

**THEORIZING THE BARRIERS AND FACILITATORS TO RELICENSING AND
RESETTLING OF ALBERTAN INTERNATIONAL MEDICAL GRADUATES**

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DEDICATION

This work is dedicated to:

my parents, Ranjani and Rohitha Baddegamage,
my husband, Sampath,
my children Dinula, Nimaya and Dewuni, and
my friends and supporters.

ABSTRACT

The purpose of this qualitative research study was to explore how Albertan International Medical Graduates (AIMGs) negotiated barriers and facilitators during their journey to Canadian medical licensure by incorporating the views and perceptions of two study groups: practicing and non-practicing. This research used Charmaz's (2014) constructivist grounded theory approach and was informed by six non-practising and seven practising AIMGs. The participants were individually interviewed with open-ended, in-depth questions. This research provided rich insight into the Canadian medical licensure experiences of AIMGs. Seven key factors to the successful licensure of AIMGs were identified: finances, language, family, culture, networks, institutional rules, and intrapersonal characteristics. A theoretical framework was developed to explain how AIMGs negotiated those factors to obtain their Canadian medical license. Furthermore, acculturation theory was used to explain the acculturation strategies of AIMGs, and institutional theory was used to explain how the existing policies and regulations acted as barriers to the licensing of AIMGs. AIMGs used two acculturation strategies, integration was the preferred choice of adaptation to the Canadian society, and assimilation was the only possibility when adapting to the hospital culture. Health care administrators and policy makers can use the concepts identified in this study to integrate more AIMGs into the Canadian health care system.

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CHAPTER ONE: INTRODUCTION

With the highest immigration rate among the Organization for Economic Cooperation and Development (OECD) countries, Canada welcomed in 2010, 280,000 permanent residents, mainly consisting of skilled workers, investors, entrepreneurs, family-class immigrants, and refugees (Toronto-Dominion Bank, 2012). Citizenship and Immigration Canada (CIC) selects skilled workers as permanent residents based on immigrants' ability to become economically established in Canada (CIC, 2013).

International Medical Graduates (IMGs) are one of the main categories of the skilled workers who encounter additional challenges compared to other skilled workers when attempting to have their professional identities recognized. The Royal College of Physicians and Surgeons of Canada (RCPSC, 2014) defines an IMG as an individual who has graduated from a medical school outside of Canada or the United States (US). The Canadian immigration process accepts IMGs' clinical and educational qualifications when issuing permanent residency status. However, once they have immigrated, their educational qualifications are insufficient to secure employment as a physician. Bauder (2003) calls this phenomenon "brain abuse"--most IMGs have the necessary credentials, but their credentials are not recognized. For example, an immigrant's foreign degree has less than one third of the educational value of a similar degree obtained in Canada (Alboim, Finnie, & Meng, 2005). Value of a degree is the measure of employability. Furthermore, when evaluating immigration applications, CIC only considers the applicant's home country credential and does not consider its comparative value in Canada (CIC, 2013). According to the House of Commons Standing Committee on Health (2009) report, CIC officials believe that because the government of Canada is

responsible for the selection of immigrants, it needs to ensure that immigrants receive employment matching their credentials. By wasting foreign skills and knowledge, the Canadian economy loses billions of dollars (Health Canada, 2007).

There are two streams of IMGs. The first stream is Canadians with foreign medical qualifications. This subset of IMGs comprises either landed immigrants or Canadian citizens who had their primary education in Canada and who pursue medical education in schools outside Canada. Walsh, et al. (2011) referred to them as Canadians Studying Abroad (CSA). According to the same authors, based on the admission data provided by the international schools and Canadian organizations, the Canadian Resident Matching Service (CaRMS) estimates that there are about 3,500 Canadian students currently studying medicine abroad. CaRMS is responsible for selecting Canadian medical graduates for post graduate training positions. The second stream is non-Canadians with international medical qualifications arriving as landed immigrants or refugees. According to the OECD (2008) report, the arrival of immigrant IMGs was low until 2003. In 1999, only 80 specialists and 100 family physicians came to Canada as landed immigrants. Thereafter, arrival of immigrant IMGs gradually increased, and in 2006 alone, around 620 specialists and 500 family doctors immigrated to Canada. Both streams require successful completion of additional medical training and examinations to receive licensure to practise in Canada. Immigrant IMGs face greater hurdles (due to poor communication skills, cultural incompetency, age differences, financial difficulties, and lack of transparency in the licensure process) than do Canadians with foreign medical qualifications (Huijskens, Hooshtaran, Scherbier, & Horst, 2010). At present, CSAs are more successful in receiving residency positions than immigrant IMGs (Watt, Violato, &

Lake, 2012). The current research study investigated the resettling and relicensing of immigrant IMGs; hereafter referred to as IMGs, in Alberta, Canada.

