

**Examining an Orientation Program for International Medical
Graduates (IMGs) Through the Lens of Critical Theory:
A Learner-Centered Program**

Gwen MacPherson

June 2011

Mount Saint Vincent University

Thesis Supervisor:

Dr. Patricia Gouthro

Thesis Committee Member:

Sandra Taylor, PhD (c)

Copyright 2011 Gwen MacPherson

Table of Contents

Dedication.....	5
Abstract.....	6
Chapter One - Introduction	
Introduction.....	7
Research focus	8
Purpose.....	10
International Medical Graduate.....	12
My Role	14
Understanding theory.....	16
Informal theory.....	16
Formal theory.....	16
Critical theories.....	17
Socialization.....	19
Lifelong Learning.....	20
Continuing Mandatory Education.....	22
Lifelong learning and the CAP Program.....	23
Overview of thesis.....	24
Chapter Two - Overview of IMG Programs and Policies in Canada	
Canadian Policy for IMGs.....	26
Current Canadian IMG Orientation Practices.....	26
IMG Orientation Programs across Canada.....	30
The CAPP Orientation Program Modules and Objectives.....	34
Considering the Learner.....	38
Assessing Curriculum in the CAP Program.....	39
Role of the Educator.....	42
Considering IMG Programs and Adult Learning Theories.....	43

Chapter Three - Adult Learning Theories and IMG Programs

Informal, Non-formal and Formal Approaches to Learning.....	46
Connections between different types of learning.....	48
Current Medical Education.....	48
Lectures.....	49
Problem-based Learning.....	49
Experiential Learning.....	50
Self-directed Learning.....	51
Reflective learning/practice	52
Collaborative Approaches to HealthCare.....	54
Influence of Learning Theories in Curriculum.....	55

Chapter Four - Critical Theories

Critical Theories.....	57
Stephen Brookfield.....	58
Paulo Freire	61
Banking Education.....	64
Multicultural Education.....	66
Critical Race Theory.....	68
Afrocentricity.....	68
Black Feminist Thought.....	69
Feminist Theories.....	70

Chapter Five - Power

Issues of Power.....	77
----------------------	----

Chapter Six - Conclusion

Beyond Instrumental needs.....	91
Evaluation of a Learner-centered Program	92
Pedagogy of Hope.....	94

Future of IMG Orientation Programs.....90

Conclusion.....97

References.....100

Dedication

I would like to express my sincere gratitude to my mentor and friend, Dr. Robert F. Maudsley, who in September 2004, introduced me to the world of International Medical Graduates. Since that time, he has assisted me tremendously with his knowledge, and encouragement to seek scholarly opportunities which in turn allowed me to develop an expertise in the field of the orientation of International Medical Graduates (IMGs). I dedicate my Masters thesis in honour of his unwavering support throughout the past seven years. It has been my good fortune to be mentored by such an exceptional educator.

I would also like to take this opportunity to express my deep appreciation to my thesis advisor, Dr. Patricia Gouthro, who demonstrated tremendous patience with me throughout this two- year process. I thank you Patti for teaching me the art of academic writing and how to ask questions critically. I enjoyed our discussions. These newly acquired skills have increased my confidence to pursue academic opportunities. It has been a pleasure to have studied under your guidance. I also wish to thank my colleague and Committee member, Sandra Taylor with whom I have had many discussions with regarding the mentorship of International Medical Graduates and have learned greatly from her expertise. Lastly, I extend my heartfelt thanks to my colleagues from the College of Physicians and Surgeons of Nova Scotia who I have driven crazy (I am sure!) talking about my thesis for the past two years. They have been very supportive and their encouragement has been very much appreciated.

“If I have the belief that I can do it, I shall surely acquire the capacity to do it even if I may not have it at the beginning”

Mahatma Gandhi

Abstract

My research will explore how although many orientation programs for International Medical Graduates (IMG's) claim to adhere to adult learning principles, they are often not designed to respond to a number of concerns critical theories in adult education would address such as power issues, including concerns around race, gender and lifelong learning. In my thesis, I will be introducing a theoretical analysis of some of the concerns around developing curriculum and designing programs for IMGs. My discussion will be informed by existing research, my own professional experience and related literature from other healthcare related disciplines such as nursing, social work, and pharmacy critical education. I will also investigate the potential of adult learning theories and, in particular, critical theories in adult education/lifelong learning to inform the development of successful IMG programs. Although the focus of my study is linked to my experience in working with the IMG program in Nova Scotia, this examination of learning theories may be applicable to developing improved curriculum for IMG programs across Canada and elsewhere. The application of a critical lens in the orientation of IMGs will enable adult educators within these programs to foster more inclusive and beneficial teaching practices.

Keywords: IMG, Orientation, CAPP

CHAPTER ONE

International Medical Graduates (IMGs) in Nova Scotia play a vital role in the delivery of healthcare services, particularly in rural areas. Inadequate orientation to the Canadian healthcare system has been identified as being a significant barrier to IMGs practicing confidently. There is little in the medical literature that describes best practices for orienting new physicians although numerous studies in Canada, the United States and Australia (Curran et al 2008, Taitz et al. 2004, Wozniak et al., 2009) have been conducted to determine new physician orientation needs and their preferred method of having these needs met. Currently IMG orientation program curriculum includes problem-based learning, and a more traditional didactic lecture approach. Although medical education in general may not often explicitly refer to learning theories, adult educators recognize that theory implicitly informs the decisions and education practice in teaching/learning relationships.

In this thesis, I will be introducing a theoretical analysis of some of the concerns around developing curriculum and designing programs for IMGs. My discussion will be informed by existing research, my own professional experience and related literature from other healthcare related disciplines such as nursing, social work, and pharmacy critical education. I will also investigate the potential of adult learning theories and, in particular, critical theories in adult education/lifelong learning to inform the development of successful IMG programs. Although the focus of my study is linked to my experience in working with IMG program in Nova Scotia, this examination of learning theories may be applicable to developing improved curriculum for IMG programs across Canada and elsewhere.

Research Focus

There are varied types of orientation programs for IMGs in Canada, the United States (US), and Australia. Some of them espouse the principles of adult learning principles but fall short of incorporating a strong theoretical basis with regards to how the orientation program is designed and delivered to participants with differing learning needs. Although many orientation programs claim to adhere to adult learning principles, they are often not designed to respond to a number of concerns critical theories in adult education would address such as power issues, including concerns around race, gender and lifelong learning.

For the most part, IMG orientation curriculum is designed as a reaction to deficiencies. By this I mean that educators of IMGs programs have built their programs based on what IMGs struggle with in terms of medical knowledge and skills. These deficiencies could include such things as knowing how to record entries in a patient chart, how to deliver ‘bad news’, in a culturally sensitive manner or the prescribing of the appropriate amount of medication. Many IMGs, whether they are residents or practice-ready physicians, are coming from medical schools/systems that do not teach or use resources that are common place within the Canadian healthcare system. Because the focus is on teaching IMGs the instrumental information such as how to conduct patient billings, what organizations you need to pay fees to in order to maintain a medical licence, prescribing guidelines, and when to withdraw a patient’s drivers licence, not much time is spent on what other factors could help them ease into their new environments such as working with diverse cultures. What is most notable in the development of the curriculum is an absence of relevant feedback from the IMG learner as well as more critical reflection or assessment from the educators.

The experience of instructors teaching IMG orientation programs is varied across the country. Instructors can be practising physicians or other healthcare professionals who teach in the medical schools or staff from regulatory bodies. They usually understand their role as instructors to be content experts who need to deliver information in order to address the deficiencies of the IMG learners and may not have theoretical background or knowledge to prepare them to teach from an adult education perspective.

In order for educators to design an effective IMG orientation program they need to critically assess the learning experiences of the IMG, and uncover elements of the orientation process that could be improved. This requires ongoing evaluation of the modules and content, reading materials, paradigms and theoretical perspectives, and the ongoing support of physician mentoring. Bringing a critical lens to the development of educational programs for IMGs could provide educators of IMG programs with an understanding of how to diminish some of the anxiety IMGs experience when they are required to adjust to a new environment. One strategy is that as educators of IMG's, we could help to manage these anxieties by constructing a supportive program that is more learner-focused and where the consequences of failure are minimal, so learning can take place. By the time an IMG arrives at the stage of orientation, they have already gone through a number of assessments, sometimes repeating exams because of their lack of prior medical training and/or familiarity with the Canadian medical context.

In my role as Program Manager for an IMG assessment program, I have observed that IMGs experience great anxiety during orientation because they are learning yet more new information with the expectation they will be tested as this is the practice in some orientation programs. Trying to develop an orientation program informed by a critical perspective that would encourage learner engagement is often challenging, given that most IMGs are coming

from education systems that have purely didactic methods of education and everything is memorized and then regurgitated on an exam. In these contexts, achieving an acceptable test score is of the utmost importance. So you can see how difficult it is to expect an IMG to engage in dialogue, openly ask questions and be able to exchange concerns that may be important but may not seem to be directly relevant to medical education i.e. What can I expect when I go to practice in a small rural community? Where will my family live? Will we fit into Canadian society?

Purpose

The purpose of this study is to explore how the application of critical theory to the design of an IMG orientation program could support a learner-centered experience and how this can be enhanced by focusing on the more non-scientific ways of knowing (Newman, 2007). There is more to the orientation of an IMG than the exchange of medical information. As part of the integration into Canadian medical practice, IMGs need to have information on how to take care of themselves and manage the stress that comes with moving into a world completely different from where they have previously lived and practiced medicine. We all have learning needs outside of our professional world. A learner-centered program design should take into account the physical, mental, and social conditions of the learner. It is important that we understand that our world is made up of a number of factors which effect how we learn.

Some of the questions that should be asked are about how learners are feeling emotionally and physically. Most times in a new environment we feel disoriented. IMGs are adapting to so many variables including the stress of many exams and whether they will be able to practice their medical profession in a new country. The fear of the unknown can take its toll on one's physical health. How we fit in socially? IMGs can feel an overwhelming sense of

isolation. Do we feel accepted? Even following an orientation program, IMGs need a continuation of assistance. Following an orientation session with a mentorship program that continues through an IMG's first year of practice may help them to adapt not only to a new medical practice and all of the responsibilities associated with it. Post-orientation follow-up is also important because of the challenges IMGs face around whether the community will accept this new physician who may speak English but struggles with the terminology a lay person would use or may not be fair-skinned and look like one of them, particularly a physician who may be wearing a scarf or veil.

What we experience in our own personal lives has an impact on learning. A learner-centered program design would recognize that IMG participants are multi-faceted. They come with their own set of values and ways of learning. "During orientation and/or training and intervention efforts, programs must also focus on the latent features of cultures such as the differences in norms, values, beliefs, attitudes and expectations" (Dorgan et al, 2009, p. 1573). Most IMGs are coming into an unfamiliar medical practice that they struggle with and some have been unsuccessful partially because programs did not provide an orientation that addresses learning from what adult educators would deem to be a more holistic framework.

One of the challenges in writing this thesis is that medical practitioners and adult educators often use language in different ways. The term 'holistic' often has negative connotations in Western medical practice as it is connected with alternative healthcare practices that may contradict or interfere with a more scientific approach to medicine. Adult educators use the term to discuss thinking about teaching and learning as a relationship that considers the needs of the learner as a whole person. For example, IMG's have needs as learners not only as medical practitioners, but also as potential Canadian citizens.

International Medical Graduates (IMGs)

IMGs are not a homogeneous group. They come from many countries all over the world. Their prior medical training, culture, language, and life and work experiences often differ from Canadian medical graduates (Steinart & Walsh, 2006, p. 3).

For the purpose of my study and adhering to the Canadian Institute for Health Information (CIHI 2008) the definition of an IMG, is a person living in Canada who has a medical degree that was obtained from an institution outside Canada. No distinction can be made between IMGs who are immigrants and physicians who are of Canadian origin who studied and received their medical degrees elsewhere. The determination of who constitutes an IMG and who is a Canadian-educated medical graduate is made according to the country where individuals attained their medical degrees (as opposed to where their postgraduate residencies were completed). For most IMGs this will not necessarily be the physician's first year of practice as he or she may have practised outside of Canada before coming to Canada.

Although each IMG's experience is individual in nature they have strengths and challenges in the learning environment common to all medical practitioners. "IMGs can also be seen as bringing valuable experience and knowledge to the patients they see and to others with whom they interact, and to our health care system" (Memorial University, 2007).

Most IMGs in Nova Scotia will practice in rural areas which possess a number of unique personal and professional challenges. "These challenges may include heavy workloads, on-call responsibilities, a population with complex health problems, personal and professional isolation, difficulties in accessing professional development, and family support issues to name a few"(Morgan, 2006, p. 202). These challenges are not unique to Nova Scotia. Nationwide, varied

orientation programs for IMGs to rural general practice have been developed to respond to these needs.

There are two groups of IMGs in Nova Scotia. The first group of IMGs is new to the Canadian Healthcare system. They have been successful in their assessment through the College's Clinician Assessment for Practice Program (CAPP), and are subsequently supported through a structured four-year program. The second group of IMGs is made up of those who are already in the Canadian system and have come from another province. Because of my experience as a program manager for an IMG assessment program based in Halifax, Nova Scotia, my research will focus on the first group.

Both groups practice under a Defined licence (a licence with restrictions) until they have successfully attained their Licentiate of the Medical Council of Canada (LMCC) and the College of Family Physicians of Canada (CCFP) certification. Within Nova Scotia, both groups must also have a sponsor (a chief of staff from a District Health Authority [DHA]), and an appointed mentor who is also a family physician practicing in the same DHA. It is important to note here that the CAPP mentors are reimbursed for their time and the other group of mentors is not. Of course, the CAPP mentors spend more hours mentoring the IMG than the other group of mentors.

In 2006, a survey of mentors with the CAP Program (R. F. Maudsley, June 21, 2006) revealed that a structured orientation of IMGs was needed. Mentors indicated a need for some specific knowledge and skills enhancement for the IMG physician as they began their family practice in Nova Scotia. In the same year, the CAP Program offered its first orientation. The orientation program was based on the identified needs of the IMGs from two prior cohorts. It was offered at no charge to the IMG and was a mandatory learning program. We also wanted

the participants who had just been through a gruelling assessment of their medical knowledge to enjoy their learning experience without the anxiety of further testing, so we made the decision not to test the acquisition of knowledge during the orientation. Essentially, the successful IMGs have done what they needed to do to obtain licensure and we did not want to place more barriers in their way.

It is important that the orientation program was designed to meet the needs of the whole individual. “Orientation processes for new IMGs must be attentive to both professional and personal needs, comprehensive, multifaceted and sustained and responsive to the various needs of new IMGs. Effective orientation processes are an important means of reducing professional isolation and supporting new IMGs in the transition to medical practice in their new communities” (Curran et al, 2008, p.169).

Considering the social needs of IMGs warrants further research and discussion and should be of importance to adult educators, specifically in those involved in medical education. Throughout the thesis, I will speak further to the orientation of the IMG population and how we can develop a learner-centred orientation program using the critical theories to inform curriculum design and improve pedagogical practices. As a part of this discussion, I will draw upon my knowledge and experience related to the CAP Program and to the learning needs of IMG’s.

My Role

As a program manager for the CAP Program, a program which assesses IMG candidates for practice readiness in Nova Scotia, I am responsible for the ongoing development and implementation of an orientation program for the IMGs who practice in rural Nova Scotia.. My role in the CAPP orientation specifically is to organize facilitators with modules, disseminate

information, personally facilitate one module, oversee the program's successful implementation of the program, program evaluation, and make improvements to the program when the opportunity arises. I also have input into the planning of the curriculum.

After reading the comments of the progress and practice audit reports from cohorts of mentors and the IMGs, I began to see gaps in our own orientation program where we could improve the experience for IMGs on a more holistic level. I believe it is important to look at the IMG as a social person who had not only clinical/medical education needs, but also has needs for a social network and personal fulfillment. I am also a student in the Masters of Arts in Education in the Graduate Studies in Lifelong Learning program at Mount Saint Vincent University and it is because of my exposure to how adult education research and critical theory can inform educational policies, I am using my thesis as a way to explore alternative perspectives for developing a more critical and holistic approach to IMG orientation programs.

My thesis draws upon existing literature and research to develop a theoretical discussion. In addition, my research draws upon my experience as a program manager for the CAPP who is responsible for the implementation and design of our own orientation program. I have used some of my observations and learning to inform my thesis. I will use the CAPP orientation to reflect on the content of the program and how it is presented, the backgrounds of the facilitators, the diversity of our cohorts, and the evaluation of the program by both the facilitators and participants. I will also discuss some of the lessons we have learned from the CAP Program. These points will be discussed further in the following chapters with attention paid to some aspects of adult learning theory.

