in the development of such programs. For example, workshops designed by a number of Canadian educators, including Rosalyn Howard, Blye Frank and Rosamund Woodhouse, would be very pertinent to teachers and supervisors. A cross-cultural training handbook, *Developing Intercultural Awareness (*Kohls & Knight, 1994), which outlines a series of exercises to develop intercultural awareness and sensitivity, would also be a very useful resource for training purposes. In many ways, the development of a faculty development program on *Educating for Cultural Awareness* could have numerous benefits.

The suggested goals of a faculty development curriculum on *Educating for Cultural Awareness* would be threefold: to assist teachers in their understanding of their own ethno-cultural backgrounds, values, attitudes and beliefs (self-awareness); to help teachers acquire a greater understanding and empathy for their IMGs' cultural backgrounds and life experiences (sensitivity); and to promote the development of skills that would enable self-awareness and cultural sensitivity (skill development). Hixon (2003) has recently re-introduced the notion of "cultural humility" – a term that is built on the concept of self-reflection and self-critique and that recognizes the power-imbalances that are often exaggerated when a common language and culture are not shared. In essence, this concept captures the goal of a faculty development program in this area. As opposed to the "mastery" of sets of information, we should promote skills that are critical to life-long learning, flexibility, openness and humility.

4. *Develop site-specific faculty development programs that are relevant to the individual context of teachers and learners and that utilize a variety of teaching and learning methods.*

The literature on faculty development indicates that workshops and short courses are the most popular format for teaching improvement activities, (McLeod, Steinert, Nasmith, & Conochie, 1997; Steinert, Levitt, & Lawn, 1988) and that faculty members value a variety of teaching methods within this format (e.g. interactive lectures; small group discussions and exercises; experiential learning and role plays; simulations and videotape reviews). These trends apply in this context as well. The majority of respondents preferred site-specific faculty development programs for teachers of IMGs. In particular, program directors identified workshops and one-on-one peer coaching as the "method of choice". Individual teachers and supervisors responded in a similar fashion. Independent reading programs and online learning modules were not rated highly, as the interaction between group members was considered invaluable for information exchange, peer support and role modeling. However, respondents did comment that they would value the availability of resource materials, to be used as needed.

To ensure the success of any site-specific activity, faculty development program planners would need to: conduct a multi-faceted needs assessment of their teachers and students; develop clearly defined objectives that would determine the choice of content; utilize a variety of instructional methods to achieve individual and institutional objectives; and evaluate effectiveness and outcomes (Steinert, 1992). Faculty development initiatives for teachers of IMGs could also be integrated into ongoing faculty development activities or become "stand alone" sessions. The value of site-specificity is the ability to tailor programs to local needs; the principles of instructional design are, however, universal.

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5. *Build in faculty support and resources for training IMGs.*

Many preceptors have commented that teaching IMGs requires significantly more time because of differences in learning styles, awareness of the Canadian medical system, and the need to identify – and sometimes remediate – gaps in content and skills (Armson, 2002). Thus, teachers need to be freed up to do this work – and appropriate resources must be invested. A number of the respondents commented that without additional resources (additional teachers; in-house peer support and consultations), they cannot teach IMGs effectively, as time, or the lack thereof, as well as a perceived sense of frustration, were considered to be significant obstacles. They also commented that we should select our faculty carefully and expect a minimum standard of core competencies that include cultural sensitivity, international experience and familiarity with post-traumatic stress, which they believe is often experienced by IMGs. To help with the task, several individuals suggested that we become more creative in the use of former IMGs as teachers for IMGs and "coaches" for clinical supervisors. More senior, or experienced, teachers could also serve as advisors or mentors.

6. *Design a national faculty development curriculum and disseminate it widely.*

Although many of the Program Directors in Family Medicine commented on the benefits of local, site-specific workshops, they all commented on the value of providing each program with faculty development materials and resources. In line with this request, it is recommended that we develop a "toolbox" of educational materials (e.g. documents on how to develop a "learning plan" or create a portfolio to demonstrate previous clinical experiences) to help teachers and program directors. This toolbox might include written materials that have already been developed in diverse faculty development programs across the country or "templates" for workshops, self-directed reading programs or online learning programs. Workshop templates should include both core content and educational methods. The section on "Core Content" could describe IMG-related issues (e.g. cultural differences; personal loss) as well as principles of teaching and learning (e.g. assessing learner needs; evaluating clinical knowledge and skills). The section on "Educational Methods" could describe ways in which a particular faculty development activity might be conducted (e.g. interactive plenary followed by small group exercises and videotape reviews).