Historically, Canada has depended on IMGs to address its physician shortage. For example, in 1970, one third of practising physicians in Canada were IMGs (Bourgeault, Neiterman, LeBrun, Viers, & Winkup, 2010). Though the percentage of practising IMGs has dropped to 23%, Canada still depends on IMGs to fulfill its physician shortage (Canadian Institute for Health Information [CIHI], 2009). According to the same report, from 1972 to 1976 the main practising IMG source countries were the United Kingdom and Ireland. At present, however, immigrating IMGs represent a wider spectrum of the world community; including Africa, Asia, the Middle East, and Eastern Europe. IMGs immigrate to Canada due to many pull and push factors (Bourgeault et al., 2010).

According to the same authors, the main pull factors are: an easy immigration process, political and economic stability, fair international policies, promotion of multiculturalism, and perceived high demand for the medical profession. The main push factors include personal reasons, insecurity, family matters, and lack of professional development opportunities in their home countries.

For IMGs, integrating into the main health care stream is highly competitive. Even after completing all of the required standard medical examinations and the English proficiency tests, there is no guarantee of a residency position. According to Watt et al. (2012), only a small percentage of IMGs are able to receive residency positions within their first few years of settlement in Canada. These authors, using 2011 CaRMS data, stated that in 2010 there were about 1,497 IMGs who had applied for residency positions,

but only 18% were successful in the first iterations; on the other hand, 96% of the Canadian Medical Graduates (CMG) received residency positions.

The Association of International Physicians and Surgeons of Ontario (AIPSO, 2013, para.16) compares the IMGs' situation as "dealing with a locked door, without a key." Even the House of Commons Standing Committee on Health (2009) recognized that IMGs compete for a limited number of residency spots, and that foreign credential recognition is a complex process. Only a few changes have been made to address the IMGs' situation. Bourgeault et al. (2010) stated that every month the media releases a new story of IMGs who deliver pizza or drive taxis instead of practising in their relevant fields.

In addition to the immigration of IMGs, Canada also experiences the emigration of qualified physicians, mainly to the US (Dauphinee, 2005; Mullan, 2005; Ryten, Thurber, & Buske, 1998). For example, between 1984 and 2004, 726 Canadian-trained physicians left Canada, and only 218 returned, resulting in a net loss of 508 physicians (Dauphinee, 2005). Canadian-trained physicians constitute the fifth-largest group of IMGs in the US (Mullan, 2005). The migration of Canadian physicians to the US further threatens Canada's physician-to-population ratio. Ryten et al. (1998) estimated that the number of Canadian-trained physicians will be insufficient to meet future Canadian health care requirements if this trend continues. Recent literature on IMGs noted that there has been an increase in residency spots for IMGs in 17 medical faculties across Canada (Canadian Post-M.D. Education Registry [CAPER] Report, 2011; Walsh et al., 2011). For example, according to the CAPER Report (2011), in 2005 there were only

1,073 (11.5%) immigrant IMG positions, but in 2010 this number increased to 2,012 (21.6%).

In 1970, Canada had one of the highest physician-to-population ratios (1.8 physicians per 1,000 population) among the OECD countries (Esmail, 2008). However, the current physician per 1,000 population ratio of Canada is only 2.4, which is much lower than the OECD standard of 3.1 (Canadian Medical Association [CMA], 2012). In 2007, 1.7 million Canadians aged 12 years or older did not have access to a regular physician (Statistics Canada, 2007). The College of Physicians and Surgeons of Alberta Quarterly Report (December, 2011) announced a net increase of 332 physicians in Alberta during 2011. Assuming 10% attrition per year, without population growth, Alberta needs 500 new physicians annually (McAlpine, 2007). Furthermore, according to Esmail (2008), under the current structure of Medicare, the present physician supply is insufficient to meet Canada's demands relative to the population growth without integrating IMGs into the Canadian health care system.

The Alberta Treasury Board and Finance (2012) estimated that Alberta's annual population will increase by 1.5% annually over the next three decades. The international migrant population is expected to contribute 65% to this growth; therefore, recruiting physicians who can understand and respect the health needs of the diverse immigrant population is required. One of the solutions to the problem is to integrate more IMGs into the Canadian health care stream. Emery, Crutcher, Harrison, and Wright (2006) revealed that integrating IMGs into the Alberta healthcare system through the Alberta International Medical Graduate Program (AIMGP) is a less costly and more efficient

approach compared to the regular Canadian medical graduate program. The details about AIMGP are provided in section 2.2 of the literature review.