Understanding Theory

It is advantageous for educators to have a wide understanding of theory to inform their teaching in different contexts. By applying theory to program design we become aware of our own beliefs and assumptions and strive to make the educational experience effective and worthwhile. “As educators, we need to ensure that the theory applied to orientation practice is comprehensive to include all types of learning, its practicality, and the universality of its application” (Merriam & Caffarella, 1991, p.264). IMGs have diverse learning needs and as adult educators we need to be able to address these needs with effective problem solving which is supported by the application of both informal and formal theory.

Informal theory

We all have our own experiences and beliefs from which we develop our own informal theories. Informal theory refers to an assumption, an opinion, or a speculation. It is not necessarily based on research. It is usually a belief, policy, or procedure proposed or followed as the basis of action. Informal theory is often used as part of the reflective evaluative process. For instance, we may use it to inform our decision making i.e. thinking learners will be less stressed if we do not give them a pass/fail grade or thinking students will be willing to talk more if they sit in a circle often guides how we conduct our teaching practices.

Formal theory

Theory helps us make sense of the world. “All education practitioners develop informal, contextually grounded theories of practice to help them understand the arenas in which they work, however, formal theory has an important contribution to make in helping to convert

context specific, informal hunches into well framed theories of practice” (Brookfield, 1992, p. 79). A formal theory is a logical statement or set of statements that attempts to explain observed phenomena, which is well tested and widely used. Formal theory helps us analyze our own perspectives on informal theories through proven frameworks by looking at research studies with empirical evidence and also through detailed frameworks that are a part of larger theoretical frameworks.

Critical Theories

In the literature I have reviewed on IMG orientation programs there is little evidence of critical theories being utilized when designing and or evaluating orientation programs. I think the perceived absence of theory in the development and evaluation of the programs short-changes both the participant and the program. Grace (2006) states “Theory helps us to problematize practice and interrogate the status quo as we make the familiar unfamiliar in a process of seeing the self, culture, society and others in a new textured light that the lens of theory offers” (p. 129). Theory prompts us to ask questions about the practices we typically take for granted. For example, we may assume that all learners learn effectively by lectures. However, if we were to incorporate theory into this assumption we would look at research that challenges us to ask why we think lectures are the only way to teach. We would then look at educational research that shows alternative ways of teaching i.e. self-directed or small group learning activities, which show learners taking ownership of their learning.

In order to critically assess our beliefs and assumptions, we can look at critical theories, including critical race theory, black feminist thought and feminist theories, to better understand the challenges that marginalized learners face. We can also gain insights from formal theories about learning experiences, particularly when addressing issues of power. Grace (2006) states

“that when we want to question how particular relationships of power impact individuals and building communities that embrace and respect difference, one theory alone may not suffice” (p. 135). It is often beneficial to explore several theories and take a diverse approach. One way of teaching does not resonate with all learners.

Our modern classrooms are made up of diverse groups with varying needs and understandings. For instance, students of color may not relate to a white teacher because that person has no understanding of the challenges faced by a person of colour or they might believe that the curriculum has no relevancy to their own societal needs. When we look at critical feminist theories, I can draw upon my own personal experiences as an adult learner with male professors who had no understanding of my challenges of juggling a full time job with those of a single parent household. Any time I had to miss a class because of professional or familial responsibilities, I was penalized. There was no flexibility so I was treated exactly the same as my younger counterparts. Those responsible for creating curriculum may merge a number of critical theories to encourage a more learner-focused learning experience.

There are many power relationships between an educator and a learner. For the most part, they are unavoidable but the negative aspects may be mitigated if the educator has a clear understanding where they exist and how they can be managed to a point where they are not at the forefront of a learner’s experience. Etienne Wenger (1998) states “power is a central question in the social theory of learning” (p. 14). By exploring critical theories of education, both educators and learners become aware of how power i.e. through race, gender, social class, and so forth. may shape teaching/learning relationships.

In my research, I will draw upon the foundational work of a number of critical theorists by highlighting Paulo Freire’s focus on dialogue and his concern for the oppressed, Stephen

Brookfield's work on critical thinking and Donald Schön's prominent work on reflective practice and discuss how their work can inform educators who work with IMGs. I will also discuss critical race/gender feminist theories and how understanding them will help adult educators recognize the complexities of linking race, class and gender issues when developing programs to assist IMGs with the integration of their personal, family and social contexts.

Socialization

Learners can actively construct their professional socialization. "Previous research also finds that professional socialization is not uniform or consistent and does not produce a homogeneous class of practitioners who subscribe to the same values" (Daniel, 2007, p.28).

Learners enter a profession with well-defined expectations of their role models that correspond to their vision of ideal family physicians.

Because socialization and training norms revolve around a white male standard, minorities may regard their instruction and expectations as unrealistic. Their values may also conflict with those of white male academic culture. For instance, many IMGs do not feel comfortable questioning an educator about what they are being taught, even when encouraged to do so. They do not want to appear confrontational or that they are lacking knowledge.

Socialization has been most successful for those who can fit the status quo.

IMG learners often find themselves isolated without appropriate role models and mentoring relationships. They are also often frustrated by the absence of a culturally relevant curriculum. "There are core themes that are related to the issues around the lack of socialization among minorities: cultural and racial isolation, lack of relevance of the curriculum to minority issues, invisibility and distance from program staff, interaction with peers, mentoring and

support, race and supervision and curricula and program wide changes” (Daniel, 2007, p.30).

The lack of diversity in the facilitators and curriculum also restricts the nature and quality of an IMG’s interactions inside and outside the classroom, threatening both the performance and social experiences. Yet ideally an orientation program should prepare and encourage IMG’s to engage in learning as a lifelong process.

Lifelong Learning

An important goal of the CAPP orientation program is to teach IMGs to think of themselves as lifelong learners. This goal is important not only for IMGs but for Canadian physicians as well. There are a number of reasons why physicians need to become lifelong learners.

Foremost in this requirement to become a lifelong learner is the ever-changing technologies in medical practice such as Electronic Medical Records (EMRs) and complementary medicine alternatives. Most IMG physicians have not been exposed to EMRs and have difficulty transitioning from the paper chart and the usage of its short forms for various procedures.

Canadian physicians also practice patient-centered care. This is also a new concept for IMGs as they may not have been exposed to patients questioning the physician about their care and suggesting alternatives other than traditional medical care. With the ubiquitous media, internet, and other technologies, patients know their rights, and can and will challenge a physician’s diagnosis or lack of one or make a complaint to their provincial College regarding how they were treated by a physician.

We experience the world through many different perspectives. Mantzoukas (2004) states that “a paradigm such as critical theory denounces the possibility of an absolute truth of a definite reality or the authoritarian power of certain narratives in explaining the world” (p. 999). Critical theorists ask us to consider how the interests of various groups are being served or denied by our tacit assumptions (Cheren, 2002, p.191). We cannot assume that a physician coming from another country can be dropped into the Canadian medical context and not need some form of support or orientation. A successful IMG may pass all of the required technical assessments but achieving a passing score does not prepare them for the actual culture shock of Canadian medical practice, particularly a rural one. IMG’s have to engage in continual lifelong learning as they adjust to working and living in a different country and cultural context.

Another reason for becoming a lifelong learner is that revalidation is coming to most Canadian provinces sooner or later. Revalidation is the proof that a physician has remained up-to-date in their medical knowledge and are fit to practice. This learning will be evidenced through a portfolio of continuing medical education and/or multi-source feedback process of peers, coworkers, and patients. “Based on the Organization for Economic Co-operation and Development (OECD) Report of 1996, lifelong learning can be defined as a means of shaping the future of societies, by fostering the personal development of the individual, countering the risks to social cohesion, promoting democratic traditions, and responding to the challenges posed by increasing global and knowledge-based economic and social system” (Schuetze, 2006, p. 291). Shuetze points that the lifelong and recurrent education concepts implied extensive changes not only in the entire education system, but also in enterprises, labour markets, social insurance and income transfers.

There are challenges involved in taking up the concept of lifelong learning. Lifelong learning is a gray area meaning different things to different people. For example, lifelong learning often encompasses adult education, and continuing professional education and higher education.

Continuing Mandatory Education

While the overall goal of the CME component of the CAPP is to assist the physician in becoming proficient and adapt to the Canadian medical context, the physician is expected to continue to engage in continuing education throughout their practice years (<http://www.capprogram.ca/mentoring-faq.htm> Retrieved August 2, 2010).

Mandatory Continuing Education (MCE) came about in Canada and the United States toward the end of the 1970s. Its focus was primarily on individual performance and economic productivity. Grace asserts that “this kind of education is usually based on official and structured knowledge, worker obsolescence, learner freedom and control, institutional manipulation and control” (Grace, 2007, p. 86). Some experts believe that MCE is based solely on technical/scientific requirements. It has little regard to the contextual, dispositional and relationship building education. “MCE goes against adult learning principles, such as voluntary participation, the informal nature of adult education, and adult self-direction. It promotes uniformity by disregarding individual learning needs and styles” (Kerka, 2005, <http://www.academyprojects.org/kerka.htm>, Retrieved November 14, 2010).

Although Kerka’s and Grace’s points are well-taken, many physician and other health professional regulatory bodies are instituting MCE to ensure in the interest of public safety that physicians, nurses, pharmacists and other health professionals are kept current in our fast-paced

ever-changing medical environment. Few people would want to see a health professional who was not current. For Canadian physicians, MCE or Continuing Medical/Professional Education (CME/CPD) is or will be a requirement to maintain licensure/certification with their respective Colleges.

Lifelong Learning and the CAP Program

Translating the concept of lifelong learning into different cultures and political contexts of countries outside of the North American context can be a challenge. During the CAPP orientation of IMGs, we take up the concept of lifelong learning by introducing the concept of mentorship which entails a learning plan, mandatory continuing medical education and an emphasis on becoming a reflective practitioner. The latter is also new concept for many seasoned Canadian physicians.

Mentorship

The CAPP mentorship program provides an opportunity for the physician to learn and experience family practice in Nova Scotia, with the coaching and facilitation of an experienced family physician. The mentorship has been designed to ensure that the CAPP physician establishes practice with competency and support, and that they are integrated into the local medical community and into the broader community in which they live and work.

The learning goals are designed to be addressed throughout the mentorship and are the responsibility of the mentored physician. These learning goals and progress towards them will be addressed during meetings between the mentor and the mentee. The mentor is a key person in providing guidance to assist the IMG physician in achieving the goals. There is a CME

Coordinator available as an on-going resource throughout the mentorship and who will work with the IMG in consultation with the Mentorship Coordinator.

Reflective Practitioner

In current medical education, there is great emphasis on reflective practice. “Society expects physicians to remain competent throughout their careers capable of assessing their own knowledge, skills and performance and direct their continued learning” (Sargeant et al., 2006, p 655). Donald Schon’s (1987) work on reflection-in-action is a way of thinking and asking ourselves could I have performed this particular task better? During the orientation program for IMG’s, learners are encouraged to develop this capacity to become reflective practitioners as they develop their medical practice.

Overview of Thesis

In this first chapter, I introduced the concept of an IMG orientation program and explained how there is more to the orientation of an IMG than the exchange of medical information. I described why a learner-centered program design should take into account the physical, mental, and social conditions of the learner.

In chapter two, I will discuss the national policy as it pertains to the integration of IMGs into the Canadian healthcare system and describe the provincial IMG orientation programs highlighting the CAP Program in Nova Scotia, which provides the basis of my personal experience on this topic. In chapter three, I will describe Critical Theory and its relevance to this particular study. Chapters four and five will explore the application of critical theory to an IMG orientation program and where we have opportunities to address a number of issues such as power, race, and gender issues of power (real and perceived), fostering lifelong learning in the

IMG and create an environment for learner-centered learning. In the final chapter of my thesis, I will discuss the pedagogy of hope and how it applies to the IMG orientation experience.

CHAPTER TWO

In this chapter, I discuss national policies as they pertain to the orientation of IMGs into the Canadian healthcare system and describe the various provincial IMG orientation programs/practices with emphasis on the CAP Program in Nova Scotia. I also discuss using adult learning principles within an orientation program, learner-centred IMG orientation programs and the curriculum along with the importance of cultural identity.

Canadian Policy for IMG's

In 2004, a 15-month-old task force had achieved a consensus on developing a national integrated approach to assessing and training IMGs, and work toward standardizing licensure evaluations. The Canadian Task Force on Licensure of International Medical Graduates would see a number of programs initiated to streamline evaluation processes with the main objective to ease and accelerate their accreditation in order to put human capital to use in Canada and provide fair treatment to immigrants.

(http://www.nationalreviewofmedicine.com/issue/2004_03_30/government_medicine04_06.htm.

Retrieved October 31, 2010).

The Health Canada IMG Task force made the following recommendations pertaining to IMG orientation programs for physicians new to the Canadian health care system:

- Develop a program to assist IMGs with cultural and professional communications so that they can meet language standards.
- Offer provincial/regional orientation programs for all physicians starting practice.
- Develop orientation programs to support faculty and physicians working with IMGs

In addition to Task Force's recommendations on Licensure of Medical Graduates (2004), it also identified the following topics as being important to new IMG orientation:

- Canadian medical system;
- Principles of medical care;
- Provincial health care system;
- Provincial health care insurance plans;
- Nature and structure of national and provincial licencing and registration requirements;
- Liability coverage;
- Professional associations and memberships;
- Practice supports
- Practicing medicine in Canada
- Context of Practice

As a point of interest, none of the above topics speaks to the physical, mental and social needs of an IMG outside of the instrumental needs of clinical practice.

Current Canadian IMG Orientation practices

Over the past few years, orientation programs for IMGs integrating to rural general practice have been developed throughout Canada. Everyone starting out in a new job needs an orientation to their surroundings and the expectations of the workplace. "There is little in the medical literature that describes best practices for orienting new medical personnel" (Taitz, 2004, p. 1). The primary purpose of orientating IMGs is to promote successful integration of the IMG into the medical community/Canadian Health Care system.

Orientation for the purpose of this study is defined as “A process of socialization to the norms, values, and working environment. It should allow new physicians to integrate into the team through informal, interactive sessions” (Hollett & Hann, 2007, p.1). What this means is that an orientation should provide an IMG with lots of interaction and opportunities to share knowledge, ideas, and to learn new skills. Orientation programs present information on a wide variety of topics such as: medical legal ethics, collaborative practice, patient centered care, cultural diversity, medical recordkeeping and prescribing etc.

Studies in Canada, the United States and Australia have been conducted to determine new physician orientation needs and their preferred method of having these needs met (Porter et al (2008), Taitz et al. (2004), Wozniak et al. (2009). An additional perspective on the increasing need for a well-prepared IMGs is added by the shifting demographics in Canada’s Health care system indicating increased numbers of IMG physicians, with currently 20-25% of physicians in Canada being IMGs (Canadian Medical Forum Task Force Report, 2000; Task Force on Physician Supply in Canada).

IMG orientation is shorter than most training programs, and vary in length from one day to five weeks. In the past, after orientation, IMGs were expected to ‘hit the ground running’ with little more than a brief, usually intensive, in-person orientation session with a staff person or none at all. Increasingly within the Canadian Healthcare system it is being recognized that if IMGs don’t get the support early on to address difficulties they may be dealing with problems which get much worse later on. Yet ideas around how much orientation is required vary from province to province. When it comes to Canadian healthcare which is supposed to be universal, it may be administered under different regulations in each province and territory. These different approaches can be very confusing for IMGs. Instead of having a single national plan, we have a

national program that is composed of 13 interlocking provincial and territorial health insurance plans, all of which share certain common features and basic standards of coverage

(<http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index-eng.php> retrieved February 27, 2011.)

An example of how different IMG programs can be is the Ontario program which offers an intensive orientation program for IMGs that are entering a residency program that is five weeks long and at the expense of the IMG. Participants also receive testing on their learning during this program. This is completely different from the CAP Program in Nova Scotia which is partially funded (the training and funding to get to the orientation are currently paid for while accommodations and personal expenses are borne by the IMG) and the orientation program is only a week in length.

Based on skill levels, orientation programs differ particularly when they are dealing with residents versus practice ready physicians. In a number of other Canadian provinces, IMGs receive their orientation as part of on-the-job training. It is my understanding that orientation is or will become mandatory in all of the Canadian IMG programs.

Relevant research literature, substantial anecdotal information which led to the IMG Taskforce recommendation for orientation programs, and my own positioning within an IMG program indicate orientation is not only required as a pre-practice activity, but also as a support needed in the first year of actual practice. These programs should ideally be developed with a learner-centred curriculum that encourages active engagement and participation by the IMG's while providing the participants with needed supports. "Both (orientation and the first year of practice) must provide opportunities for learners to experiment with guided learning activities in a safe supported environment with the freedom to make mistakes" (Wozniak, 2009, p.222). When a person has the freedom to make mistakes, learning is much more enjoyable.