During the consultation, one respondent, Alison Dugan, kindly offered to provide a series of case examples for teaching purposes. Based on this suggestion, it is recommended that we consider the development of a "case-based workbook" for faculty development in this area, using case examples to highlight issues and stimulate discussion of skills and strategies. In fact, we should remember to emulate the principles that we want to transmit; for example, if we believe that a problem-based approach will enhance learning for IMGs, we should foster this approach with teachers as well.

The success of any proposed curriculum will lie in its utility, relevance and applicability. Clearly, consensus among faculty developers and educational administrators will need to be sought as will a mechanism for dissemination. A number of the respondents suggested that we create a "train the trainer" program to implement the national curriculum. Based on previous work in this area (Skeff, Stratos, Berman, & Bergen, 1992), it appears that such an approach would be an effective method for disseminating a faculty development curriculum.

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## CONCLUSION

Crutcher (2001) has stated that we should "embrace opportunities to work with IMGs with enthusiasm as the rewards are great". It is this belief that must pervade all faculty development training programs. As has been noted by many, IMGs contribute to Canada and our health care system in numerous ways. In addition to helping to meet the health care needs of the population, they offer a richness of experience, culture and language. As stated earlier, Bates and Andrew (2001) observed that "the inclusion of IMGs into postgraduate training can, through spirited dialogue, enhance the cultural basis of clinical practice in North America as well as the requirements of delivering culturally appropriate care to patients of differing ethnic origins". By creating an innovative and responsive faculty development program for teachers of IMGs, we will enrich the experience of all students, residents and teachers as we try to deal with the complexities of an ever-changing multi-cultural society.

It has been said that to teach is "to learn twice". Teaching IMGs and helping faculty members prepare for their roles as teachers and supervisors is an opportunity that should not be missed.

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**APPENDIX A.1**

## KEY FINDINGS OF NEEDS ASSESSMENT – CONSULTATIONS

### 1. Issues Identified in Preliminary Discussions with Key Individuals

*The following issues were identified in preliminary discussions:*

- Faculty development issues for IMG teachers are essentially the "same" as for all teachers; however, some become more "acute" when teaching IMGs.
- Faculty development for teachers of IMGs has to be different because we approach IMGs differently.
- The literature on IMGs is "deficit"- based. We must look at IMGs' strengths and encourage a spirit of "appreciative inquiry" that acknowledges what is going well. We must also honour and respect IMGs' previous experiences and learn from them.
- We must acknowledge the fact that IMGs are already physicians, as this adds a level of complexity to the teaching and learning process. Moreover, as one individual reported, "so does the fact that many of them end up in Family Medicine by default".
- We must address the following concerns:
    - Helping IMGs acclimatize to the North American "medical model". This includes an emphasis on patient-centred care and the concept of partnership rather than paternalism.
    - Cultural issues – and cultural sensitivity training – for teachers and learners.
    - History-taking skills (e.g. sexual history taking).
    - Ethical decision-making skills.
    - Facilitating the IMG-teacher relationship. This would include helping IMGs say that they "don't know"; enabling them to speak their mind more openly and honestly; etc.
    - We must understand gaps produced by cultural differences so that we can address these gaps. In this respect, we must help IMGs articulate their previous teaching and learning experiences.
    - Faculty development should be "problem-based".

### 2. Issues Identified in Group Consultation at McGill

*General Issues:*

- We must carefully define "Who is an IMG". The issues might vary depending on the definition. As well, teachers' expectations and assumptions vary with where an IMG will practice.
- We must consider teacher variables (e.g. teacher's gender, years of experience, cultural biases and prejudices, etc).
- We must find an effective way to orient IMGs. We need to define the content of such programs and perhaps consider including former IMGs in the process.
- We must carefully assess skills and foster an individualized approach. Teaching and learning should be problem-based.