1.1 Topic, Purpose, and Research Questions

This qualitative study explored the barriers and facilitating factors encountered during the resettling and relicensing of Albertan IMGs. The two processes, “relicensing” and “resettling,” were closely associated, and were indistinguishable. The two processes cannot be distinct from each other. For an AIMG, relicensing can be referred to as a process of obtaining the license to practise medicine in Canada. The Oxford online dictionary defines resettle as “settle or cause to settle in a different place” (“Resettle,” n.d para.1). The relicensing process consists of two main components. The first one represents the period between time of arrival in Canada and securing of a residency position. The second component represents the residency training.

During the initial step, IMGs do the preparatory work to secure a residency position. They need to verify their educational credentials through the Physician Credential Registry of Canada (PCRC) and pass the Medical Council of Canada Evaluating Exam (EE), Qualifying Exams (QEI and QEII), English proficiency exams, and the National Assessment Collaboration-Objective Structured Clinical Examination (NAC-OSCE). This process is completed while the individual cares and provides financial support for his/her family. It is common for individuals going through this process to be employed in low-level labour jobs, which is a loss for the individual and also for Canada.

This research focused on the experiences and perceptions of two categories of Albertan IMGs (currently practicing and non-practising) encountered during their

relicensing and resettling process. Receiving many views, experiences and perceptions from two categories of AIMGs provided a holistic picture of the relicensing and resettling process for AIMGs. The research questions for this study were:

- 1) What is the process for resettlement and securing a residency position?
- 2) How do AIMGs negotiate the facilitators and barriers for securing a residency position?

In addition, the acculturation strategies of AIMGs were analyzed using Berry's (1997) acculturation theory; as well, and institutional theory (Scott, 2001) was applied to explain the institutional challenges faced by the AIMGs.

1.2 Significance of the Study

The significance of this research can be justified under three levels: personal, practical, and intellectual (Maxwell, 2013). At the intellectual (scholarly) level, findings of this research may contribute to filling existing knowledge gaps about Albertan IMGs (AIMG) and drawing a holistic picture of the resettling and relicensing process of the AIMGs by identifying the factors affecting it. At the practical level, insights gained from this research may be useful for health and educational policy makers and administrators to streamline the assessment, evaluation, and relicensing of AIMGs by identifying and correcting the drawbacks of the current relicensing process. The study findings may also help the Alberta International Medical Graduate Program (AIMGP) to initiate new supportive measures to help AIMGs overcome institutional barriers. Furthermore, the results of this study might set the stage for a political discussion to reap the full potential of AIMGs' skills and experience to fully contribute to the Alberta health care system. This discussion is particularly timely as fiscal constraints are placed on the education and

training of physicians in Alberta; IMG integration may be a cost-effective alternative to physician training. The research also may provide a road map to guide AIMGs towards licensure. I will present the findings of this study to the officials of the CIC, allowing them to reflect on the personal and structural implications of the criteria for immigration. At the personal level the experience I am gaining by doing this research will help my own journey toward licensure.

1.3 Summary

In this first chapter, I discussed the background of the relicensing process of immigrant IMGs and established a framework for the central theme of the study: the process by which barriers and facilitators impact IMGs' relicensing and resettling process in Alberta.

In the next chapter, I will provide the results of other Canadian and international studies that were closely related to the current study and that created a logical framework for the research. Furthermore, I will identify the gaps in the previous research and show how this study fills those gaps. I will also review and critique the previous research and provide a brief summary of research methodology, findings, strengths and weaknesses. Finally, I will use acculturation theory to explain AIMGs' cultural adaptation and institutional theory that explains the impact of barriers and facilitators on relicensing and resettling of IMGs.

CHAPTER TWO: LITERATURE REVIEW

International Medical Graduates (IMGs) with a wide range of educational, social, and cultural backgrounds immigrate to Canada seeking to become licensed medical practitioners. The integration process of IMGs in Canada is not static, but dynamic. This chapter presents the literature pertinent to experiences, barriers, and facilitators encountered by IMGs during their relicensing and resettling process.

Inclusion/exclusion criteria

The problems associated with the integration of IMGs are not limited to Canada, but also affect other immigrant recipient countries like Australia, New Zealand, the Netherlands, United Kingdom (UK) and the US (Huijskens et al., 2010). This review integrates on academic and grey literature from the Canadian and international contexts published during the past fifteen years. Inclusion of international publications helps to gain a broader understanding of the experiences of other IMG recipient countries.