Orientation Programs Across Canada

The following section provides an overview of the varied orientation programs available to IMGs in different provinces and territories across Canada.

Ontario

The Orientation to Practice in Canada (OTPC) is a mandatory orientation program for all International Medical Graduates who are accepted into an Ontario residency program either through the Canadian Resident Matching Service (CaRMS), or through the Postgraduate second year (PGY2) Advanced training stream, or the Practice Ready Assessment. It is four weeks in duration and must be completed before a training/assessment program begins. The topics covered focus on communication skills, the patient-centered interview, CanMEDs, and Canadian medical culture. There are also information sessions from various medical organizations such as the College of Physicians and Surgeons of Ontario www.cpsso.on.ca and the Canadian Medical Protective Association www.cmpa-acpm.ca.

Quebec

Orientation pertains to only those physicians participating in a residency program. There is no information available on orientation in practice-ready scenarios (MacLellan et al, 2010, p. 917).

Newfoundland & Labrador

The College of Physicians and Surgeons of Newfoundland and Labrador Orientation Program is intended for physicians who have applied to the College for a license to practice

medicine in the province. The College's orientation program consists of two key parts: 1) An Orientation Guide for New Physicians in Newfoundland and Labrador presenting information on topics that physicians are likely to face each day; 2) Writing Prescriptions is a self-directed learning module. It consists of a series of slides describing the physician-pharmacist relationship, the legal and other requirements for writing prescriptions in Newfoundland and Labrador as well as Internet links to more information. Applicants must be thoroughly familiar with the orientation information before receiving a license www.cpsnl.ca .

Manitoba

All IMG candidates who are selected must complete a four week mandatory structured orientation period prior to commencing the enhanced residency training. Modules include the Canadian health care system, the role of the physician in the Canadian healthcare system, patient-centred approach, the team-based practice environment, the typical Canadian learning settings, patient-centred interviewing and socio-cultural training and ethics.

<http://umanitoba.ca/faculties/medicine/education/imgp/orientation.html>.

Alberta

Externship (orientation and clinical assessment). Candidates participating in Externship are required to complete a four month orientation and clinical assessment phase as stipulated in their written offer of a position <http://www.aimg.ca>

Saskatchewan

The College of Physicians and Surgeons, in conjunction with the College of Medicine has arranged an orientation conference that will be held three times per year. The conference occurs over two days. Attendance at this conference is a mandatory condition of licensure for international medical graduates.

http://www.usask.ca/cme/learning_resources/IMGOrientationGuide/index.php

British Columbia

The Program is comprised of a two day orientation conference held in Vancouver (mandatory participation for all temporary licensure IMGs arriving after January 1st, 2008) as well as a variety of ongoing support resources. http://www.bc-pip.ca/img_conference.htm.

PEI & NB & Territories

There are currently no formal IMG assessment or orientation programs in these provinces although under a current federal grant, PEI and New Brunswick are able to participate in the Nova Scotia orientation program. <http://iehpatlanticconnection.org/en/faqs/>.

Nova Scotia

As previously mentioned, my point of reference for this study is the Clinician Assessment for Practice Program (CAPP). The Clinician Assessment for Practice Program is a program of the College of Physicians and Surgeons of Nova Scotia. It is intended for International Medical Graduate (IMG) physicians who believe they are PRACTICE READY for entry into family practice without any additional formal residency training in Canada. The CAPP is intended to

provide medical services to underserved areas of Nova Scotia as defined by the Department of Health of the Government of Nova Scotia with a return of service requirement.

(<http://www.capprogram.ca/faq.htm>, retrieved July 18, 2009).

In 2005, The CAPP orientation was developed and implemented as a response to concerns expressed by the first two cohorts of mentors. In this regard, the program's objectives were to both meet the expressed needs and to facilitate a smooth transition into family practice. The CAPP formally requested mentors to rate and comment upon topics that, in their opinion, should be included in a structured orientation program for new CAPP physicians, ideally before they begin their mentored practice. Based on the information gathered, the CAPP has developed a 5-day orientation program for the new CAPP physicians who will begin their practices later this year. The program, primarily funded by Health Canada as a pilot project, is intended to address a number of important aspects of practice in Nova Scotia.

The culture of a learner-centered program, which is the intent of the CAP Program, is that it will be cooperative, collaborative, and supportive where the IMGs and instructors learn together (Thompson et al, 2003, p 133). The CAPP orientation program incorporates a learner-centered perspective recognizing that it promotes a sense of control, less pressure, and more enjoyment of the learning process. CAPP physicians are provided with a five-day, 10 module program to assist with integration into practice. Because continuous individual assessment during an orientation tends to be unnecessarily anxiety provoking no formal testing of participants is conducted; informal self-assessment is encouraged.

Participant feedback suggests that inclusion of personal and social aspects in the orientation, as well as professional needs, is important. A six-month follow-up evaluation

demonstrates that a more comprehensive approach to orientation supports IMGs in their transition to medical practice in their new communities.

CAPP Orientation Objectives

The following is the blueprint for the CAPP Orientation Program. It is reviewed on an annual basis. Changes are made to the program based on participant and facilitator feedback

<http://iehpatlanticconnection.org/en/faqs/> .

- To enhance participant understanding of the Canadian healthcare system
- To enhance participant understanding of relevant communication and cultural issues
- To provide participants with relevant information to assist in the transition to clinical practice.

CAP Program Modules and Objectives

The Department of Health contract orientation and site visits. Participants review their contract for employment with the Province. The orientation program is followed immediately with site visits by the new CAPP physicians to rural communities in the province which are identified by the Department of Health and the District Health Authorities in need of new family practitioners. There are generally 4-5 site visits for each candidate. The CAPP physicians may attend site visits as a group or individually. The modules are as follows:

Cultural Diversity

Practice-based management skills of analyzing practice experience and performing practice based improvement activities would be considered disrespectful in many international

systems (Porter et al, 2008, p.38). The objective of this module is that participants be able to understand and practice in a diverse culture of Canadian health care system with a decrease in medical errors and an increase in patient satisfaction. (Module 3 & 4 have merged into one module)

Patient Centred Care/Collaborative Practice

IMGs come from many countries where the concept of patient autonomy and patient involvement in decision making is rare. Physicians often practice in a paternalistic way and it would be unusual for a patient to question their authority. Sessions are focused on the importance of the entire health team to the care of the patient and emphasized how the other members of the team are open to suggestions from each member even when they differ from their own plan.

Female Breast and Genital Examination

Opportunities to examine women are rare especially to male IMGs. Generally with respect to women and reproduction, only women examine women and vice versa. In many countries preventive health pelvic exams are not routinely performed (Porter, J. Et al, 2008, p. 38). The CAPP orientation offers supervised pelvic exams on standardized patients, preceded by a lecture on how to correctly perform a pelvic exam and how to protect the patient.

Male Genital Examination.

Same as above as it relates to males.

Ethical and Legal Issues of Practice

Ethical practice is concerned directly with values, attitudes, and the formation of professional character. Kenny et al (2001) states that “it is likely that most new physicians have received little to no formal education in ethics as it is relatively new subject matter coming into the curriculum around the 1980’s” (p. 25). Practising physicians need fundamental skills in analyzing and resolving ethical issues. Patients expect physicians to have this knowledge and skill. This area can prove to be a great challenge to IMGs.

For many IMGs, there are few opportunities while in practice to learn and discuss ethical principles pertaining to provision or withholding medical care, confidentiality of patient information, informed consent, and ethical business practices. Porter et al (2008) report that “IMG physicians rarely have an opportunity to model the way in which to discuss a disease with a patient or deal with the range of emotions that may occur over the length of a serious illness” (p.38). Unfortunately, without these issues being addressed, sometimes the learning only occurs when a complaint regarding a perceived lack of care or communication is received via the regulatory authority.

Prescribing and Narcotic Prescribing in Nova Scotia

In an open-dialogue session, the facilitator and participants discuss the provision of a prescription to a patient by a physician and the importance of keeping well-documented patient records which include the medication prescribed. Topics include informing patients about matters such as drug effects and interactions, side effects, contraindications, precautions, and any other information pertinent to the patient’s use of the medication.

Doctors Nova Scotia Electronic Bookshelf/Continuing Medical Education

Doctors Nova Scotia is the professional association representing all physicians in the province of Nova Scotia. The Electronic Bookshelf enables the licensed physician free access to medical textbooks and journals. Participants are instructed on how to use this electronic mode of information to inform their clinical practice.

Mentorship/CME Overview

The mentorship is an opportunity for the CAPP physician to learn and experience family practice in Nova Scotia, with the coaching and facilitation of an experienced family physician. The mentorship has been designed to ensure that the CAPP physician establishes practice with competency and support, and that they are integrated into the local medical community and into the broader community in which they live and work.

Medical Charting & Recordkeeping (Electronic Records)

Participants discuss the medical record as a legal document which records events and decisions that help physicians manage patient care. Discussion will also entail the primary use of medical records for the treating physician and other health care professionals to ascertain the patient's medical history and identify problems or patterns that may help determine the course of healthcare that should follow. In addition how keeping good records provides information essential to others for a wide variety of purposes such as: billing; research; and response to public complaints, legal proceedings or insurance claims.

Social luncheon

The luncheon was a new event introduced in 2009 based on participant feedback following the week-long orientation. Participants requested that an effort be made to bring in prior CAPP physicians to discuss what it was like for them to go through this year-long program. They wanted information from the people who actually lived the experience. They wanted some assurance that they too could be successful. It has been an overwhelming success. We have seen great feedback on participant feedback and as well as our six-month follow-up feedback reports. Current and past participants are invited to meet with the new cohort to discuss lessons learned and to give support to them as they enter their first year. This event was extended to another new CAP Program (Assessment & Remediation Program) which again added to social and moral support for the IMGs who have not quite gotten through to the next level of licensure. The orientation participants exchange email addresses with the guest members and keep in touch regarding their progress and to ask questions from others who have been there. This event is held on the first day to kick off the week. It will definitely become a staple of the orientation program.

Considering the Learner

Although the CAPP is a week-long orientation program, and a lot of information is conveyed to the participants, it is also important for program designers to realize that this can also lead to mental overload for the participant. I found this out in our last orientation when I scheduled an intense module (due to no other time available) for a Friday afternoon. It was evident that everyone was tired and preoccupied with catching flights home to the impending job interviews that following weekend and week. So I think these are a few examples of the physical,

mental and social conditions of the learner we need to pay attention to if we are going to adhere to all of the conditions of a learner-focused program.

For IMGs, in most cases, an orientation program will be the first step to integrating into the medical community following a successful assessment process. As educators we need to look at the support systems that the IMG will need post-orientation. It is not enough to put anyone, let alone physicians who are new to the Canadian healthcare system into practice without support such as a mentorship and/or a supervised program for a period of time to reinforce the learning in the orientation program. Ideally, there should be a post-orientation program, and it could also become a component of an extended orientation program. For example, the Nova Scotia CAP Program uses its orientation program as a lead-in to a 13-month mentorship program.

Assessing Curriculum in the CAP Program

As a program manager who is responsible for the delivery of an orientation program for IMGs each fall, I am able to observe and experience what is working and what is not within our own program. I review the feedback from both the participants and facilitators and based on the feedback I make the changes necessary to keep the program content relevant. For example, a number of CAPP physicians over the last couple of years have asked to meet other prior CAPP physicians so they can talk with them and hear about their experiences first-hand. I realized that it was important to understand that the year ahead of them was fraught with the unknown causing them much angst and worry. Conversely, one year we introduced a new pilot module meant to assist the physicians in managing their appointments and office practice efficiently.

Unfortunately, most did not make the connection and because it was not directly a medically

related module, it was not received as being relevant to their learning. We have not used this module since.

Sometimes it is difficult to get candid feedback from IMG learners. This statement is not meant to reflect poorly on IMGs, merely that they are in a precarious position in trying to become licensed, and do not want to jeopardize their standing. They have jumped through many hoops in the credentialing process to finally get to a point where they can practice, and do not want to say anything that may seem critical of the process. Therefore, we as educators cannot become complacent and think because our program has received no criticism from the participant that we are providing the program in the best way possible.

A significant benefit of the CAPP Orientation Program has been the development of important and unique partnerships between regulators, educators, employers, and government, all of whom have similar interest in ensuring safe and effective family physicians. Meeting staff and catching up with peers in an informal environment is an important part of the orientation process. It does allow new physicians to network and identify key role players in the organization. IMGs have high anxiety around if they would be successful in their first year in Canadian practice. The orientation program sets the tone for collaboration and trust up front.

To create a learner-centred program, ongoing support such as a mentorship program should also be a consideration (Hollett & Hann, 2007; Maudsley, 2008; Wendling-Aloi, 2003; Walpert, 2001). Post-orientation support programs are necessary in order to help close a gap in learning that may be imposed by the limitation of time in an orientation program. One of the highlights of the CAP Program is the mechanism in the form of a mentorship program which offers continued support while also identifying those IMGs who struggle with the transfer and

application of certain knowledge and medical procedures. These challenges are identified on a learning plan and developed throughout the 13 month mentorship program.

Adult educators and providers of IMG orientation programs need to evaluate critically the curriculum and how we design and deliver them. We need to ask ourselves the following questions:

Does the curriculum meet the needs of the learner notwithstanding any instrumental requirements?

Are we as the facilitators of such programs allowing and non-judgmental as to how we approach this specific group of learners?

If we are following a learner-centered ideal, we would also be questioning if the program meets the mental, physical and social needs of the learners.

I would ask if we are continuing to deliver the same program in spite of feedback (and hopefully we are all collecting participant feedback) and making the necessary changes when we can. Are we making changes based on what we observe? Remember, earlier I stated that IMGs do not like to criticize the system that has enabled them to finally get where they have tried to get for many years. We must remember everyone does not learn in the same way. Are we adapting our program to meet these differing needs?

It is not only the IMG participants that need to be educated in embracing lifelong learning, but we as educators must avail ourselves of the various adult learning theories as they relate to cross-cultural learning, the discipline of medicine, and the development of curriculum for orientation programs so that we can enhance the learning experience for not only the learner but for ourselves as well.

Role of the Educators

In the orientation of IMGs we often have a facilitator conducting the sessions. The terminology we use for those who conduct learning or information sessions does matter as it has an impact on the learning experience for the participant. Some see the role of an adult educator as being a lecturer, which is more typical of a didactic approach or what Paulo Freire calls, a banking form of education. His critique of “banking education” will be discussed in chapter four.

Other adult educators follow a humanistic model of adult learning, which focuses more on the perceived needs of the learner. A humanistic framework suggests that the role of the adult educators is to be a facilitator of the learning process. This approach requires a number of good human relations skills and self knowledge to manage positive group dynamics.

Kolb et al (2008) defines a facilitator as:

a person who remains neutral in the actual decision of the group but who assumes the responsibility for managing the groups’ process while it is attempting to solve a problem or reach a decision. The role of the facilitator is to present information, direct structured learning experiences and manage group discussion and process. They also lead group discussions and elicit answers. One of the core competencies of the facilitator is as an ability to build an atmosphere of openness and collaboration. Facilitators should be able to communicate to the group and manage the participants’ diverse thinking (p.14-1).

A skilled facilitator has the ability to conduct organized learning experiences and discussion with the members of the group to achieve the objectives. A good facilitator does not always have to belong to the particular profession of the group in order to achieve a successful end.

Educators working from a critical perspective sometimes argue that being a facilitator is not enough, because facilitators do not always raise difficult questions about power and how that impacts on educational contexts. Freire argues that a critical approach to education involves “problem-posing” – a strategy that will be discussed in more detail in Chapter Four.

Considering IMG Programs and Adult Learning Theories

There are varied types of orientation programs for IMGs in Canada, the United States (US), and Australia. Internationally, Australia has been in the forefront of orientation practices for IMGs (Carlier et al 2005; Morgan 2006; Couser, 2007). Their experience in identifying the topics such as an overview of the healthcare system, medical/legal issues, patient centred care to name a few led to the development of a template for other programs to replicate. Australia’s lessons learned from those working with new IMGs in the medical offices and institutions have contributed to my research.

Some of the research in various orientation practices espouses the principles of adult learning principles but fall short of incorporating any explicit theoretical basis for how the program is designed and delivered to participants with differing learning needs. For example, orientations tend to be comprised of didactic presentations in 20 -30 minute intervals with perhaps a Q &A at the conclusion. The sessions are usually chalk full of information, with a handout of the presentation so participants can refer to them post-orientation.

We have to consider that the best way to attain the orientation program objectives is to deliver core information to the learners in a flexible format without making it an overwhelming experience. Hollett and Hann (2007) discuss Wendling-Aloi (2003) “The delivery mechanism must be whatever is best suited to attain the objectives of the orientation program” (p. 3). This is why an understanding and application of adult learning principles to the curriculum can encourage a more learner-focused learning experience for both the participant and the educator.