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*Areas of "Challenge" (also considered areas that should be addressed in a faculty development program):*

- Clinical skills
- Psychosocial issues
- Inter-professional issues
- Understanding the hospital system
- How to function when English is not a first language
- Moving from practice to residency and back!
- Finding the "courage" to evaluate honestly

*Faculty development Issues:*

- Orientation of IMGs to the Canadian health care system and "way" of working
- Assessment of knowledge base and clinical skills
- Assessment of IMGs' needs
- Learning how to "tailor" a program to individual needs
- Cultural competence and teaching of cultural competence
- Gender issues
- Formative and summative evaluation
- Design of remedial programs

*Other Issues:*

- Consider using the "Problem" Resident Workshop at McGill

## 3. Issues Identified in Group Consultation at the ACMC

*General Issues:*

- IMGs can enter the system through different routes (e.g. visa training programs; CARMS; or programs specifically designed for IMGs). The definition of IMGs must be clarified.
- We should consider using IMGs as trainers.
- Time – or the lack thereof – is a big issue.
- Faculty must possess "core competencies" (e.g. cultural sensitivity; expertise in PTSD)
- Faculty should be selected carefully (e.g. people with experience, sensitivity, and international experience)
- Systems issues must be considered (e.g. select your faculty; expect core competencies; invest resources to free up time)

*Areas of Challenge:*

- Language issues
- Cultural issues
- Communication issues (i.e. verbal and written)
- The concept of "patient-centred" care (this is where cultural differences re: how medicine is practiced can become quite pronounced)
- Gender issues (and biases)

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- Orientation of IMGs
- Understanding individual backgrounds – including knowledge, previous training, cultural background
- Evaluation (e.g. there are different "mental sets" regarding evaluation)
- Personal stress and "life issues"

*Faculty development Issues:*

- Provide a "toolbox"
- Provide written materials that allow us to take what we have and tailor the materials to IMGs
- Consider a "train the trainer" model
- Consider asking IMGs to create a portfolio on their background experiences
- Distinguish between faculty "development" and faculty "support" and faculty "orientation"
- Consider using standardized patients

*Available Programs:*

- OIMG
- IMG Program in Alberta – to identify, register and assess IMGs and eventually to bring them into a two-year Family Medicine program

**4. <u>Survey of Faculty Developers</u>**

*The survey of faculty developers helped to identify:*

- Individuals with expertise in cultural competence (e.g. Blye Frank); diversity issues (e.g. Rosalyn Howard); teaching students from diverse linguistic and cultural backgrounds (e.g. Ros Woodhouse); needs analysis of IMGs (e.g. Meridith Marks).
- Programs that are being given to IMGs (e.g. communication skills training at U of T and Dalhousie).
- Orientation programs for IMGs (e.g. Dalhousie; Ottawa).
- Other sources of literature.
  As one respondent noted: "Cultural/professional (re-learning) are not quite unique to MD's. This is also an issue in pilot training; teacher training; international TA training, and supervision of international graduate students." There is also a vast literature in second language acquisition, culture and learning, multicultural/diversity issues in education and HE that are fundamental to our understanding diverse learners and effective educational practices. These contribute significantly to the conceptual basis that should underlie any program to help faculty work effectively with such learners."
- Other avenues of inquiry, which included:
  - Programs for teaching English as a second language - for assessment and intervention.
  - Programs offered by the Department of External Affairs in Ottawa (i.e. for new diplomats).
  - Programs developed in "Business", Aerospace Industry and other professions (e.g. Engineering; Architecture).

## 5. Results of Program Directors' Survey

The results of the program directors' survey are summarized in **Appendix A.2**.

## 6. Issues Identified in Follow-Up Phone Calls and E-Mail Exchanges

Phone calls and e-mail exchanges with the different individuals described in **Appendix A.4** were particularly helpful in broadening my thinking and steering me to different programs and resource materials, many of which will be referred to in the faculty development curriculum. Of note at this time is a series of semi-structured interviews conducted by Heather Armson with IMGs during their Family Medicine Residency program. These interviews highlighted the following concerns that will be integrated into the final report:

- The need for preceptors to clarify their common expectations on a routine basis so that "IMGs don't end up in trouble for not doing things that they didn't know they were supposed to do".
- The value of "shadowing" a resident to help identify the different roles that residents play in our system.
- The need to carefully assess language proficiency and cultural differences. As one IMG reported: "Preceptors assume that if you (the IMG) don't speak, it is because you don't know or don't care, when in fact, we are trying to be respectful in ways congruent with our previous medical cultures".
- The need to respect the differences in prior training – both from a content and a process point of view. As another IMG reported: "Our previous training usually focused on textbooks and lectures, whereas the Canadian system has more of an emphasis on practice based applications, clinical practice guidelines, etc."