Databases and keywords

I used electronic search engines including CINAHL, Google Scholar, PubMed, MedLine, and Academic Search Complete to locate scholarly articles. Table 1 shows some of the different key word combinations used. In addition, I examined reference lists from relevant articles and informally published reports from conference proceedings, study reports from CaRMS, the Alberta International Medical Graduate Association (AIMGA), the College of Family Physicians of Canada (CFPC), and the Royal College of Physicians and Surgeons (RCPS). I also reviewed and incorporated a number of recent master's theses and doctoral dissertations.

Table 1. Key Word Combinations Used in Electronic Search Engines

Subjects	AND / OR	AND / OR
International Medical Graduates	Barriers	Social
Foreign trained doctors		Institutional
International healthcare professionals	Facilitators	Institutional
		Personal
	Acculturation	Culture
	Discrimination	Doctor shortage
	Communication	Challenges
	Skill labor	Medical licensure
	Experiences	Resettling

The findings from the literature review are summarized in the following sections.

The first section contains the historical background and the current status of IMG licensure in Canada. The second section contains the current process of IMG licensure in Alberta. The third section contains the underpinning theories relevant to the IMG issue. The fourth and fifth sections contain the barriers and facilitators encountered by the IMGs during relicensing and resettling processes respectively. The final section summarizes the rationale for the current research.

2.1 Historical Background and Current Status

In the past and even at present, Canada depends on IMGs. Between the late 1960s and early 1970s, Canada recruited more IMGs than the number of physicians it produced to meet the health needs of the increased post-Second World War population (Mullally & Wright, 2007). From 1970 to 1976, the number of practicing IMGs increased steadily; the

overall percentage was as high as 34% in 1976, with a decline to just over 22% in 2006 (Bourgeault & Baumann, 2011, p. 4). This drop is attributed to the increased intake of Canadian students to medical programs in Canada. For example, in 2007, British Columbia (BC) increased medical student intake from 128 to 256 (Bourgeault et al., 2010, p. 14) in partnership with the University of Northern BC and the University of Victoria (Bates, 2008). The licensing of IMGs became a critical issue when more IMGs began immigrating to Canada (Alberta International Medical Graduates Association [AIMGA], 2002; Dauphinee, 2005; Esmail, 2008; Walsh et al., 2011). Walsh et al. (2011) noted that in the past, Canada recruited IMGs mainly from Britain, Ireland, and South Africa--countries that had medical training and accreditation practices similar to those of Canada. According to the same author, on the other hand, many Asian, Middle-Eastern, and Eastern European countries have different medical training environments and clinical practices. Citing Health Canada, Zweck and Burnett (2006) stated that the IMGs from countries other than the UK, Ireland, and South Africa require in-depth assessment and additional training. This requisite delays and lowers the chances of IMGs integrating into the Canadian healthcare system.

Over time, varying percentages of IMGs have been employed in different provinces. For example, CIHI (2009, p. 15) documented that from 1972-1976 Saskatchewan had the highest percentage (72%) of IMG physicians, followed by Newfoundland (60%), Manitoba (53%), Ontario (45%), and Alberta (41%). On the other hand, from 2003-2007, the Northwest Territories (68%) had the highest percentage of IMG physicians followed by Saskatchewan (65%), Newfoundland (61%), Nova Scotia

(53%), Manitoba (48%), and Alberta (32%). These statistics illustrate the Canadian health care system is dependent upon IMGs.

Many researchers link the underutilization of IMGs with the prevailing low Canadian physician-to-population ratio. As a solution, they recommend integration of more IMGs into the Canadian health care system (Chewa, Amirthalingam, Firoz, Goyal, & Singh, 2010; Dauphinee, 2005; Esmail, 2008; Foster, 2008). Esmail (2006) predicted that without a significant integration of IMGs into the Canadian health care system, the physician-to-population ratio will further decline. In other notable research, Reitz (2005) pointed out that from a human capital perspective, de-skilling causes great emotional pain for IMGs and is also a major loss for both Canada and the country of origin. Andrew and Bates (2001) noted that integration of IMGs into the Canadian health care system fosters the cultural basis of clinical practice in North America and helps to provide culturally suitable care to patients of differing ethnic backgrounds.

In recent times, the relicensing process of IMGs has become increasingly complicated due to the increased number of CSAs applying for residency positions through CaRMS (Walsh et al., 2011). According to the same report, in the last three CaRMS matches, the number of CSAs has doubled; in 2011, they represented 33% of the IMGs applying for residency positions. In 2010, while 47% of the CSAs were matched, only 17% of the IMGs were matched. If this practice continues, many more Canadians will follow the new CSA route to receive residency positions, further reducing chances for immigrant IMGs to secure residency positions. In Ontario around 5,000 IMGs and in Alberta about 600 IMGs are not working in their professional capacity (Bobrosky, 2010; Bourgeault & Baumann 2011).