An interactive program design that uses the principles of adult learning is also an essential element of physician orientation. Jarvis (1995) discusses Knowles (1989) interpretation of adult learning principles which include: “adults need to know why they are learning; they need to be responsible for their own lives; adults bring greater quality and quantity of experience to their new learning; adults are ready to learn what they need to know; their learning is life-centered; and adults have intrinsic motivation to learn” (Knowles as cited in Jarvis, 1995, p. 197).

When delivering an orientation program that meets adult learning principles we need to inform our learners about why an orientation is an important part of their acculturation to North American medical practice. IMGs can decide how they incorporate the information into their professional and personal lives. We know IMGs have achieved success prior to coming to Canada and their experience cannot be dismissed. Educators need to encourage discussion so we can all understand and discuss similarities and differences from how IMGs have practiced in their own countries. We also want to be careful not to overwhelm learners with too much information so we should be succinct in our delivery of an orientation program. IMGs want to learn about the Canadian healthcare system and want to fit in with their colleagues and community.

Within the context of my study, I believe that it is not only important to apply these principles to the orientation program, but to also view them through the lens of critical theory. “How does adult learning help develop confidence, draw new meanings from life, and be open to new perspectives of the world” (Brookfield, 2005, p. 24). When the principles of adult learning are followed, it opens the door for adults to be autonomous in their learning choices. We know that adult learners will usually seek out information when they are motivated to do so. In the next chapter, I will review some of the current theories of adult learning that inform medical education in Canada today before moving on to explore some critical theoretical alternatives.

CHAPTER THREE

This chapter provides an overview on informal, non-formal, and formal approaches to learning. I will discuss past and current medical education (lectures and problem based learning) and how the various types of learning theories such as experiential learning, self directed learning, and reflection-in-practice may influence the development of curriculum in IMG programs. I will conclude the chapter with a discussion on alternative approaches to education.

Informal, Non-formal, and Formal Approaches to Learning

Adult educators recognize that there are three commonly acknowledged opportunities for learning; informal, non-formal, and formal learning.

Informal Learning

We can't escape it. Informal learning is ubiquitous. Schurgurensky and Mundel (2005) describe informal learning as "learning that people report doing on their own outside any educational institutions or organized courses" (p.2). We learn at home, at work, hanging out with our friends, and now through social media, video games and so on. "Informal learning is a natural accompaniment to everyday life and may well not be recognised as learning even by individuals themselves" (Perulli, 2009, p. 95). Informal learning is not necessarily taught by an instructor so we may not recognize that we are learning when we are participating in activities that we enjoy such as passive reading, volunteerism and through hobbies or other interests we may have. Some theories taken up within the fields of adult education/lifelong learning emphasize the importance of informal learning such as Schöns (1983) work on reflection-in-action and Wenger's (1998) models of communities of practice which looks at workplace and

community learning. IMGs can benefit from informal learning as it assists with socialization into the medical community in terms of its networking potential.

Non-formal learning

Non-formal learning is learning that occurs in a formal learning institute, but is not officially recognized. It may involve workshops, community courses, interest based courses, short courses, or conference style sessions. Non-formal learning differs from informal learning which is sometimes more self-directed. Many physicians participate in workshops and conferences as attendees or presenters in order to share scholarly work and best practices. In light of impending revalidation, physicians may want to participate in non-formal learning workshops or conference events where they can receive official credits for continuing medical education (CME).

Formal Learning

Most medical education occurs in a formal learning context. “Formal learning refers to the highly institutionalized, curricular-based instruction that takes place in schools and postsecondary institutions” (Mundel & Schurgurensky, 2005, p. 49). Formal learning involves credentialization or certification of one’s knowledge and skills. It often occurs within walls of educational or clinical institutions. Obtaining a M.D. would be an example of education that is considered to be a part of formal learning.

Connections Between Different Types of Learning

Informal, non formal and formal learning often overlap and may occur simultaneously. “Today’s workplace learning provides a mixture of formal instruction and informal experience. It addresses individual personal development as well as work-related knowledge, skills and values” (Zepke & Leach, 2006, p. 514). With the advancement of technology, medical education frequently occurs far beyond the formality of the classroom and is often found at the fingertips of a doctor via a personal digital assistant (PDA) or another electronic device.

All of the aforementioned realms of the learning may be found in an IMG orientation program, whether the program is made up of only didactic presentations and a social event or it is interactive with case studies and discussion. “Informal and non formal learning can occur at the same time as formal learning in an educational setting” (Schugurensky & Mundel, 2005, p.3). Important learning often occurs not only in the classroom but in the discussions in the hallways or over the water cooler. Learning is always happening whether or not it is formally recognized or acknowledged.

Current Medical Education

Throughout a physician’s medical education and clinical practice they will experience many ways of learning. There is no one single explanation or theory of adult learning (Merriam, 2001, p. 1). In this next section, I will take you through some of the learning theories and teaching practices found within an IMG orientation program and that are currently being used in medical education.

Lectures

It is doubtful that the use of presentations and lectures will become a thing of the past anytime soon. McCrorie (2007) notes “lectures or didactic learning continues to be one of the main methods of knowledge transmission in both undergraduates and post graduate education despite evidence to suggest that they have little impact on ‘deep’ learning even in spite of the data that only 5% of what is taught in lectures is actually retained and what is done with the lectures notes subsequent to the lecture that determines the extent of learning” (p.1). Not every presenter is engaging and it is easier for learners to disengage in a lecture format. While lectures can sometimes be useful, it should not be the only strategy used for teaching.

IMGs come from medical schools that are predominantly lecture-based, so the concept of more interactive approaches to teaching may be new to them. Problem-Based Learning (PBL) can be another learning hurdle for them as they have to learn to think critically about how to make a diagnosis while working with other students in a collaborative way to independently research the information that they need.

Problem-Based Learning

One of the more influential changes to medical curriculum in recent decades has been the introduction of problem-based learning. Problem-based Learning (PBL) has been around more than 30 years (Albanese, 2007, p 1). PBL consists of a patient problem serving as a stimulus for learning: for example, a scenario would be presented to a group of students where they would be asked to make a diagnosis. They would be presented with a list of symptoms such as a 62 year old white female with a large mass on her neck along with her lab results. After discussing the

case, learners would identify topics for further study. From those topics would come questions which would be prepared for testing.

PBL involves small group instruction, between 6-8 learners, and instructors serve as tutors or facilitators. Students determine their own learning needs to address the problem, make assignments to each other to obtain necessary information, report what they have learned thus far and then continue on with the problem. It is meant to promote self-directed learning which in turn will hopefully promote lifelong learning. There may be a perceived criticism of PBL in that it enables a student to learn medicine from a clinical perspective initially rather than from a theoretical perspective commonly found in lecture-based education. In addition, some long term faculty used to the old way of teaching may not be ready to relinquish their hard-earned authority to a student-centred approach.

Experiential Learning

Much has been written about experiential education. “In much of the literature experiential education is presented as an educational methodology that can be applied to a wide range of contexts” (Zink & Dyson, 2009, p. 165). We apply it in everyday life situations whether it is work or play. Fenwick (2003) asserts that “the term experiential learning is often used both to distinguish the flow of ongoing meaning-making in our lives from theoretical knowledge and to distinguish nondirected ‘informal’ life experience from ‘formal’ education”(p.1). We can draw upon our previously learned experiences to assist us with current learning challenges. Each person translates their current experience based on their past experience or knowledge.

An example of experiential learning is when IMGs participate in the orientation's sensitive clinical scenarios where they may never have conducted a medical examination with someone of the opposite sex because of not having the opportunity in their previous practice or it was not deemed acceptable in their respective culture.

Self-directed learning

Within the medical context, SDL is considered essential in the development and maintenance of professional competence (Kaufman & Mann, 2007, p. 23). Although, we talked earlier about mandatory continuing education which does not have the tone of autonomy, there is still lots of opportunity for medical practitioners to undertake meaningful self-directed learning. There are those professionals who do not feel they need to learn anymore than they already know, which could pose significant risk to patient safety. Although much of IMG orientation is facilitated much of it can also be self-directed. This gives the orientation a self-directed learning approach where individuals are responsible for their increased capacity for success. SDL facilitates critical reflection via the identification of one's own personal needs in order to be aware of the learning (soft or technical skills) which needs to take place.

Self-directed learning (SDL) is well accepted in many professions. However, self-directed learning should be accompanied by a social conscience and peer feedback (Bleakly, 2006, p. 152). When we choose our learning opportunities, individuals generally choose those which will enhance their own lives or for the betterment of someone else or society. In a humanistic framework, self-directed individuals need to feel that they have input in what they need to learn and be a part of setting achievable goals for themselves. Pearson & Podeschi (1999) state that "the issue of self and others plays out ultimately in the day-to-day lives of

people and their institutions” (p.41). Self directed learning is not only self -actualizing but it makes us accountable for our own learning. Self-efficacy is the highest level of Maslow’s (1962) hierarchy of needs. Humans have a need to reach their full potential.

Self-directed learning contained within the practice of orientation can be facilitated when information is sent to participants ahead of time so they can read, absorb, and perhaps conduct their own research upon a particular topic. When they attend the course they are well prepared to contribute to the discussion. They may be asked to scan the newspaper for articles related to medicine to discuss. This activity provides the learner with an opportunity to discuss with their group and educator, current healthcare issues and how they may approach these issues when faced with them in their own medical practice.

It is difficult in an ever-changing healthcare environment to teach a new physician everything they need to know before they begin to practice independently. Developing the capacity to engage in self-directed learning is therefore an important aspect of encouraging physicians to be involved in lifelong learning throughout their careers.

Reflective learning/practice

Reflective learning/practice is linked to deeper learning which can enable us to develop and mature as individuals and as professionals. “It has been argued that ‘reflective practice’ is a descriptor that could be refined within education, where the term has been used loosely and uncritically to describe a variety of practices based on contrasting. In medical education literature in particular, reflective practice has been used unreflectively” (Bleakly, 2006 p. 151). Reflective learning/practice enables a learner to reflect on their experiences and contributes to continuous learning. We can reflect on our own learning or it can be a facilitated process.

Donald Schön was a researcher and consultant with a focus on organizational learning and professional effectiveness. He is best known for his innovative work in developing the theory and practice of reflective professional learning in the twentieth century. Schön's work draws attention to the need for medical practitioners to engage in lifelong learning, and use informal learning from their everyday experiences to help them improve their practice. In our current IMG program, we draw upon the notion of the reflective practitioner in the curriculum.

According to Schön, reflection is not only found in professional practice but in all of our life experiences be it work or personal. Schön (1987) defines reflection as an action we take when a common experience does not meet our expectations. "We may respond to the surprise by brushing it aside or by "reflection on action" which can occur during the action or after when we have had time to think about the experience" (26). For some practitioners, to be unsure of one's decisions would show a sign of weakness, while others who learn from reflecting-in-action would not be able to tell you how they do it. Schön (1983) asserts "When a practitioner sees a new situation as some element of his repertoire, he gets a new way of seeing it and a new possibility for action in it, but the adequacy and utility of his new view must still be discovered in action. Reflection-in-action involves experiment" (p.141). Generally, when we brush an unexpected outcome aside, we are not giving the experience a lot of importance. However, if we do take time to reflect either in the experience or post-experience, we deem the experience worthy of changing that particular outcome or a similar situation in the future by changing our actions.

When a practitioner has an interest in transforming the situation from what it is to something better, they also seek to understand the situation that they are in. This understanding happens in reflection-in-action. Reflection may be initiated by something that bothers us or has

potential to be different and concludes when we have reached a satisfactory outcome. Sometimes when are in a situation we do not have time to reflect carefully so we simply react. Taking time later on to reflect upon what actions have been effective and what situations have been problematic is a way to learn how to improve our teaching practices.

Schön's work has been taken up in many professions such as medicine, nursing, legal, teaching, business and the military (Schön,1983). For example, when we look at religious teachers, Mantarnach (2002) states that "reflection-in-action suggests how teachers reflectively frame and solve problems on the spot while they are engaged with learners" (p. 279). Reflection-on-action is the reflection that occurs before or after an action. This reflective activity can take place immediately, or over the course of time. For example, Manatarnach (2002) argues that "stressing the importance of the periods of preparation prior to teaching and the evaluation period after teaching that are key to the learning reflection process" (p. 279). Ideally, the preparation period should contain lessons learned from the evaluation period from the session that was taught previously. This would make reflection and learning a cyclical process.

Collaborative Approaches to HealthCare

The Canadian healthcare system is working towards becoming a collaborative framework for the delivery of patient care. This means that nurses, physicians, physiotherapists, pharmacists and other healthcare providers are now part of a team so the patient's care could be spread over a number of providers. This is a new concept for many IMGs who come from systems where the physician is the only one making decisions regarding patient care with no other professional input.

Broaching the subject of the social and/or personal needs of a learner and addressing the need for better communication between different groups of medical professionals within an environment of medical education can be challenging. After all, we are dealing with a profession steeped in science. “In recent years, more medical schools have moved to hybrid curricula which have spawned some success and identified intriguing complexities” (Albanese, 2007, p.25). These complexities include today’s more educated patient with access to the internet and the most up-to-date information enabling them to make more sophisticated choices thereby requiring more sophisticated responses; more of a patient’s healing process is happening at home rather than in an institution; and changing regulations. Having medical staff work together as a team has the potential to improve patient care, but this requires a different approach to medical education than many IMG’s are used to.

In order for the IMG to become lifelong learners, reflective practitioners, and to engage critically in the learning process, educators in the IMG orientation programs need to design a program that acknowledges the prior learning experiences of the IMG and how their experiences can be used to create a new understanding of their Canadian experience. The curriculum therefore should be relevant and meaningful. This could have a profound effect on the attitude of the learner and whether or not they choose to continue with their education/lifelong learning post-orientation.

Influence of Learning Theories in Curriculum

We have discussed that medical education in general may not explicitly refer to learning theories within the classroom. For example, a new medical student learning how to take a blood pressure may not consciously realize that he is participating in experiential learning, however, the educator developing the curriculum might be drawing upon their understanding of the importance of experiential learning during the development of the module.

Some of the information delivered during the CAPP Orientation is meant to provide the IMGs a new way of learning. For example, one module we deliver is on Continuing Medical Education (CME). In this module, we familiarize the IMGs with the material that focuses on how to be reflective in their practice and to know how to access resources in order to answer questions they may have. Ideally, we are encouraging IMG's to become reflective practitioners and self-directed learners.

Information does not always have to be related to our professional lives to be useful. For instance, this year we implemented a module as a pilot to help IMGs organize their workload, include time for learning and also have a balanced lifestyle. This module has to be revisited as it was not received as well as we would have anticipated. Some of the group feedback stated that they did not see the relevance of this course to their medical profession. Reflecting upon this, I think that we did not provide an explanation in our objectives as to why we were including this module in their learning program. Again this takes us back to the mindset of medical education and how we need to explore new strategies in order to assist the learning of new IMGs.

In this chapter, I discussed the adult learning theories which have influenced orientation curriculum used in the CAP program. In the next chapter, I will discuss some of the insights that critical theorists can offer.

Chapter Four

In this chapter, I examine critical theories and how these have contributed to the discourse of adult education beginning with contemporary theorist, Stephen Brookfield's work on the power of critical theory. In addition I will look at Paulo Freire's work, particularly with regards to his critique of banking education. I also examine how critical race theory, Afrocentricity and Black Feminist Thought, feminist theories, multicultural education and knowledge around cultural competencies contribute to our understanding of how power influences educational contexts, including the orientation of IMGs.

Critical Theories

Critical theory allows us to examine and challenge the status quo by looking at dimensions of power and how it is used consciously or unconsciously. "It (CT) has the ability to promote and facilitate well being" (Cox & Hardwick, 2002, p. 36). Critical pedagogy, which draws upon critical theories of education is emancipatory in its intent and recognizes the influences of larger social and political contexts and power relations. If we know and understand what keeps individuals oppressed or not fulfilling their potential, as educators we can assist in removing barriers. In addition, through critical pedagogy learners in marginalized positions can learn to consider how power shapes education. Critical pedagogy brings to light that barriers do exist for certain groups of people and that by discussing them and bringing them to the forefront, we can begin to address the inequities.

We can view CT as a tool for reflection. Chen (2005) states that "critical theory raises consciousness as the first step in transformation". Critical pedagogy can assist learners and instructors to work towards social and personal transformation (p.17). We need to reflect upon

which issues concern the groups' cultural identity and how it relates to power. How does power real or perceived inhibit learning? IMGs are a vulnerable group. So it is relevant to see IMG orientation through a critical lens because of its need to become more learner-centred process. We must look at the IMG as a whole person with needs on a number of levels outside of receiving medical knowledge, skills and abilities.