Heather Armson's willingness to share this information, as well as the results of her semi-structured interviews with faculty members involved in teaching IMGs, is very much appreciated.


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## APPENDIX A.2

## SUMMARY OF RESPONSES TO SURVEY OF CANADIAN PROGRAM DIRECTORS

***Please note:*** 11 (69%) of the 16 Program Directors responded after two mailings. As well, the 4 Quebec Program Directors chose to answer this questionnaire as a group. The "raw data" is provided here to reflect the richness of the responses.

### 1. Does your school have a faculty development program that addresses the needs of teachers of IMGs? If so, please describe briefly – or enclose relevant materials.

*NO – 4*
*No formalized, organized program – however have several faculty development sessions devoted to IMGs (PPT presentation attached); Not so far - but some issues covered at a faculty development workshop*
*Yes - Presentations on history, cultural ethics, program progress*

*Aucun de nos quatre programmes n'a choisi de former les professeurs pour travailler avec les DHCEU indépendamment du reste des activités de formation professorale. Chacun considère qu'il est surtout question d'une démarche d'encadrement ou de « coaching » de résidents avec difficultés pédagogiques en général et qu'il ne faut pas en faire une problématique dissociée. Par contre, on peut aborder les particularités d'encadrement de ces candidats lorsqu'ils sont en difficulté, s'il y a lieu, comme un exemple parmi d'autres. En effet, on aime bien faire la formation à partir d'exemples concrets.*

### 2. In your opinion, what are your teachers' major needs re: faculty development?

*Communication skills development; analysis of areas of weakness; methods of remediating clinical, cultural, and communication concerns;*

*a. The ability to do a needs assessment at the beginning of the program. Our IMGs come into our program with a variety of challenges including medical knowledge deficits, knowledge deficits surrounding the culture of Canadian medicine and Canadian attitudes towards the medical system, attitudinal deficits, social isolation, etc…. b. Difficulties providing feedback (particularly negative) to residents who culturally take negative feedback, or even feedback meant to improve performance and not necessarily negative in the eyes of the teacher, as a great slur and loss of face. c. Our faculty need to develop techniques to teach problem-based learning and deductive reasoning to residents whose previous medical training has all been based on memorization of facts.*

*Identifying the specific needs of IMGs and assessing their skills and needs early in the program*

*A program that covers the differences that are apparent in the teaching of IMGs – both positive and negative*

*a. Cultural competence (including cultural communication workshop – put on by metro immigrant association). b. Language assessment skills. c. Teaching communication skills to people for whom English is second language. d. Recognizing – and addressing their own racial and cultural biases*

*Information about common difficulties encountered by IMGs.*

*Information and discussions to address stereotyped misconceptions.*

*a. Ability to assess level of training/experience - what is documented on paper is not at all helpful in most cases. b. Cultural sensitivity training. Feedback skills - especially when dealing with struggling residents and awareness that feedback may be perceived in quite different ways by different cultures. For instance, any praise may be taken very literally and may negate the impact of negative feedback; conversely, certain cultures do not accept criticism well and saving face is all important. This is particularly true of female preceptors and male residents. c. Assess basic technical skills early.*

*Nous avons tout de même tenté de formuler les quelques besoins de formation professorale plus spécifiques relatifs à cette clientèle de résidents (cf. en annexe) et ceci peut se résumer à deux objectifs. Cela ne signifie toutefois pas qu'on doive faire des actions de formation exclusivement en regard de ces sujets.*

**3. Which of the following content areas do you think a faculty development program for teachers of IMGs should address? (Please rank order – and please add others.)**

- Methods of assessment and evaluation, including the diagnosis of individual learning problems – *1.6*
- Training for cultural diversity – *2.2*
- Principles and strategies of effective feedback – *3.5*
- Needs assessments and the establishment of learning agreements/contracts – *4*
- Common teaching and learning methods, including self-directed learning and the role of reflection in teaching and learning – *4.2*
- Principles of adult learning – *5.75*
- Other …