Because family medicine is the shortest residency program, many IMGs favour family medicine over the other disciplines (Walsh et al., 2011). Bourgeault and Baumann (2011) noted that even though many IMGs are left without residency positions, many residency spots are left vacant in many universities. For example, 126 residency spots were vacant in 2009. Not filling the available residency spots with IMGs further threatens the IMGs' chances of integration into the Canadian health care system.

2.2 The Current Process of IMG Licensure in Alberta

The College of Physicians and Surgeons of Alberta (CPSA) regulates the practice of medicine in Alberta. To obtain a license to practice, a physician must be registered with the Medical Council of Canada (MCC) and be certified by the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC). To satisfy both requirements, immigrant IMGs who are residents of Alberta need to complete several steps: credential evaluation; a series of medical and language proficiency examinations; and postgraduate training. Currently, each province and territory has its own regulatory bodies to absorb IMGs into the provincial health care system. According to the CAPER (2012) report, at present, the Federation of Medical Regulatory Authorities of Canada (FMRAC) and the MCC are developing a national process of application for medical registration in Canada. The MCC has also partnered with Canada's IMG assessment centres (provincial regulatory bodies) and other stakeholder organizations on the National Assessment Collaboration (NAC) to bring greater uniformity to absorb IMGs across Canada. For example, the Alberta International Medical Graduate Program (AIMGP) was created in 2001 as a provincial program for the assessment and placement of Alberta IMGs into the post graduate residency positions at

the University of Alberta and the University of Calgary. The AIMGP Program offers a competitive and merit-based assessment protocol to determine if IMGs have the clinical skills, knowledge and behavior needed to enter an Alberta post-graduate residency program (AIMGP, 2012).

The credential evaluation confirms that an immigrant's medical degree is from a recognized medical school. The medical school should have existed for more than ten years and be listed in the International Medical Education Directory (IMED) or Foundation for Advancement of International Medical Education and Research (FAMIER). The Physicians Credential Registry of Canada (PCRC) is responsible for verifying the physicians' credentials and serves as a centralized electronic repository of a physician's source-verified core medical credentials. After successful credential evaluation, a candidate must complete a series of examinations offered by the MCC. As detailed on the official MCC (2014) web site, the first exam is a four hour computer-based Evaluation Exam (EE), which assesses the candidate's basic medical knowledge of the principal fields of medicine, including Internal Medicine, Surgery, Pediatrics, Psychiatry, Gynecology, and Obstetrics. The exam consists of 180 multiple-choice questions. The second exam is the Qualifying Exam Part I (QEI). The QEI content is similar to the content of the EE, but the QEI is comprehensive and intensive. It consists of 196 multiple-choice and short-answer questions. It assesses the knowledge and clinical skills related to the principal medical fields noted above. A candidate who passes the EE may apply for the National Assessment Collaboration-Objective Structured Clinical Examination (NAC-OSCE) conducted by the MCC through the AIMGP. NAC-OSCE is a national, standardized examination, and it assesses IMGs' knowledge, skills, and attitudes

necessary for post-graduate training entrance. During the examination, candidates are given a series of clinical cases in medicine, pediatrics, obstetrics, gynecology, psychiatry, and surgery and a written therapeutic test (MCC, 2014). IMGs who pass the NAC-OSCE are invited for Multiple Mini Interviews (MMI). MMI consist of nine stations which assess teamwork, ethics, and conflict management skills. Each station is nine minutes long and the candidate is evaluated by an examiner (AIMGP, 2013).

Applicants who are short-listed following the MMI are invited to the medical specialty-oriented interviews to confirm the decision on the residency position. Applicants not successful in receiving a residency position in the first iteration may apply for a residency position through the second iteration of the CaRMS. To receive licensure from the MCC, an IMG needs to pass the Qualifying Exam Part I (QEI) and Part II (QEII). To sit for the QEII, a candidate should have successfully completed at least one year of residency training. The content of the QEII is similar to the NAC-OSCE, and assesses the knowledge, skills, and attitudes of candidates. IMG across all provinces need to complete the EE, QEI, and QEII exams in order to move towards licensure.

In addition to the technical requirements described above, an IMG must be either a Canadian citizen or a permanent resident, and have resided in Alberta for at least six months. A candidate should also meet English language proficiency requirements. IMGs emigrating from certain countries like Australia, Bermuda, the British Virgin Islands, Canada, Ireland, New Zealand, Singapore, and South Africa do not have to pass the language requirements. IMGs emigrating from other countries need to receive pass marks for either the Test of English as a Foreign Language (TOEFL) or International English Language Testing System (IELTS) exams (AIMGP, 2014). Passing all these

examinations still does not guarantee a residency position. Figure 1 illustrates the current process of IMG licensure in Alberta.