Stephen Brookfield

Stephen Brookfield is a leading figure in contemporary adult education. His work in the field of adult learning, and self-directed learning in particular, has been enormously influential (http://www.resources.scalingtheheights.com/stephen_brookfield.htm). (Retrieved on September 24, 2010). Stephen Brookfield's work as a contemporary critical theorist and adult educator draws upon the work of many varied critical thinkers such as Herbert Marcuse's *Repressive Tolerance* (Brookfield, 2005), Michel Foucault's (1987) *The Subject and Power*, and Jurgen Habermas' work on the *Theory of Communicative Action* (1987).

In the initial stages of my research, I had some trepidation about using critical theories to examine the orientation of IMGs. I was concerned that critical theories would portray a seemingly positive experience such as IMG orientation in an over-politicized and negative light. I was also not sure if I could understand these complex theories. After reading Brookfield, I found that although critical theories are naturally political, it is more about learning how to develop a personal power and influence to be able to negotiate your way through life.

Brookfield (2005) explains that "critical theory in adult learning explores and investigates how adults learn to decide when power is being exercised responsibly and how they learn to defend themselves against unjust and arbitrary user"(p. 39). In order to find some examples of

how adults do this, I turned to the creative ideas and concepts from other disciplines and practices outside of medicine such as nursing, pharmacy and religious education. These other professions represent a cumulative body of research relating to the interdisciplinary practices of orientation. Some of these studies take up how the application of critical theory can be used along with a process of reflection.

According to Brookfield (2005) some critical methodologies pertaining to educating in a politically responsible way involve:

- 1) Teaching in a structuralized view relates to how our lives are formed and disturbed by working of capitalism. “A structuralized worldview always analyzes private problems and personal problems as structurally produced” (p.353). An example of this is how technology has increased our access to information and people all over the world, but has also had the capacity to breach high-level government security databases with the potential to cause harm to soldiers, diplomats as well as victims of radical political extremists. It has also the capacity to affect our own health as well as our children through fostering sedentary lives and the rise in obesity.
- 2) The need for abstract, conceptual reasoning means going beyond making decisions based on what’s good for me but rather involves doing what is right for the greater population. “How we decide what these limits should be based on some broad concepts of fairness or social well-being” (p. 353). This approach to education entails thinking about broader social, political and cultural structures. So, for example, when we think about our teaching contexts, we need to consider how other factors impact upon what happens within our classrooms.

With IMG’s, for example, the need for orientation programs was recognized because of the struggles that IMG’s faced when going into the Canadian healthcare system without adequate supports. Differences in cultural backgrounds and gender roles meant that IMG’s were not

always used to communicating in the same way as their Canadian counterparts with other colleagues and with patients. To understand these problems, it is helpful to refer to theories which take up issues such as cultural competencies that address racial tensions IMG's may encounter in their new communities, and that explore gender differences in roles and behaviour.

3) The need for adults as learners to become “uncoupled from the stream of cultural givens” (p.353). What this means is being able to think for yourself. Brookfield recommends achieving this through the practice of self-directed learning. It is good to get away from the group think that can occur and conduct our own investigations. Change can happen with a diverse point of view. We find this when learners undertake an independent line of study or other research work such as a thesis. It enables us to see things from another perspective. Before I undertook my thesis, my information regarding IMGs came from other professionals in the field and from my own experience with IMGs. Researching my thesis has opened my mind to consider the IMG not just as a physician resource but as an individual who has their own history and life outside of their profession.

As designers of orientation programs we need to consider the IMG as a whole individual and not only cater to the physician. IMGs do not come from countries that have the same kind of universal healthcare system we do in Canada so not only do we have to educate them on how to work within a new medical system, we have to provide supports for the learning that they will require outside of their professional work life i.e. around settlement of family in a new place and adjusting to life in a rural Canadian town.

4) The dialogic methods of cohort groups, such as the IMG orientation groups, can be seen as a good approach to learning but there are also some drawbacks. “Because groups are often willing to acknowledge and confront the hierarchies and power dynamics they import into the classroom,

teachers can help illuminate these” (p. 356). An educator facilitating cohort discussions may choose not to participate in the actual discussion other than to set the ground rules for equal participation by all members of the group, but should make their presence known throughout the discussion by intervening when someone is dominating the conversation to the detriment of other participants. “An ethics of responsibility and respect has to guide any interaction since it is through knowing, respecting and honouring learners that educators have a basis to intervene in reality in ways that matter”(Grace et al, 2003, p. 53). One must be cognizant of the fact that different cultures particularly IMGs do not always feel comfortable participating in a group discussion. They may feel uneasy having the focus on them or there may be a gender issue that would see the males of the group speak while the females stay silent.

Having these themes outlined by Brookfield helped me to begin to understand how to apply critical theory to an IMG orientation program. As adult educators we have to be aware of our own biases and consider how we can provide a truly democratic experience for those adults we teach and from whom we can also learn. If we feel uncomfortable in an educative experience, we need to ask ourselves why this discomfort is occurring. This is a way that we can consider how power issues come into play in our educational settings, realizing the way we interact is shaped by culture, race and gender as well as other factors.

Paulo Freire

Paulo Freire, a Brazilian educator well-known in the field of literacy training is considered one of the most influential adult educators of the twentieth century particularly in the area of informal education. Freire’s work has been influenced by critical theorists such as Karl Marx, Antonio Gramsci, and Herbert Marcuse from the Frankfurt School in Germany. The Frankfurt School which was founded in 1923 at the University of Frankfurt by Felix Weil, a

political scientist with a passion for Marxism. Seiler (2006) asserts “One of the major purposes of the institute was to study (and eventually explain) the dynamics of social change” (retrieved from <http://people.ucalgary.ca/~rseiler/critical.htm> on July 11, 2010.)

Freire’s work has been taken up by adult educators in a broad range of contexts such as the effect of membership in virtual learning (Allan & Lewis, 2006), postgraduate supervision - challenges and opportunities (Moriarity et al, 2008), and around learning connected to citizenship (Johnston, 1999) to name a few.

There has been little introduction of Freire’s ideas into medicine, beyond community-based health education. However, the aforementioned theorists have a common philosophy in that they believed in freeing people from the social, political, and economic constraints that prevent them from reaching their full potential. Therefore, I see Freire’s work as having great significance when discussing the orientation of IMGs as they are learners struggling to overcome many challenges to become full participants in a new society. Their struggles include having their credentials recognized, possibly learning a new language, assimilating into a new culture and obtaining meaningful employment opportunities in Canada’s healthcare system.

Some IMGs who are recruited or hear media reports that Canadian citizens are suffering from a shortage of physicians leave their own countries thinking they will be able to continue to work as physicians and have a better life for their families in Canada. Yet when they arrive they are met with immigration and credentialing/licensing issues which in a lot of cases forces them to take on low-paying work to feed their families and pay for all of the exams and fees associated with trying to penetrate the Canadian healthcare system. Freire (2005) asserts that “any attempt to ‘soften’ the power of the oppressor in deference to the weakness of the oppressed almost always manifests itself in the form of false generosity. Indeed the attempt never goes beyond

this....that is why the dispensers of false generosity become desperate at the slightest threat to its source “(p 44). For many, the years of taking exams, paying fees takes its toll. A small percentage of IMGs make it through the system leaving them disheartened and some return to their home countries to take up their profession. There is also the fact that Canadians studying abroad and come back to Canada obtain the residency positions that others who are not born in Canada do not.

Praxis involves combining the practical side and application of something such as a professional skill, while drawing upon theory. “Human activity is theory and practice; it is reflection and action” (Freire, 2005, p. 125). Praxis is part of the learning process. We practice it in our every part of our lives - professional and personal. Praxis requires us to bring what we know about theory into our practice. “Praxis goes beyond just thinking about what can be done or should be done.” (Freire, 2005, p. 551). When we think of praxis in terms of the struggles of IMGs, we cannot just talk about what should be done to help them to practice medicine in Canada, we have to find ways to have their credentials recognized or alternatively, training programs to integrate them into the Canadian healthcare system if not in medicine perhaps another health-related profession.

Educators need to be able to critique their own methods of teaching and consider whether they could possibly contribute to the oppression of another. If it is our job to enforce rules that restricts another from questioning the fairness of the information then how can we say what we do is liberating another? Freire (2005) explains that “the pedagogy of the oppressed cannot be developed or practiced by oppressors, it would be a contradiction in terms if the oppressors not only defended but actually implemented a liberating education” (p54). Suffice to say that oppressors do not create an education that is dialogical in nature. This type of education can still

be found in some learning institutes today. In this context, the educator is perceived to be the expert, and the learner is a passive recipient of knowledge, a relationship that Freire refers to as “banking education”.

Banking Education

Freire is most recognized for his work *Pedagogy of the Oppressed* which regards society as being characterized by relations of power and domination. Pedagogy of the Oppressed characterized mainstream education as “banking of education”. Freire (1994) defines “banking education as the process in which the scope of action allowed to the students extends only as far as receiving, filing and storing the deposits. They lose themselves in this process, lacking creativity and transformation and knowledge” (p. 72). In other words, this is a process by which teachers just give learners the information with no opportunity for discussion or interaction. When this happens one assumes that the information delivered by the teacher has also been understood by learner in the exact manner in which it was intended. “In the banking concept of education, knowledge is a gift bestowed by those who consider themselves knowledgeable upon those whom they consider to know nothing” (Freire, 1993, p. 58). Freire (1986) states "Implicit in the banking concept is the assumption of a dichotomy between man and the world: man is merely in the world, not with the world or with others; man is spectator, not re-creator" (p. 62). Freire is describing banking education as a process where the learner is assumed to have no prior knowledge and is essentially is an empty vessel.

Banking education places the educator in a role of knowing all and the student is merely an empty vessel with no opinions of their own. This method is still used today in some medical

education settings, particularly for IMGs. However, in a critical environment of learning, students would be encouraged by educators to challenge the information being given to them.

Freire's alternative to banking education is liberating education, which was originally carried out in the area of non-formal education. Freire's liberating education places the emphasis of learning on the parallel relationships of the educator and the learner by using an alternative method to the banking of education which is problem-posing. Problem-posing is a process of teaching that accentuates critical thinking for the purpose of freedom. For example, in some medical education sessions, participants are asked to review newspaper articles regarding medical/legal issues and then to reflect on the outcomes of the particular cases. Through problem-posing, participants learn to question answers rather than merely answer questions.

Freire's definition of banking education as the process in which the scope of action allowed to the students extends only as far as receiving, filing and storing the deposits whereby losing themselves in this process, lacking creativity and transformation and knowledge. Freire (1986) asserts "It follows logically from the banking notion of consciousness that the educator's role is to regulate the way the world 'enters into' the students.... to 'fill' the students by making deposits of information which he considers to constitute true knowledge. And since men "receive" the world as passive entities, education should make them more passive still, and adapt them to the world" (pp. 62-63).

A critical, or liberatory approach to education, uses a dialogical approach. Through dialogue, respect and trust for each other's knowledge base, I feel it is our role as adult educators to dissuade passivity in our students so that they become engaged in the process of education where both the educator and the learner learn from each other.

Multi-Cultural Education and Cultural Competencies

We cannot talk about critical theory and social justice without discussing Multicultural Education (MCE). MCE espouses that everyone has a right to education and to be able to position oneself in their own educational experience, and also points to the need to take differences in cultural backgrounds and experience into consideration in educational contexts.

MCE and critical theory have the power to inform adult educators to make meaningful changes to their respective educational programs, and empower those whom are marginalized. “Although critical theory is connected to social justice and multicultural education, its roots are in curriculum reform through the detection of bias in texts and instruction, and developing a classroom environment concentrating on learner-focused achievement through a more critical paradigm” (Parker & Stovall, 2004, p.168). I will be drawing upon the discourses in critical feminist (CFT) and race theories (CRT) as well, which also focus on vulnerable populations.

Multicultural education is complicated because culture has many facets. “Culture is dynamic, shared, symbolic, learned, and integrated. Due to the many aspects of culture, it is difficult to generalize characteristics to all members of the group” (Dunn, 2002, p. 106). For example, a group of university students may have several similar characteristics such as age, a high school diploma, stress, but their differences may far outweigh the similarities i.e. ethnicity, language spoken at home, lifestyles, family size and so on.

IMGs come from countries from all over the world. Orientation programs are faced with a wide array of culturally diverse participants. When it comes to conducting orientation programs for IMGs, the facilitator’s own level of cultural competency will influence their perspective in the knowledge development of cultural competence. There is no simple consensus as to what constitutes effective instructional ingredients for cultural competence. However, there are a

number of ways to define cultural competence. For this paper, I will describe cultural competence as “a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations’ which often do not include the merging of cultural competency education and social justice”
Retrieved January 2, 2011 from <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=11>.

Understanding the role of critical theory has in an orientation program can help the educator critically assess how their own experiences influence their cultural competence. Brigham and Gouthro (2006) assert that “researchers working in cross-cultural contexts need to be critically reflective of both the methodologies that they use in their work and in their interpretations of research” (p.87). When we are in the responsible position of researcher and/or teacher, we have a responsibility to our subject and the audiences who will read our research and learn within our courses to consider our own biases and/or judgements.

It is a challenge to make a classroom a neutral zone. Brookfield (2005) states that “we should not assume our classrooms are safe havens. Neither learners or educators leave their racial, class, or gender identities at the door...” (p. 355). As adult educators we have to be cognizant of our own beliefs and biases and those of our learners. Although you can assure a learner that they are free to discuss anything they wish within your classroom, you have no control as to what happens once they leave the classroom.

Recently there has been an increasing amount of literature regarding the need to prepare IMGs for medical practice in a culturally competent manner. An orientation program or an acculturation program addresses these needs preceding entering medical practice. “An orientation program will assist in accelerating the IMGs ability to learn about the culture of the

Canadian health care system before entering family practice” (Porter, 2008, p. 42). This is when a learner is the most motivated to succeed.

Critical Race Theory

Critical race theory is a tool designed to describe, analyze, and empower people of color and to help change negative social forces as they impact on everyday life. “Critical race theory in education connects with the experiences, ways of thinking, believing and knowing the racial communities in their struggle for self-determination and equity in education” (Parker & Stovall, 2004 p. 174). As a white researcher, I have lived a somewhat privileged life meaning that I cannot personally speak to the struggles of someone of a different race. I am aware of the struggles of inequitable education because of the documented work of researchers of color such as George Dei (2005) and bell hooks (1994). In the last several years, educational institutes have been paying more attention to multicultural education, however for the most part it is still being taught by white educators who have not lived the struggles, so there is still a disconnect for many students of color.

Afrocentricity

Molefi Kete Asante (2003) a professor and creator of the first doctoral program in African American Studies defines Afrocentricity as “a mode of thought and action in which the centrality of African interests, values, and perspectives predominate. In regards to theory, it is the placing of African people in the center of any analysis of African phenomena (p.2). Afrocentricity challenges Eurocentric assumptions that privilege knowledge coming from Western, white society.

George Dei (2005) is also a black educator, prolific author and researcher in areas of anti-racism education. He is currently teaching at the University of Toronto and he uses an Africentric approach to education. He describes the notion of 'inclusive education' as "an approach to education that focuses on the lived experiences of the learners defined by difference: class, gender, ethnic, religious language and cultural differences and the unbalanced relations based on difference" (p.268). Taking an Afrocentric approach to research and teaching highlights the lived experiences of people of African descent.

Black Feminist Thought

Carrying on the theme of the Afrocentric approach, black feminist thought demonstrates the rising up of black women as intelligent and powerful in their own right. When black women are independent and empowered they can take on oppression with knowledge and self confidence. Collins (1990) states "One distinguishing feature of black feminist thought is its insistence that both the changed consciousness of individuals and the social transformation of political and economic institutions constitute essential ingredients for social change. New knowledge is important for both dimensions for change" (Retrieved <http://www.hartford-hwp.com/archives/45a/252.html> on January 9, 2011). We need to see more qualified women of color in all levels of government, corporations and educational institutes to ensure social transformation is taking place.

The inclusion of black feminist thought to the intersectionality of power through race, class and gender oppression, providing a lens in which to view other groups' experience. The importance of Afrocentricism in informing Black Feminist thought and its alignment to political power is key. For instance, when educators are developing 'inclusive curriculum' they should

challenge the conventional curriculum by seeing its limitations. Collins (1991) states that “standpoints such as black feminist thoughts are more likely to develop outside the boundaries of legitimate elite white male knowledge and thus are less influenced by the existing terms, theories, and pedagogies of dominant frameworks” (p. 372). Suffice to say that if there is to be a change in the status quo then the voices of diverse educators need to be at the table to ensure that there is a change when it comes to an inclusive education for all.

Feminist Theories

Women have made great strides over the decades to reach common ground with men. Feminist theory has been used in an array of adult education contexts such as the sciences, research, technology and management which have been typically dominated by males. Gouthro’s (2005) work around the homeplace as a place of learning which has been undervalued brings to light the inequities woman still experience in many areas educational and professional.