*As we integrate IMGs fully (and often invisibly) the whole list applies to all of our residents.*

**4. Which of the following teaching/learning methods would your faculty members prefer?**

- Site-specific faculty development workshops – *1*
- Faculty-wide faculty development workshops – *2*
- One-on-one peer coaching – *3*
- Co-teaching/supervision – *4*
- Independent reading program – *5 - Not so helpful, but useful as pre-workshop reading material perhaps*
- On-line learning module – *6 - This really needs to be done face-to-face*
- Other…

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*Nous considérons que la formation des professeurs se fera surtout au quotidien par des méthodes de « coaching » ou de consultation des pairs qui sont plus efficaces à moyen terme puisque plus régulières et accessibles. Aussi, ces contenus pourraient être intégrés dans des ateliers donnés dans les milieux ou dans les programmes; toutefois, cela devra rester à l'échelle des milieux ou des programmes parce qu'il est important que la formation colle à des cas vécus par les superviseurs.*

**5. If we were to design a faculty development curriculum for teachers of IMGs, would this be helpful to you?**

YES = *6*
*YES, our Faculty are as diverse as our learners, thus some choices in FD are appreciated.*

*Les activités de formation doivent donc être élaborées avec la souplesse nécessaire pour s'adapter à la réalité locale. Il serait sans doute utile de mettre en commun les efforts des professeurs qui ont l'expérience avec cette clientèle pour développer certains contenus spécifiques et des exemples d'exercices pouvant être inclus dans la formation pour chacun des volets. Cela pourrait se faire à l'échelle provinciale ou nationale et être mis à la disposition des milieux et des programmes.*

**6. If we were to "mount" a faculty development program for teachers of IMGs, would you prefer that this be conducted locally or nationally?**

*DEPARTMENT WIDE = 1; LOCALLY = 3, WITH AN INITIAL NEEDS ASSESSMENT AND A TAILORED PROGRAM; NATIONALLY= 1; BOTH = 2*
*We also need an adequate national assessment process.*

*Annexe - EN RÉPONSE AUX QUESTIONS N$^{OS}$ 2 ET 3*
*En plus de l'apprentissage des compétences générales requises pour reconnaître, documenter et prendre en charge les difficultés scolaires éprouvées par les résidents en médecine de famille, les superviseurs qui interviennent auprès des résidents issus de la cohorte des DHCEU doivent développer les deux compétences qui suivent :*

1. *inclure, dans une approche centrée sur chaque candidat, l'exploration des dimensions suivantes dans la démarche pour préciser des objectifs d'apprentissages personnalisés :*
   a. *caractéristique de la formation médicale antérieure (incluant les différences majeures par rapport à la formation nord-américaine)*
   b. *pratique médicale du candidat en insistant sur les caractéristiques de la démarche clinique propre à cette pratique (incluant une notion des problèmes courants par rapport à ceux rencontrés dans nos milieux)*
   c. *particularités du rôle du médecin par rapport au rôle du patient et caractéristiques de la relation patient-médecin dans leur expérience antérieure (en formation et en pratique)*

*N.B. À ce propos, un inventaire des caractéristiques générales de formation et de pratique en regard d'un certain nombre de pays d'origine des candidats DHCEU serait utile.*

2. *Effectuer la démarche de raisonnement pédagogique face aux indices de difficulté en tenant compte des problématiques pédagogiques rencontrées le plus souvent* par les candidats de cette cohorte.*

**Le tout devrait être documenté à partir de l'expérience des dernières années des équipes de superviseurs qui ont travaillé avec ces candidats, en partant du schéma suivant et en sachant que les difficultés sont souvent mixtes : difficultés inhérentes au candidat lui-même et difficultés inhérentes à la relation superviseur-supervisé et défis conséquents dans l'adoption d'une position d'apprentissage appropriée.*

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## APPENDIX A.3

## INDIVIDUALS CONSULTED IN THE DEVELOPMENT OF THIS PROPOSAL

**Preliminary discussions were held with the following individuals who are very familiar with IMG-related issues:**

- Dr. Heather Armson, University of Calgary
- Dr. Joanna Bates, University of British Columbia
- Dr. Miriam Boillat, McGill University
- Dr. Rod Crutcher, University of Calgary