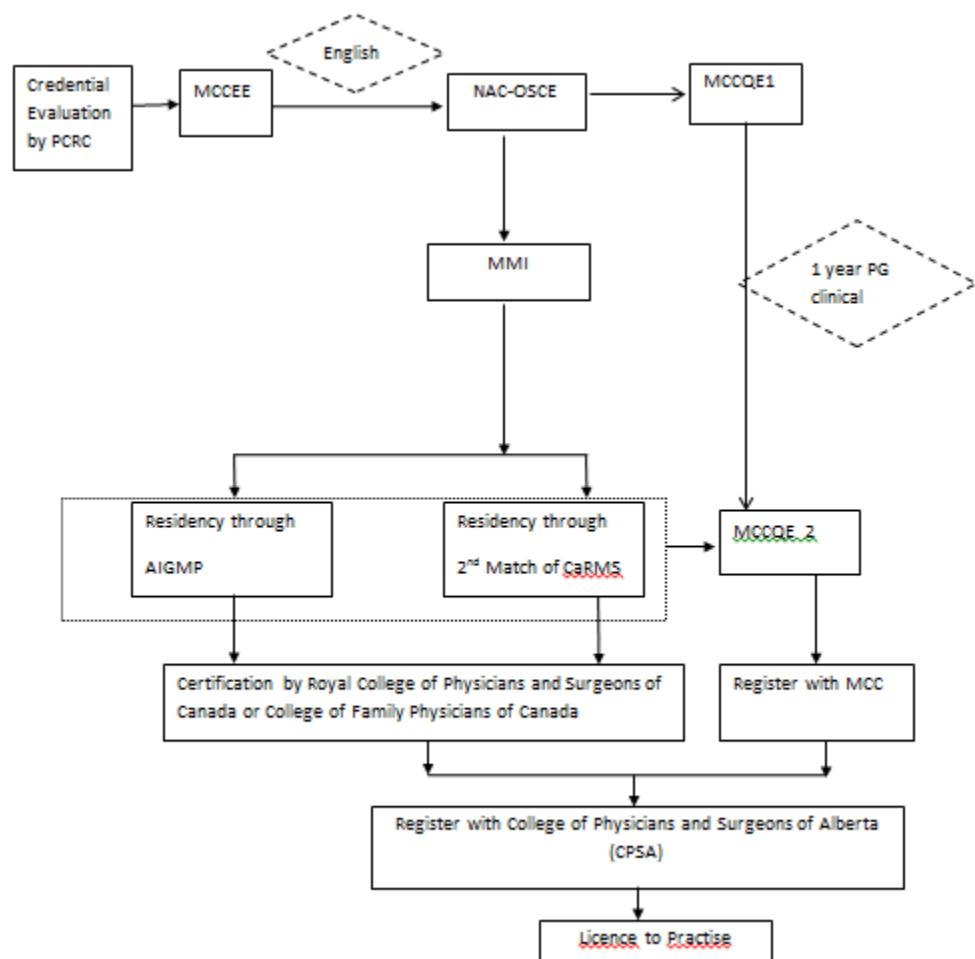


Figure 1. The Current Process of IMG Licensure in Alberta

2.3 Underpinning Theories Relevant to Relicensing and Resettling of IMGs

I identified and reviewed the acculturation and institutional theories relevant to this research. I believe that adaptation to a new culture, as explained by Berry's (1997) acculturation theory and policies and regulations set forth by the professional bodies which guide the selection and allocation of residency positions for IMGs, are the main components of the relicensing and resettling process of IMGs.

Acculturation is “the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members” (Berry, 2005, p. 697). According to the same author, these cultural and psychological changes occur through a long-term process, sometimes taking years, sometimes generations, and sometimes centuries. At the group level, acculturation involves changes in social, institutional, and cultural practices. At the individual level, it involves changes in a person's behavioral repertoire. Within the Canadian context, acculturation is a process in which immigrant IMGs from different cultures adopt the beliefs and behaviors of the Canadian hospital and social culture. This is an immense challenge encountered by IMGs during both the resettling and relicensing processes (Fiscella, Roman-Diaz, Lue, & Frankel, 1997; Majumdar, Keystone, & Cuttress, 1999).