Through the lens of critical theory we are able to acknowledge that power differentials still exist. Critical feminist theory provides an opportunity to examine the connection between societal oppression and the individual experiences of women. Breitzkreuz (2005) states that “showing the connection between individual experiences and societal contexts, critical feminists theorize issues such as poverty to emphasize structural explanations over individualistic explanations of particular phenomena” (p.147). We see this kind of analysis can be helpful in understanding problems, such as the challenges that single mothers face. Many single-parent families are headed by the women who are living below the poverty line due to the lack of educational opportunities as well as difficulties in holding down a job and paying for childcare at the same time. Rather than seeing issues such as this as indicators of individual women’s

inability to deal effectively with problems, we can see that these concerns are linked with larger social, legal, and cultural structures.

We have women in politics, science, and many other once male-dominated professions such as family medicine, are now boasting enrolments of more females than males. While that sounds impressive, it doesn't mean to say that women have achieved equality. "Despite the many successes of the women's movement, academic research provides important empirical evidence that challenges the assumption that women have attained full social, political, and economic equality" (Taber & Gouthro, 2006, p. 59). There are many areas that are still dominated by men such as politics. Women still are expected to manage familial duties while holding down a profession. I see this particularly in women of non-North American cultures, although there are still many inequalities in North America. On the global front we are seeing more women in leadership roles, but not to the degree that women have achieved equality, Tiessen, (2008); Kruse et al, (2008); Eagly, (2007).

When we speak about feminism being about equality for women, the literature tells us a definition of equality has not been agreed upon or how to achieve it. Learning for women takes place in many unconventional environments and within informal contexts such as the home. When there is a gathering of women to work on a quilt, or meet at a women's church group, or theatre group, learning may occur (see Clover (2010); Butterwick, (2003); Gouthro (2005); Tisdell (1998); English (1999). The scholarship of feminism covers a large scope of different educational contexts ranging from within the walls of the workplace around dealing with issues of equal pay for equal work, to the value of domestic work done within the home. It places value on education for all and not just those who have already achieved a great deal.

All women do not have the same experience and it can be argued that differences in experience provide greater insights into certain issues around power and learning. “People who are in more marginalized positions of power such as women of colour, may have a more privileged perspective from which to construct certain kinds knowledge ” (Taber & Gouthro, 2006, p. 59). For example, a white woman cannot speak from a marginalized black woman’s perspective.

When we look at learning environments we cannot ignore the consideration of gender in the evaluation of a group’s experience. “Gender is a significant issue in dealing with explanations of social phenomenon. Gender is an important element when we are considering how an individual(s) is treated differently in varied cultures. In many cultures women are devalued or take a backseat to their husbands, brothers, fathers in terms of career opportunities.

Critical feminist theory serves as reflection on and critical examination of the research process. As with critical feminist theory we as educators need to assist learners when it comes to “finding balance” in the integration of personal, family and social contexts much the same of women. Gouthro (2005) asserts “While acknowledging this diversity in identity and experience, women of different cultures have many shared concerns that affect learning opportunities, which are often connected to the homeplace (p.8). Many times the female learner, in particular, still carries the traditional roles of wife and mother and are expected to make sure her family’s welfare is paramount and the career is secondary. Often she is primarily responsible for familial duties, so essentially she carries a very heavy responsibility of family and career.

When we approach feminism from a critical perspective, it makes us stop and take notice to how we can improve the experience someone is having. “Feminist and critical approaches adopt a commitment to liberating people from constricting ideologies. Research conducted from

these approaches has the responsibility to connect findings to social transformation and to illuminate, among other things, women's subordination and the pervasiveness of gendered social norms" (Kinzie, 2007, p.91). Similar to critical race and black feminist theories, when we conduct our research from a critical perspective, it generates a greater knowledge about how complex people's experiences are. Cox & Hardwick (2002) maintains "that an instrumental approach to research places no value on the experiences of excluded women: it devalues their experience and renders them powerless to make choices and change for themselves. To address these inequalities it is essential to look to critical and feminist theories" (p.40). A critical perspective allows us to question the norms and whether there is a provision of support so that those who are powerless can be involved in change when they understand the world around them.

Examining the orientation of IMGs through a number of critical theories such as critical race, feminist theories, Afrocentricity, black feminist thought and multicultural education assists our understanding of how these theories contribute to how we approach the orientation of IMGs. The aforementioned theories support the notion that everyone, no matter your race, gender, nationality, sexual or religious orientation everyone has a right to an education and to be able to position themselves in their own cultural experience. This notion also needs to be supported by IMGs seeing themselves reflected in the learning experience as orientation programs are usually conducted by white educators/facilitators who may not have the cultural competency to connect to the IMG and their experience. We as adult educators in IMG programs must acknowledge that IMGs are highly educated and intelligent individuals who bring a wealth of knowledge to the Canadian healthcare system. We need to assist them with the incorporation of their prior medical experience into their new Canadian experience. It would be beneficial, therefore, for

educators teaching in IMG orientation programs to reflect upon these very issues and be familiar with critical perspectives that connect knowledge to power and become an advocate on their behalf.

Chapter Five

Critical learning theories have been taken up in many contexts in adult and lifelong learning to explore power issues in teaching and learning contexts. In this chapter, I discuss how critical theories can be applied to an IMG orientation program. I explore some issues around power and learning and argue that being aware of our own cultural differences and those of others, particularly IMGs can enhance a learner-focused orientation. The use of critical theory as a lens for evaluating the design and implementation of an orientation program for IMGs may result in a more positive learning experience for both the IMG and the educator.

Applying critical theory can enable adult educators to examine their teaching practices and take action by changing what needs to be changed. Since the practice of IMG orientation is relatively recent, we need to examine if the learning activities contained within the program are meeting the needs of the learner. The application of a critical lens to current orientation practices and learning activities may expose ways in which hegemonic beliefs may be perpetuated. “Hegemonic beliefs concern the dominant classes’ depiction of reality in such a way that it is accepted by other classes as sound even though it serves only the dominant classes”(Kilgore, 2001, p. 55). Critical theory enables us to question hegemonic beliefs on an individual or collective basis by assessing which beliefs and practices represent the interests of the majority.

For example, in the United States where the capacity to train physicians is plentiful, we see so many Americans without any kind of access to healthcare because they are unable to afford it. There is political opposition to adopt a system similar to Canada’s Medicare program, even by many people who might benefit from better access to public healthcare. Critical theories insist that opportunities for development do not remain with the privileged few and that everyone should have access to learning (and many people would believe – to health care!)

Applying a critical lens to our current IMG orientation practices and learning activities exposes issues of power and liberation. Through reviewing the literature and reflecting upon my own experiences, I have come to realize that some practices such as offering orientation programs that offer mostly didactic presentations with no time for discussion or that do not provide ongoing support following the program are often not in the best interest of the IMGs. Instead, it may set them up for failure. Would you or I be able to go to a new job and just be able to jump in and hit the ground running without some type of meaningful orientation and support program? As educators within Canada, we should not do this in good conscience and think our job is done.

Critical theory highlights how we also have to think about power issues. IMGs are a vulnerable group, and we as educators have to mitigate where possible, anything that will impede the learning experience. Another challenge of orientation programs to consider is that it is mandatory learning with no choice to the IMG. In a sense, this contradicts adult learning principles of self directed and being voluntary. It is also delivered or co-delivered by a regulatory body in concert with a medical school adding another power dimension. While there might be justifications for this, in that the public is entitled to have highly qualified professionals delivering their healthcare, it does pose some serious questions around how these programs should be organized and mandated.

Issues of Power

Hegemony exists without our consciousness. Brookfield (2005) describes hegemony as “a process by which we enthusiastically learn to embrace a system of beliefs and practices that end up harming us and working to support the interests of others who have power over us” (p.

93). We don't realize we are complying because we are socialized to believe the way things are is the way they are supposed to be. The media is an effective tool in this compliance. What we hear and see on television influences our beliefs and behaviour whether we are aware of it or not.

In looking at the curriculum and mandatory process of IMG orientation before entering medical practice in most Canadian provinces, hegemony can be seen in terms of the assumption that IMG's are deficient and orientation should be designed as a way to compensate for these deficiencies. This is a reflection of the belief that Western education is always superior. This approach does not recognize what learners bring to the educational context. In addition, the "banking education" approach is often seen within orientation programs that are still often basically delivered as a lecture-based program, where the educators are experts and the learners are "empty vessels". This didactic approach also ignores the fact that adults learn in different ways.

When the IMG arrives in Canada, it takes a number of years to obtain residency status and then work their way through a barrage of examinations and/or assessments. During this time they also have to support families and therefore end up taking low paying jobs and usually several of them in order to make ends meet. The financial burden to IMGs is a terrific barrier particularly when they are unable to have their credentials recognized in a timely fashion or at all. This is a dramatic paradigm shift for the IMG compared to the lifestyle they had been accustomed to in their home countries. Being a physician in other parts of the world puts you in a completely different sector of the population. Most are used to being highly respected and live a life of privilege. Yet by coming to Canada to practice medicine, they often discover that they are facing many disadvantages because of issues around racism and discomfort linked to cultural differences. IMG programs should be designed to address some of these concerns.

Can the application of critical theory to an orientation program for IMGs translate into an enriched learner-focused experience? In order to make the learning in orientation learner-focused, power relationships have to be acknowledged and addressed. “In a cross-cultural context, it is the responsibility of the educator to become aware of their own cultural attributes and to become educated about the cultural aspects of the learners” (Osman-Gani & Zidan, 2001, p. 456). Most educators in an orientation program will have received their socialization and education within the North American context. A competent educator working from a multicultural perspective will respect the IMG’s education and prior medical practice and seek ways to work with them to assist in their integration into the Canadian healthcare context.

Policy Issues and IMG Orientation Programs

Education is rarely free from the decisions of national and local government and so policy affects curriculum (Jarvis, 1995, p 209). This is particularly evident when it comes to the funding, capacity and sustainability of programs. An example of the application of government policy is evident in the prescribed curriculum in IMG orientation. The IMG Task force recommendations based on The Health Canada Report of the Canadian Task Force on Licensure of International Medical Graduates is an example how the Canadian government recognizes the need for IMG orientation but does not delineate how this will be carried out. Therefore, many Canadian IMG programs are carried out quite differently i.e.in terms of program design and at whether it takes place pre or post assessment. Orientation programs are also not standardized. These programs are not always offered to IMGs when beginning practice or assessment, but that is beginning to change.

In order to remove as many barriers as possible to the success of IMGs practicing in Canada, the Human Resource Development Department of the Canadian Government is providing funding to institutions to develop, assessments, orientations, and integration programs. Yet most IMGs do not anticipate the challenges of a new practice when they leave their countries of origin. They may have been given inaccurate information by physician recruiters regarding the credentialing processes or they may not have been provided with all of the information that they require around the difficult immigration process. In most provinces, because of the shortage of physician resources in rural underserved communities, IMGs will not be permitted to work in the larger municipalities and therefore, will have to work in rural/remote locations, away from family and community and personal needs.

When we look at the Canadian government policy regarding IMGs from a Freirian lens, it might be argued that the concept of “false generosity” can be seen when government encourages physicians from other countries to come to practice in Canada. Patients in the underserved areas of the country trying to find a physician are also hopeful that someday their community will have a much-needed physician and rely on government to address the shortage of physicians in rural communities. The goal of recruiting IMG’s is to address these shortages. Although medical doctors are desperately needed in underserved rural and remote communities it sometimes seems that when they come here the welcome mat is rolled up.

IMGs put a lot of faith and hope in IMG programs that can be unpredictable in nature. The programs are very dependent on government funding which is not always consistent or the support of the medical community is not always there. “In many cases, licensing processes that devalue immigrant professionals’ human capital leave them with little choice but to settle in

Canada's largest cities where "survival" job opportunities are more plentiful and ethnic and social networks are better developed" (Girard & Bauder, 2005, p. 2).

IMGs coming to Canada will go through years of immigration bureaucratic red tape only not to have their credentials recognized or they have been out of practice too long and have lost a lot of their skills. This may mean that an IMG will potentially have to go back to medical school for a couple of years of residency training depending on their discipline, and/or endure endless assessment exams incurring lots of debt doing so. In the meantime, they often have to work at low-skilled jobs, such as driving taxis or working in restaurants, to make enough money to pay their bills.

Weeks before the recent Canadian federal election, it was reported by Canadian Broadcasting Corporation (CBC) that the Stephen Harper Conservative government had a strategy for getting immigrant professionals credentials recognized and employment opportunities in their respective professional capacity if his government were re-elected. This strategy was in the form of a new loan program for immigrants promising \$6 million in direct loans to immigrant professionals. However, when the fine print was revealed what the government was really going to do was provide the money to immigrant organizations instead to hire staff so that they as an agency could help immigrant professionals get loans from banks or other financial institutions. No money was going directly to the immigrant professionals.

Many immigrant professionals come to Canada every year in search of opportunities that they did not have in their own countries. However, when the reality of immigration and professional credentialing systems that are time consuming, daunting and end in disappointment in the end we have a lot of wasted talent in low paying jobs. I am not advocating that medical training is equal in all areas of the world but I think capacity in funding additional training needs

to be made available so they are successful and we do not lose the valuable skills these highly educated immigrants can provide to patients who do not have a family doctor in their community. The educational training that many immigrant doctors have to pay for when they arrive in Canada is not only of benefit to them, but also to Canadians who require health care providers in their communities. In addition, bringing in IMG's is a cheaper alternative than subsidizing the full cost of a medical education for doctors completely trained within Canada.

If we were to examine how IMGs are introduced to the Canadian healthcare system, we would see that when there is no standardized way of an IMG entering an assessment program, Canada has the Canadian Residency Matching Service (CaRMS) which is the organization that matches resident training to the various training opportunities across Canada. Up until a few years ago, Canadian medical graduates had first take on all the available residency programs in the first iteration of the match. The second iteration offered up positions that were not matched in the first round. Until recently, IMGs were not permitted to apply to the first round. This practice sparked a lot of heated debate and subsequently was deemed an unfair practice. Now IMGs are permitted to apply to both iterations of the match. When we talk about treating IMGs fairly, this seemed to be the first of many changes or "doors opening" for the IMG practicing in the Canadian Healthcare System.

In planning an IMG program there is a lot of discussion regarding to the length of time that would be appropriate to conduct one and have it be meaningful. Therefore programs across Canada vary greatly. Some last only one month, and others last from three months to one year. Educators usually decide the length of time based on the resources available i.e. human or financial. However, this may not be the optimal to determine the length of an orientation program. A standardized time frame for orientation needs to be determined.

Practicing as a physician in a new country can be a rewarding experience and can also be daunting depending on your prior training, practice experience and your ability to integrate into a completely new culture. In Canada, physicians work within the CaNMEDS framework of competencies. This framework includes seven roles: medical expert, professional, collaborator, communicator, manager, health advocate, and scholar. Most new IMGs are unfamiliar with this framework by which they will be ultimately assessed against either in residency or through a peer review program and be expected to develop professionally throughout their medical career in Canada.

Cultural Competency

Cultural competency, which was mentioned briefly earlier in this thesis, is an important competency an educator needs when teaching a diversified group of learners such as IMGs. Critical theories encourage educators to look at social cultural and political structures that shape the learning context. It is important that adult educators transmit more than their own culture-specific knowledge when instructing IMGs. It is also important for the IMGs to learn cultural competency. Both educators and IMGs will need to have the skills to manage a variety of reactions to cultural situations that IMG learners must deal with. These situations could be as simple as learning the terminology used in certain regions of the Canada. For example, I recall a story about an IMG who gave a patient some unfavourable news. The patient responding in a moment of disbelief exclaimed “Get out!” which for a lot of Maritimers refers to the disbelief of something they have heard, but to the IMG meant that the patient was angry and ordered them out of the examining room. Some of the more difficult situations may be telling a patient they are dying or performing sensitive examinations on patients of the opposite sex which in some

countries is unheard of, but for the Canadian healthcare system they would have to perform these examinations dependent on the type of practice. These situations need to be discussed during an IMG orientation program in order to assist IMGs in knowing what they can expect and how they can take what they already know from their previous experiences in their own culture and apply it to the Canadian context. Educators need to acknowledge the IMG's anxiety and reassure them that it is natural to feel disoriented and be encouraged to talk about their concerns and new ways of learning.