**Follow-up telephone calls and e-mail exchanges were held with the following individuals who were identified as having expertise in this and related areas:**

- Gisele Bourgeois-Law, University of Manitoba
- Catherine Cervin, Dalhousie University
- Alison Dugan, University of Ottawa
- Blye Frank, Dalhousie University
- Rosalyn Howard, University of Manitoba
- Meridith Marks, University of Ottawa
- Susan Strasser, Northern Medical Program
- Rosamund Woodhouse, Queens University

These individuals have all given generously of their time and expertise, and their willingness to share information, resources and materials is gratefully acknowledged. As stated in this report, we have many “well-kept secrets” regarding training and development in this area in Canada, and it is hoped that the dissemination of this report will help to recognize and bring together this collective wisdom and expertise.

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## APPENDIX A.4

### GENERAL PRINCIPLES TO GUIDE THE DEVELOPMENT OF A FACULTY DEVELOPMENT PROGRAM FOR TEACHERS OF IMGS

1. The content and process of a faculty development program for teachers of IMGs is not fundamentally different than one for teachers of all postgraduate trainees. However, certain topics may be encountered more frequently – or become more pronounced – when working with IMGs.

2. Faculty development refers to different approaches to helping faculty in their multiple roles. This includes faculty development, faculty *orientation*, and faculty *support*.

3. Principles of effective faculty development must be applied in this context as in all others. That is, faculty development programs should incorporate principles of instructional design and educational relevance, and the outcome of all faculty development initiatives should be evaluated.

4. A “deficit-based approach” to understanding learner differences must be avoided.

5. All educators must recognize – and acknowledge – that each IMG is a unique individual.

6. All educators must recognize – and acknowledge – that each teacher/supervisor is a unique individual, different from his/her colleagues.

7. Opportunities for training IMGs should be used to benefit all trainees.

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## APPENDIX A.5

## SPECIFIC RECOMMENDATIONS TO GUIDE THE DEVELOPMENT OF A FACULTY DEVELOPMENT PROGRAM FOR TEACHERS OF IMGS

1. Develop an orientation program for teachers of IMGs.

2. Incorporate at least six key content areas into a faculty development program for teachers of IMGs. This should include:

   - Assessing learner needs & establishing mutual goals and expectations
   - Evaluating clinical knowledge and skills
   - Providing effective feedback
   - Promoting patient-centred care
   - Teaching communication skills
   - Developing a collaborative teacher-learner relationship & designing individually tailored learning programs

3. Include cultural diversity training programs into a faculty development program for teachers and supervisors of IMGs.

4. Develop site-specific faculty development programs that are relevant to the individual context of teachers and learners and that utilize a variety of teaching and learning methods.

5. Build in faculty support and resources for training IMGs.

6. Design a national faculty development curriculum and disseminate it widely.

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Teacher Learner Advocacy Committee. Diversity. Programs. American English for Internationals. Underrepresented in Medicine. Funding Request Form.Â  The program helps international medical professionals develop the confidence and determination to pursue more conversations â€“ professional and personal â€“ in American English.Â  The program is taught by experienced ESL instructors who specializes in accent modification and has been approved for 22 AMA PRA Category 1 Credit(s)â„¢ by IU School of Medicineâ€™s Division of Continuing Medical Education. This is not a class for learning to speak English. To be eligible to participate, individuals must have a moderate degree of fluency in spoken English. Registration. A Faculty Development Program for Teachers of International Medical Graduates. Program Overview Available at: http://www.afmc.ca/ img/programoverview_en.htm. Nov 2012. Y Steinert.Â  This article describes the Medical Education Research Certificate (MERC) program, a national faculty development program that focuses exclusively on MER. Sponsored by the Association of American Medical Colleges and led by a committee of established medical education researchers from across the United States, the MERC program is built on a set of 11 interactive workshops offered at various times and places across the United States. MERC participants can customize the program by selecting six workshops from this set to fulfill requirements for certification. An International Medical Graduate is a physician who received his/her basic medical degree or qualification from a medical school located outside the United States and Canada. The location of the medical school, not the citizenship of the physician, determines whether the graduate is an IMG. This means that U.S. citizens who graduated from medical schools outside the United States and Canada are considered IMGs. Residents & Fellows.