Institutional theory is used to explain the role of structure in social behavior (Scott, 2001). Institutions are social structures with a high degree of resilience to provide meaning to social life, and institutional theory considers the processes by which structures, schemes, rules, norms, and routines become established as authoritative guidelines for social behavior (Scott, 2004). Lawrence (2008) explored the intersection of power, institutions and organizations, and argued that institutions have the power to control individual and group behaviors and attitudes. For the proposed research, institutional theory can help to explain how curriculum and clinical training requirements set by different Canadian governing and professional bodies hampers the absorption of new AIMGs into the Alberta health care system while trying to regulate the standard of the Canadian health care system. For example, Foster (2008) admitted that IMGs face a number of institutional challenges during their relicensing process.

2.4 Relicensing and Resettling Challenges of IMGs

IMGs face numerous barriers while attempting to integrate into the Canadian health care system. Some of these barriers are unique to IMGs and some are similar to those experienced by people in other skilled labor categories. Over the last fifteen years, considerable research has been undertaken into the barriers faced by IMGs during the resettling and relicensing process (Bougalt et al., 2010; Colette, 2011; Eyford, 2011; Hall, Kelly, Dojeiji, Byszewski, & Marks, 2004; Majumdar et al., 1999; Reitz, 2005; Rothman & Cusimano, 2001). In the following subsections, I categorize barriers under six major headings: acculturation challenges, communication challenges, social exclusion, challenges during residency training, institutional and policy issues, and resettling challenges.

2.4.1 Acculturation challenges

Much of the acculturation research focuses on IMGs currently undergoing residency training. All researchers found that acculturation training is crucial for IMGs to successfully complete their residency (De Carvalho, 2007; Fiscella, Roman-Diaz, Lue, & Frankel, 1997; Majumdar et al., 1999; Porter, Towneley, Huggett, & Warrier, 2008). Majumdar et al. (1999) conducted a quantitative pre-and post-test study of IMGs licensed to practice in Ontario to assess the effectiveness of cultural sensitivity training on their emotional resilience, flexibility, perceptual acuity, and personal autonomy using a self-scoring approach. According to Stafford, Bowman, Hanna, and Lopez-De Fede (1997), the term cultural sensitivity recognizes the existing cultural differences and similarities. Knowledge of cultural sensitivity facilitates IMGs' acculturation. The researchers found that emotional resilience, flexibility and perceptual acuity were significantly changed

after exposure to cultural sensitivity training. Changes in emotional resilience help physicians to effectively handle stressful clinical encounters. Flexibility enhances physician-patient communication and relationship, and perceptual acuity helps physicians to understand verbal and nonverbal cues. The main weakness of this study was the use of voluntary (self-selected) sampling and the self-scoring approach. The self-selected samples affect the internal validity and external validity of results and might also affect generalizability of results. Furthermore, self-scoring measuring instruments are open to individual feelings and biases. Another weakness is that confounding variables (age, maturity, gender, religion, and race) in the experimental and control groups were not adjusted. Due to those limitations, the findings of this research are questionable.

Fiscella et al. (1997) examined the trans-cultural experiences of IMG residents in Ohio, US during primary care training using critical incident and focus group techniques. The critical incident analysis results revealed that the IMGs were hiding their frustration due to language barriers when interacting with patients. In addition, the focus group findings revealed that the IMGs faced difficulties in expressing emotional support for the patients due to cultural mismatches. The authors concluded that the use of the two methods was complementary. The combined critical incident analysis and focus group techniques of this research enhanced its credibility. Porter et al. (2008) assessed the effectiveness of an acculturation pre-course for 11 IMGs matched for residency training at Creighton University, US using the nonparametric Wilcoxon Signed Rank test. The testing parameters were: writing admission and discharge orders; use of intravenous fluids; and questions related to informed consent, insurance issues, and confidentiality. After the pre-course, the study participants showed statistically significant improvement

in writing prescriptions and SOAP notes as well as understanding confidentiality laws and expectations. The SOAP note is the Subjective, Objective, Assessment, and Planning of patient care as documented by health care providers. I believe that it would have been more appropriate to conduct a study using a normally-distributed large sample using a student paired t-test because the results of the parametric test are more powerful and generalizable.

Acculturation research on currently practicing IMGs and those waiting for residency is not very common. I found only one study involving practicing IMGs (Eyford, 2011). Eyford studied the acculturation experiences of ten IMGs from four different countries working as physicians in Alberta for more than five years using narrative inquiry. The author found that previous exposure to international and other local cultures; determined, optimistic, and flexible personality types; and English language ability facilitate IMGs' adaptation to the new Canadian culture. The use of a narrative approach seemed to facilitate the ability of the author to explore the breadth of the acculturation process of IMGs as newcomers to Canada because it allows the researcher to gain closer proximity to study participants' stories.