Chang (2007) states that in order for the learner to become inter-culturally competent, he may wish to review Taylor's (1994) five learning strategies:

- *learning readiness* –In most instances, IMGs come to orientation ready to learn but with different cultural, educational, and environmental experiences to draw from. It is the responsibility of the educators to meet IMGs where they are and encourage and support their development from that point. Educators must provide an environment that acknowledges diverse backgrounds, assist transition comfortably into medical practice, and provides resources when necessary.
- *facing cultural disequilibrium* – IMGs may face competing values and beliefs of their new environment with their own. Educators may also face cultural disequilibrium when they do not acknowledge the IMGs prior medical education and experiences by not being supportive and understanding.
- *utilizing different cognitive approaches (reflective/non reflective)* – There are different tools used to teaching effectively. We have already discussed PBL, however, this method would be used very little in an orientation because of time constraints depending on whether the physician is going into a residency or practice. Residencies take place in a

medical school setting and practicing physicians would be in an actual office setting seeing patients. Small group learning, self directed and experiential learning in a clinical setting are also approaches that appeal to different learning needs. IMG Orientation programs should have a mix of varied approaches to appeal to the diversity of the group.

- *developing learning strategies* – Incorporating feedback from IMG learners on how they would like to learn and what they need to learn about into the design of the program may effect positive changes. It would be impossible to cover everything as different people have different needs or wants, but what cannot be incorporated into an orientation program can be useful in developing the individual learning plans.
- *evolving intercultural identity* – The first point of most IMGs' experience with intercultural identity is when they take their Canadian Medical Council qualifying examinations. If successful they go onto residency training or practice-ready assessments. The questions or scenarios found on these varied assessments of knowledge opens the proverbial door to the expectations of the Canadian healthcare system. From there, if successful, an IMG, in most provinces will go onto an orientation program, where they will learn more about the Canadian medical culture and onto a supervised or mentored practice. Here the IMG will be with an experienced Canadian physician(s) who will hopefully, introduce the IMG not only to the community's medical culture but to the other aspects of the community such as churches, settlement organizations, other community groups or the nearest golf course (p. 190).

Having dialogical discussions can be an unfamiliar process for IMGs as their prior learning experience has been taught for the most part in a didactic fashion. Dialogical discussions are used for today's collaborative practical scenarios. An educator does not want to

impose their own opinions in a discussion with learners. There are times though that a dominant person in the group may do a lot of the talking because others do not want to challenge the person or they are just as content to let someone else do the all of the talking. Sometimes this is cultural. Some female IMGs may not want to challenge a male because this is not what is done in their own country. Allowing someone to dominate a discussion does not allow the learner to develop or express their own ideas. This is where critical educators take a more proactive role than facilitators sometimes, in addressing these issues of power imbalances within various learning contexts.

IMGs are a heterogonous group. It is important to realize that within this group lies the possibility of race, gender, culture issues and possibly political or religious conflict. It is critical that an educator be aware of these differences and be able to diffuse any tension by recognizing and respecting the diversity amongst the group and allowing everyone to have a voice. These women and men have only one obvious thing is common – they are IMGs. They come from different countries with different customs, and beliefs. They all have different views of the world and it cannot be assumed they all learn the same. Adult educators have to be aware of the differences and adjust our methods of teaching realizing also that we have a lot to learn from our students.

CHAPTER SIX

I began my thesis by exploring how IMG orientation programs may not be designed to respond to a number of concerns critical theories in adult education would address such as power issues, concerns around race, gender and lifelong learning. In this final chapter I will discuss what I have learned through my research relating to a learner-focused approach of the orientation of IMGs into the Canadian healthcare system. Finally, I want to share with my readers how we can go beyond the instrumental needs of the IMG by striving to meet the personal needs of the IMG and doing this through the evaluation of our orientation programs to ensure that they are learner-centered. Before I close my research with my final thoughts, I would like to share the concept of The Pedagogy of Hope and how it portrays the journey and struggles of IMGs coming from their own countries full of hope in pursuit of a medical career in Canada and we as educators involved in these programs could do to improve the experience for all.

Critical theory is one way through which to examine the orientation of IMG. It brings to light that the needs of the learner that need to be central to the planning process. While a humanistic framework in adult education such as Maslow's hierarchy of needs will address basic learner physiological and safety needs such as financial stress, fatigue from many assessments and credentialing hoops, it does not address power issues such as tensions relating to race or cultural differences, or other inequalities.

Ideally, orientation programs should be dialogical in nature. Dialogical programs include discussion among all the participating members, including adult educators, learners and their families, staff and the regional health authorities who are the potential employers and others relevant to the IMG's learning experience. A post-orientation support program such as a

mentorship program is also important to establishing relationships within the medical system and the community itself.

We must not lose sight that an important element that exists in most learning programs is the position of power (real or perceived) that educators/facilitators have over a group of learners, in this case, IMGs. By using critical theories when examining orientation program design and practices, we as adult educators, facilitators/providers of such programs can increase our understanding and awareness of the pivotal role we have to play in an empowered IMG successfully integrating into the Canadian Healthcare System. “One of the criticisms about critical theory is that it complains about all of the problems regarding adult education, but does not offer any solutions” (Brookfield, 2005, p. 6). There are no pre-packaged solutions that come with theories. They (theories) provoke adult educators (and others) into making us think about how we can make necessary change come about.

Within the CAPP orientation program, the facilitators and the IMG learners create the conditions for supportive and mutual action. During this time, IMGs should have an opportunity to develop relationships with other IMGs and educators. The goal is to establish a consistent and standardized learner centered orientation for all new IMGs. Too much information covered in a one day orientation program does not translate into greater knowledge retention. However, do several weeks of testing knowledge create a better orientation?

A learner-centered program design should take into account the physical, mental, and social conditions of the learner. For example, the CAP Program currently has funding that will offset the cost of accommodation, some travel, meals etc. during the week of orientation. Having these costs covered assists the IMG in not having the burden of enduring additional

financial hardship as many have had their earning power significantly reduced while going through costly assessment while supporting families.

It is important to realize that we as ethical adult educators, engage the IMG learner in the predetermined curriculum of orientation, that we are in effect increasing their ability to make informed choices when they enter into practice. In the CAP Program, we do a six-month follow up with our IMGs to ascertain whether their learning during orientation was meaningful and knowing what they know now, what suggestions would they make.

Throughout my thesis, I have provided a general overview of critical learning theories such as critical race and feminist theories, and how these have been taken up in other contexts in adult education/lifelong learning to explore power issues in teaching/learning contexts. I set out to introduce the reader to the idea of the IMG orientation program and how there is so much more to the orientation of an IMG than the exchange of medical information. I explained why a learner-centered program design should take a holistic approach accounting for the physical, mental, and social conditions of the learner. I discussed national policy as it pertains to the integration of IMGs into the Canadian healthcare system and described the various provincial IMG orientation programs highlighting the CAP program in Nova Scotia. I described how the application of critical theories to an IMG orientation program provide educators with opportunities to address a number of issues such as power, race, and gender issues of power (real and perceived). In my research, I drew upon ideas and concepts which represent a cumulative body of previous research relating to the interdisciplinary practices of orientation and critical theory through a process of reflection and discourse. By addressing these issues we may be able to promote lifelong learning in the IMG. In this chapter of my thesis, I will discuss how we must go beyond just giving information to the learner and expecting them to be able to be successful

in their medical practice. I will conclude with the pedagogy of hope and how it applies to the IMG orientation experience.

I discussed how education is rarely free from the decisions of national and local government and so policy affects curriculum. This speaks to the prescribed curriculum in IMG orientation. The IMG Task force recommendations based on The Health Canada Report of the Canadian Task Force on Licensure of International Medical Graduates is a great example how the Canadian government recognizes the need for IMG orientation but does not delineate how this will be carried out. Therefore, for as many Canadian IMG programs there are, we all are carrying them out quite differently.

All of the IMG programs in Canada are offering IMGs an orientation program before residency or practice to ease the transition into the healthcare system. This is a starting point and their work should not be considered over at the end of a week or two. IMGs need to continue with ongoing support and have resources to turn to when they are dealing with issues whether professional or personal. They are not only dealing with a new healthcare system but also a new way of living for most. In order to promote successful integration into Canadian medical practice, elements beyond knowledge and skill acquisition are important inclusions in an IMG orientation program. Considering these non-scientific elements warrants further research and discussion and should be of importance to adult educators when designing a learner-centered program.

In any field or discipline there are normative rules for behaviour within that field. These rules may or may not be clear. “At the same time, the field produces active individuals who exert the power necessary to establish, maintain, reinforce, or change the rules” (Usher Bryant and Johnston et al, 1997 as cited in Kilgore, 2001, p. 48). Not following the rules can result in

serious consequences including exclusion from the group. “Critical theory recognizes that individuals are not equal due to their various positions in power relations” (Chen, 2005, p. 16). Critical theory considers the influences from a broader perspective, in this case the Canadian health care system and broader social, cultural and political issues that may impact upon IMG’s learning experiences.

Through my research I have reflected on my own experience as to how we can make our own program here in Nova Scotia more meaningful and to be able to share this learning with others who are in a position to make a difference. “It (reflection) helps us to locate our work within a project that critically reflects on the limits of our particular positionalities to inform our practices” (Grace et al, 2003, p. 57). This research is not meant to produce any ready-made solutions to all the challenges associated with the orientation of IMGs. However in the same breath this paper has afforded me the privilege of coming to some understanding of how to apply critical theory to a process in order to improve it.

I have come to realize that some practices we take for granted as being in the best interest of the IMG are not always. I envision my research as an opportunity to contribute to this field of research with the added benefit of allowing me to reflect on the CAP Program’s current practices and what we can do to improve the learner-centered experiences for IMGs.

Up until the last several years, IMGs have gone into medical practice situations without any kind of orientation and they were often left in the dark to figure things out for themselves. “A lack of a systematic professional development and enculturation program for immigrant professionals may result in unnecessary boundaries” (Austin & Dean, 2004, p. 43). These boundaries could include professional isolation because they are not introduced to the other staff

and do not have the knowledge of the how things are done differently from where they are used to practising.

Beyond instrumental needs

Reflection is a part of our everyday activity. When we design IMG orientation programs we need to reflect on how issues of power, race, gender influence the way we teach and the way participants learn. As educators, we are required or expected by our learners to be able to make quick decisions on how to react to any given situation we may find ourselves a part of. For instance, a common teaching/learning method during coursework is to give group presentations on a specific topic of a learner's own choosing. It is no surprise that not all individual learners make cohesive workgroups, particularly if they have not spent a lot of time together and don't know anything about each other. Problems can arise amongst groups of learners when there is a disparate amount of time spent on the project by individuals or differing views of who will do what. Learners feel a great deal of anxiety when they feel they have little control over a group project whether it be not having a big part in the presentation or not doing enough of it. The orientation space is most importantly what brings the learners together. "The approach is one that starts by recognizing that in order to successfully orient students to our learning space we need to orient ourselves to theirs"(Wozniak, 2009, p. 223). During the group's final evaluation of the presentation with the educator, a learner may voice discontent on the outcome of the presentation and how it will reflect on his/her mark. An educator has to be prepared on how to handle varying group dynamics. Incorporating a social activity into the orientation by inviting previous candidates to come and have an informal Q & A goes a long way in alleviating some of the 'unknown'. Seeing someone like themselves who has been successful and can provide them with

insight as to what they may endure the first year in practice should also go along way to alleviate stress. This will give participants a chance to ask questions and have some light shed on what they may expect during their first year of practice.

Evaluation of a Learner-centred Program

There is no doubt that when anyone begins any new job we all require some information to begin. “A successful orientation can go a long way to reduce this anxiety and allow them to feel and be more competently quickly. This translates into safer doctors , improved patient care and enhanced training experience for trainees” (Taitz, 2004, p.3). An orientation is particularly necessary when coming from one country to another.

In my own experience with the CAPP’s post-orientation follow-up surveys, it has been difficult to obtain enough feedback to substantiate as to whether we have met the needs of the IMG. IMGs do not wish to criticize the process that has given them an opportunity to practice medicine. The literature suggests that orientation process for new IMGs be attentive to both professional and personal needs, comprehensive, multifaceted and sustained (Curran et al, 2008, Simon, 2006). An effective orientation process is an important means of reducing professional isolation and supporting new IMGs in the transition to medical practice in their new communities. “Orientation that is responsive to the various needs of new IMGs may increase retention” (Curran et al, 2008, p.167).

IMGs are eager to learn everything they can before entering practice. All of the programs are a finite period of time however, support could be continued post-orientation. The most appropriate length of the program is undecided. Some relate successful programs of three to five days duration. IMGs will gain more confidence when they know and feel supported by first receiving an orientation and learning what will be expected of them to perform their jobs in the

Canadian healthcare context, and then that support should be continued through a peer support or mentorship program.

What I found really interesting was that the evaluation process should not be done by teachers or facilitators themselves in the education of adults (Jarvis, 1995, p.195) and that the students should be full participants in the process. I know that in the CAP Program we do have both facilitators and participants participate in the evaluation of each module and the overall program. But it is interesting that although we look at both evaluations, the participant evaluations offer us the most useful information in gaining a perspective in what they need or did not get or how it can be improved. It was in fact, an evaluation from a participant that gave me the idea to write my thesis on the how we can improve a normally prescribed orientation for a group of people who also have needs outside of the usual prescribed program such as a social event where they can talk to others who have come before them. As a matter of fact, we also have made changes to programs based on feedback from the facilitators with respect to notable boredom of the issues amongst participants. So it speaks to some negotiation among participants to what they learn.

Participant feedback suggests that inclusion of personal and social aspects in the orientation, as well as professional needs, is important. A six-month follow-up evaluation demonstrates that a more comprehensive approach to orientation supports IMGs in their transition to medical practice in their new communities. It has been suggested that pretest and post tests provide baseline information in order to glean useful program evaluation information. The CAPP has struggled with how to do this as IMGs tend to study for everything and we do not want to contradict our process of just having a meaningful learning experience without the testing of knowledge.

Although the use of critical theory in my research may not provoke nationwide social and/or political change, I will use my learning from this research to invoke changes that I feel can have a positive influence the CAPP orientation program. “The aim of research is to critique and change factors that constrain and exploit individuals” (Illing, 2007, p. 10). My research will serve as a personal reflection of the CAPP’s successes and shortcomings.

Pedagogy of Hope

The study of hope has spread to the health professions. “The scientific study of hope which used to belong theologians, has now moved to philosophy and more recently to health sciences such as medicine, nursing and psychology” (Li et al, 2008, p. 247). We hear how one’s outlook on their own health crisis can cause one to move to a more positive or hopeful mindset. The attitude of not giving up when things look hopeless has produced many inspiring feats of accomplishment or simply ‘beating the odds’. “When addressing the problems that affect the educational process, critical educators such as Paulo Freire and bell hooks consistently refer to the pedagogy of hope”(Shade, 2006, p.192). Discourses relating to hope are found in a number of theorists particularly those who have dealt with adversity because of the color of their skin, or their religion beliefs or their sexual orientation. Shade (2006) states that “the most important function of hope is to provide an end or good that resolves the original problem”(p.194). When we are hopeful, we believe that learning is possible. We also believe that there is more than one way to teach and/or learn.

Many IMGs coming into the healthcare system are understandably disappointed when they learn that their credentials from their country of origin are not meeting Canadian

requirements. After all, their belief is that they have a medical degree which should allow them access to any healthcare system they choose to practice within. All medical or related institutes are charged with protecting the safety of the public they serve. Part of that responsibility is to ensure the credentials provided in one country will serve the purpose of another country's population. IMGs do not always realize that family medicine practiced in one country can be very different from the North American standard.

The Pedagogy of Hope is one of Freire's follow-up books to *Pedagogy of the Oppressed*. Freire continues his critical, liberationist pedagogy. I have felt quite inspired by this book not only as it speaks to my own personal educational journey but for the IMGs who continuously strive to gain back what they have lost coming to a new country on both a personal and professional level. Some never do. Freire (2005) laments "exile is a difficult experience - waiting and not having what we expect come" (p.33). For many IMGs with the expectation of re-establishing a medical career that has been interrupted because of immigration issues, Canadian credentialing exams and then entering the Canadian healthcare system, Freire's words have an eerily ring of familiarity for many an IMG's journey.

Hope is a practical habit we all tend to have. We must first realize that our hopes can come to fruition when they are connected to actual conditions and abilities which occasionally means we have to take risks. Hope also entails having trust that other people or conditions contribute to the end result. I see all of these characteristics of hope in the IMG participants. More times than not, they have gone through many assessments and dead-end opportunities in the hope of gaining licensure within the Canadian healthcare system. When forming the habit of hope, we need to be courageous and not allow ourselves to become discouraged in the face of disappointment. Persistence is important in hope.

When one looks to expanding their resources such as increasing our knowledge by acquiring education about any particular topic it help us become more confident in achieving our end result. Becoming confident assists us in building capacity. “Hope is also used as part of reflective practice which allows us to see not only our own possibilities but others as well” (Li et al, 2008, p.253). Hope within the context of IMGs entering the Canadian healthcare system is reaching out to those who are invested in our hopes (regulatory/licensing bodies) and ours in theirs (the Canadian healthcare system).

Shade’s (2006) definition of a ‘community of hope’ as being one that is committed to promoting the development of habits of hope applies to the IMG orientation experience. Currently, the IMG orientation programs are under the auspices of a university or an IMG assessment centre are part of this community genuinely devoted to cultivating hope to ensure that all IMGs entering the Canadian healthcare system receive preparation to pursue their hopes. This practice of hope aligns with the principles of social justice (p.199).

The Future of IMG Orientation Programs

Orientation programs for IMGs in most provinces is a mandatory process before going out into medical practice. Many IMG programs are costly to deliver and most organizations administering these programs rely on government funding for sustainability. Programs that do not have consistent funding create an uncertainty for the organizations providing this valuable learning experience. If we are to truly integrate IMGs into the Canadian healthcare system, we have to find a way to conduct IMG orientation programs effectively without the imposition of more fees upon the individual. Orientation for IMGs has been deemed a second level priority for the Federation of Medical Regulatory

Authorities (FMRAC), the organization that is the national organization, both nationally and internationally, of the provincial and territorial medical regulatory authorities. It considers, develops and shares positions and policies on matters of common concern and interest. It also develops and maintains services and benefits for its Members. Retrieved June 5, 2011 from <http://www.fmrac.ca/about-us/mission.html> .

As previously discussed in Chapter Two, orientation programs are delivered differently across Canada. I am currently involved in a FMRAC initiative in an effort to find out where the gaps in IMG orientation programs are and how we can assist the provinces that are not conducting these orientations do so effectively.

My thesis was an opportunity to contribute to this field of research with the added advantage of enabling me to reflect upon Nova Scotia's CAPP orientation program and to confidently make meaningful changes to improve the program's delivery and the learning experiences of IMGs as they enter the Canadian healthcare system. I feel privileged to be in the position as program manager responsible for the delivery of the Nova Scotia College's IMG orientation program. I believe that conducting orientation programs for IMGs in a learner-focused way preserves the IMG learner as an individual outside of their professional role.

Conclusion:

I have discussed how some orientation programs are an exercise in delivering the most information to the maximum amount of participants in the shortest amount of time and in a cost efficient way. The dilemma with this method is that there is no relationship building or personal connection on the part of the IMG to the healthcare system they are about to embark upon. In

fact, this deluge of information leaves the IMG with more uncertainty and more questions unanswered.

Throughout my research and through my own personal observations and experience, I have come to believe that in order to promote successful integration into Canadian medical practice, elements beyond knowledge and skill acquisition are important inclusions in an IMG orientation program. Considering these non-scientific elements warrants further research and discussion and should be of importance to adult educators when designing a learner-centered program.

I have often heard and been involved with the debate around what is the most appropriate length of time for orientation. “Orientation should not be limited to a point in time but a continuum of support, a timeframe extended before and after the commencement of learning” (Wozniak, 2009, p. 223). Orientation should be viewed not as a ‘one off’ information session but rather as an ongoing learning experience. In order for orientation program planners to critically assess the learning experiences of the IMG, they must uncover elements of the orientation process that are taken for granted. For instance, we assume that IMGs just need the skills information to take them out into the workplace. Yet we are not addressing the other information IMGs need to be successful such as how to take care of yourself during the stressful time of re-entering a new workplace with a new set of rules. To address these needs, an orientation program requires ongoing evaluation of the modules and content, reading materials, paradigms and theoretical perspectives to ensure the individual’s needs are addressed as well as the professional needs. On-going support post-orientation such as a physician mentor should also be a consideration.

Educational organizations face challenges around developing critical approaches to education. Dependence on government funding can adversely affect how a program is implemented. Mayo (1993) states that “a lot of times ideas/programs originally introduced with transformative ends in mind, become diluted because of stifling bureaucratic procedures” (<http://web.ebscohost.com/ehost/delivery?vid=4&hid=7&sid=582efee> Retrieved March 24, 2010). In addition, funding may be discontinued if the curriculum is not perceived to be valuable or a worthwhile investment of tax dollars.

My research is not meant to produce any ready-made solutions to all the challenges associated with the orientation of IMGs. However, writing this thesis has afforded me the opportunity of coming to an understanding of how the utility of applying critical theories as an evaluative process to an educational process in order to improve it. Will the application of CT to an IMG orientation Program make a difference? I believe it will. "The theory's utility depends on people recognizing that it expresses accurately the yearnings they have for a better, more authentic way to live"(Brookfield, 2001, p. 12). CT will assist in the evaluation of a learner-focused program that recognizes the individual IMG as the whole person with many facets and not just the medical expert. I am optimistic that those who design programs to assist IMGs will realize the importance of looking at all facets of an IMG's life and plan programs accordingly. It will not only make for a more successful integration of an IMG into the Canadian healthcare system, it may also improve retention if the individual feels welcomed and is being set up for success.

References

- Albanese, M. (2007). *Problem-based learning: Understanding Medical Education*. Edinburgh, UK: Association for the Study of Medical Education.
- Austin, Z. & Dean, M. (2004). Development of a curriculum for foreign trained pharmacists seeking licensure in Canada. *Pharmacy Education*, 4(3/4), 143-151.
- Asante, M. (2003) *Afrocentricity: The Theory of Social Change*. Chicago, IL: African American Images.
- Bleakly, A. (2006). Broadening conceptions of learning in medical education: the message from teamworking. *Learning Theories, Medical Education*, 40, 150-157.
- Brigham, S. & Gouthro, P. (2006). Cross Cultural Teaching and Research in Adult Education. In T. Fenwick, T. Nesbitt & B, Spencer (Eds.), *Contexts of Adult Education: Canadian Perspectives* (pp 81-90). Toronto, CA: Thompson.
- Brookfield, S. (2001). Repositioning ideology critique in a critical theory of adult learning. *Adult Education Quarterly*, 52(1), 7-22.
- Brookfield, S. (2005). Exploring the meaning of Critical Theory for Adult Learning. *The Power of Critical Theory*. San Francisco, CA: Josey Bass.
- Brookfield, S. (1992). Developing criteria for formal theory building in adult education. *Adult Education Quarterly*, 42(2), 79-93.
- Clinician Assessment for Practice Program website. Retrieved August 2, 2010 from <http://www.caprogram.ca/mentoring-faq.htm>
- Chang, W. (2007). Cultural competence of international humanitarian workers. *Adult Education Quarterly*, 57(3), 187-204.

- Chen, H. (2005). The rationale for critical pedagogy in facilitating cultural identity development. *Curriculum and Teaching Dialogue*, 7, 11-22.
- Cheren, M. (2002). A concise review of adult learning theory. *The Journal of Education in the Health Professions*, 22, 190-191.
- Canadian Institute on Health Information (CIHI, 2009) *International medical graduates in Canada*. Retrieved June 5, 2011, from http://secure.cihi.ca/cihiweb/products/img_1972-2007_aib_e.pdf
- Collins, P. (1990) *Black Feminist Thought in the Matrix of Domination*. Retrieved January 9, from <http://www.hartford-hwp.com/archives/45a/252.html>
- Cox, P. Hardwick, L. (2002). Research and critical theory: their contribution to social work education and practice. *Social Work Education*, 21(1), 35-47.
- Curran, V, Hollett, A, Hann, S. (2008). A qualitative study of the international medical graduate and the orientation process. *Canadian Journal of Rural Medicine*, 13(4), 163-169.
- Daniel, C. (2007). Outsiders Within: Critical Race Theory, Graduate Education and Barriers to Professionalization, *Journal of Sociology & Social Welfare*, 34(1), 25-42.
- Dei, G. (2005). The challenge of inclusive schooling in Africa: a Ghanaian case study. *Comparative Education*, 41, 267-289.
- Dorgan, K., Lang, F., Floyd, M., Kemp, E. (2009). International medical graduate-patient communication: A qualitative analysis of perceived barriers, *Academic Medicine*, 84(11), 1567-1575.
- Dunn, A. (2002). Cultural competence and the primary care provider. *Journal of Paediatric Health Care*, 16, 105-111.

Federation of Medical Regulatory Authorities (FMRAC). Retrieved June 5, 2011 from
<http://www.fmrac.ca/about-us/mission.html>

Fenwick, Tara (2003). Learning Through Experience: Troubling Orthodoxies and Intersecting Questions. *Professional Practices in Adult Education and Lifelong Learning*. In S. Merriam & R. Cervero (Eds). Malabar, FL: Krieger.

Freire, P. (1986). *Pedagogy of the oppressed*. New York: Continuum.

Freire, P. (1993). *Pedagogy of the oppressed*. New rev. 20th-Anniversary ed. New York: Continuum

Freire, P. (1994). *Pedagogy of Hope: Reliving Pedagogy of the Oppressed*. London, UK & New York, NY: Continuum.

Freire, P. (1998). *Teachers as Cultural Workers: Letters to Those Who Dare Teach*. In J. Kinchloe, P. McLaren & S. Steinberg (Eds.), New York, NY & London, UK: Westview Press.

Freire, P. (2005). *Pedagogy of the Oppressed*. 30th (ed). New York, NY & London, UK: Continuum.

Girard, E., Bauder, H. (2005). Barriers Blocking the Integration of Foreign-Trained Immigrant Professionals: Implications for Smaller Communities in Ontario. University of Guelph.

Gouthro, P. (2005) A critical feminist analysis of the homeplace as learning site: expanding the discourse of lifelong learning to consider adult women learners. *International Journal of Lifelong Education*, 24(1), 5–19.

Grace, A. P., Gouthro, P., Mojab, S. (2003). “Thinking the practice”: Academic adult educators’ reflections on mediating a summer institute as a multicultural learning journey for graduate students. *Studies in Continuing Education*, 25(1), 51-73.

- Grace, A. (2007). Envisioning a critical social pedagogy of learning and work in a contemporary culture of cyclical lifelong learning. *Studies in Continuing Education*. 29(1), 85-103.
- Health Canada Report of the Canadian Task Force on Licensure of International Medical Graduates. (2004). *Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources*; Retrieved July 24, 2009 from www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgs/pdf/hht/medical-graduates.pdf.
- Health Canada. *Canada's Healthcare System (Medicare)* Retrieved from <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/index-eng.php> on February 27, 2011.
- Hollett, A. & Hann, S. (2007). *Physician orientation: Best practices and perceived needs*. Memorial University, NL.
- Illing, J. (2007). *Thinking about research: frameworks, ethics and scholarship: Understanding Medical Education*. Edinburgh, UK: Association for the Study of Medical Education.
- Jarvis, P. (1995). *Adult and continuing education: Theory and practice*. (2nd ed). London & New York: Routledge
- Kaufman, D. & Mann, K. (2007). *Self-directed learning: Understanding Medical Education*. Edinburgh, UK: Association for the Study of Medical Education.
- Kerka, S. (2005). Mandatory Continuing Education, *Academy for the Study of the Psychoanalytic Arts*, Retrieved November 14, 2010 from <http://www.academyprojects.org/kerka.htm>.
- Kilgore, D. (2001). Critical Postmodern Perspectives on Adult Learning, *The New Update on Adult Learning*, San Francisco, CA: Josey Bass.
- Kinzie, J. (2007). Women's paths in science: A critical feminist analysis. *New Directions for Institutional Research*, 133, 81-93.
- Li, Y., Mitton-KuknerYeom, J. (2008). Keeping hope alive. *Reflective Practice*. 9(3), 245-256.

MacLellan, A., Brailovsky, C., Raionsberry, P., Bowmer, I., Desrochers, M. (2010).

Examination outcomes for international medical graduates pursuing or completing family medicine residency training in Quebec. *Canadian Family Physician*, 56, 912-918.

Manatarnach, D. (2002). Fostering reflective teachers in globalized age, religious education, *Religious Education*, 97(3), 271-287.

Mantzoukas, S. (2004). Issues of representation with qualitative inquiry. *Qualitative Health Research*, 4(7), 994-1007.

Maudsley, R., June 21, 2006 personal communications.

Mayo, P. (1993). When Does It Work? Freire's pedagogy in context. *Studies in the Education of Adults*. Retrieved March 24, 2010 from <http://web.ebscohost.com.www.musvu.ca:2048/ehost/delivery?vid=4&hid=7&sid=582efee>

McCrorie, P. (2007). *Teaching and Leading Small Groups: Understanding Medical Education*, Edinburgh, UK: Association for the Study of Medical Education.

Merriam, S. (2001). *The New Update on Adult Learning Theory*. San Francisco, CA: Jossey-Bass.

Merriam, S., Caffarella (1991). *Learning in Adulthood. A comprehensive guide*. San Francisco, CA: Jossey-Bass.

Morgan, S. (2006). Orientation for general practice in remote aboriginal communities: A program for registrars in the northern territory, *Australian Journal of Rural Health*, 14, 202-208.

Newman, M. (2006) *Teaching Defiance: Stories and Strategies for Activist Educators*. San Francisco, CA: Jossey Bass.

- Osman-Gani, A., Zidan, S. (2001). Cross-cultural implications of planned on-the-job training. *Advances in Developing Human Resources*, Retrieved February 25, 2009 from <http://adh.sagepub.com/cgi/content/abstract/3/4/452>
- Parker, L., Stovall, D. (2004). Actions Following Words: Critical race theory connects to critical pedagogy. *Educational Philosophy and Theory*, 36(2), 167-182.
- Porter, J., Townley, T., Huggett, K., Warriar, R. (2008). An acculturation curriculum: Orienting international medical graduates to an internal medicine residency program. *Teaching and Learning in Medicine*, 20(1), 37-43.
- Pearson, E. & Podeschi, R. (1999). Humanism and Individualism: Maslow and his critics. *Adult Education Quarterly*, 50(1), 41-55.
- Perulli, E. (2009). Recognizing non-formal and informal learning: An open challenge. *The Quality of Higher Education*. Retrieved June 5, 2011 from <http://eric.ed.gov/PDFS/EJ870191.pdf>
- Roaten, G. & Schmidt, E. (2009). Using experiential activities with adolescents to promote respect for diversity. *Professional School Counseling*, 12(4), 309-314.
- Sargeant, J., Mann, K., Sinclair, D. Ferrier, S. Muirhead, P., van der Vleuten, C. et al (2006). Learning in practice: Experiences and perceptions of high scoring physicians. *Academic Medicine*, 81(7), 655-660.
- Seiler, R. (2006). Human communication in the critical theory tradition, Retrieved July 11, 2010, from <http://people.ucalgary.ca/~rseiler/critical.htm>.
- Schon, D.(1983). *The Reflective Practitioner: How Professionals Think in Action*. New York, NY: Basic Books Inc.

- Schon, D. (1987). *Educating the Reflective Practitioner: Toward a new Design for Teaching and Learning in the Professions*. San Francisco, CA: Jossey Bass.
- Schuetze, H. (2006). International concepts and agendas of lifelong learning, *Compare*. 36(3), 289-306.
- Schurgurensky, D., Mundel, K. (2005). Volunteer work and learning: Hidden dimensions of labour force training. *International Handbook of Educational Policy*, Basica, N, Cumming, A, Datnow, A. Leithwood, K., Livingstone, D. (Eds). (pp. 1-26). Springer, GB.
- Shade, P. (2006). Educating hopes. *Studies in Philosophy and Education*. 25, 191-225.
- Steinart, Y. & Walsh, A., (2006), *A faculty development programs for teachers of international medical graduates*. Association of Faculties of Medicine of Canada (AFMC). Ottawa, CA.
- Taber, N., Gouthro, P. (2006), Women and Adult Education in Canadian Society. In T. Fenwick, T. Nesbitt & B, Spencer (Eds,), *Contexts of Adult Education: Canadian Perspectives* (pp 58-67). Toronto, CA: Thompson.
- Taitz, J et al. (2004) Making the most of medical orientation-A new approach. *Med Education Online*, 9:2, 1-4.
- Thompson, J, Licklider, B., Jungst, S. (2003), Learner-centered teaching: Postsecondary strategies that promote “thinking like a professional”. *Theory into practice*, 42(2), 133-141.
- US Department of Health and Human Services. The Office of Minority Health. (2005). What is cultural competency? Retrieved January 2, 2011, from <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=11>

- Wenger E. (1998). *Communities of practices. Learning, meaning and identity. (In)*. New York, NY: Cambridge University Press.
- Wozniak, H. et al. (2009). Stepping through the orientation looking glass: A staged approach for postgraduate students. *Australian Journal of Educational Technology*, 25(2), 221-234.
- Zepke, N. & Leach, L. (2006). Improving learner outcomes in lifelong education: formal pedagogies in non-formal learning contexts? *International Journal of Lifelong Learning*, 25(5), 507–518.
- Zink, R. & Dyson, M. (2009), What does it mean when they don't seem to learn from experience? *Cambridge Journal of Education*, 39(2), 163-174.