The above research only explored acculturation challenges during residency. In my research, I not only explored residency training challenges but also explored the obstacles faced by IMGs when adapting to Canadian society. Furthermore, none of the above research included the acculturation experiences of non-practicing IMGs. In the current research, I invited both practicing and non-practicing IMGs to explore the acculturation challenges they faced when adopting to Canadian society.

2.4.2 Communication challenges

Communication establishes the main bridge within the physician-patient relationship. Effective “patient communication is a central clinical function in building a therapeutic relationship, which is the heart and art of medicine” (Ha & Longnecker, 2010, p. 38). Improved physician-patient communication enhances patient involvement and increases quality of care (Diette & Rand, 2007). Research on physician-patient communication has shown that patients were unhappy even when physicians believed that they effectively conveyed information to the patients (Stewart, 1995).

Communication involves two main components: verbal and nonverbal. The verbal component refers to the words, and the nonverbal component refers to body language (Majumdar et al., 1999). According to Lamar (1985), 80% of physician-patient communication consists of non-verbal cues. In addition, communication skills include both style and content. Some components of effective communication are alternate listening skills, empathy, and use of open-ended questions (Chio, Montuschi, & Cammarosano, 2008). The Kalamazoo consensus statement (Makoul, 2001) has identified seven fundamental components of physician-patient communication: build the physician-patient relationship; open the discussion; gather information; understand the patient’s perspective; share information; reach agreement on problems and plans; provide closure. Even Statistics Canada (2007) identified communication skills as one of the four main challenges faced by new Canadian immigrants, justifying the importance of communication skills.

Several authors have suggested that the lack of communication skills of IMGs undermines effective physician-patient relationships both in Canada and other IMG

recipient countries (Dickson, 2007; Fergusan & Candib, 2002; Colette, 2011; Rothman & Cusimano, 2001). Furthermore, several authors indicated that IMGs with poor communication skills have difficulties in understanding non-medical, colloquial language and interpreting cues, body language, and patient-focused vocabulary (Dorgan, Lang, Floyd & Kemp, 2009; Hall, Kelly, Dojeiji, Byszewski, & Marks, 2004; Jane & Krieger, 2011). Hall et al. (2004) used externally-funded nonimmigrant IMGs (studying for fellowships), program directors, and communication skill educators participating in the Pre Entry Assessment Program (PEAP) at the University of Ottawa as participants in their qualitative exploration of communication skills of IMGs in the residency training program. The authors found that IMGs lack communication skills and knowledge specific to the Canadian health care system. Because this study used different categories of participants and two types of data collection strategies (focus group and individual interviews), the researchers were able to generate a holistic picture of the communication challenges faced by IMGs.

Dorgan et al. (2009) conducted a grounded theory study of 12 IMGs and directors in the residency training program in southern Appalachia, US. The authors found that the IMGs' home country medical education lacked patient-oriented communication. The researchers recommended better communication skills and incorporation of "regional dialect and informal English" modules in IMGs' training curricula (Dorgan et al., p. 1567).

To understand the communication strategies used by IMGs, Jain and Krieger (2010) conducted a qualitative study with 12 IMGs completing residency training in mid-western Ohio, US. The authors concluded that effective communication skills were

essential for a successful physician–patient relationship and recommended the inclusion of socio-cultural practices of the region into the IMGs’ training curricula.

The researchers discussed above only explored the communication challenges IMGs faced when interacting with patients. However, in my research, I explored the language and communication challenges of both practicing and non-practicing IMGs, because the intention is to generate a holistic picture of the entire licensure process.

2.4.3 Social exclusion

Numerous studies have been conducted to understand the social exclusion of IMGs, and in general, there is a similarity of findings across studies in this regard (Carr, Palepu, Salacha, Caswell, & Inui, 2007; De Carvalho, 2007; Han & Humphreys, 2005; Louis, Lalonde, & Esses, 2010; Malat, Ryn, & Purcell, 2009; Reitz, 2005). In their work exploring social exclusion of Australian IMGs, Louis et al. (2010) included European students as study participants (patients) and inquired about patients’ preference for physicians. The study revealed that the patients’ preference for the physician’s competence and trustworthiness depended on the location of his/her medical school and his/her nationality. The study participants preferred physicians with UK credentials over those with Australian credentials. On the other hand, when a choice was to be made between Pakistan and Australian-trained physicians, preference was given to Australian qualified physicians. Malat et al. (2009) used random digit dialing telephone interviews with 695 Whites and 510 Blacks, and supported Louis and colleagues’ (2010) conclusion that race was a factor in the physician-patient relationship. The authors found that 16% of the study participants believed that same race physicians were in a better position to

diagnose their health problems, and 22% felt comfortable when receiving treatments from same-race physicians.

In another notable assessment of social exclusion of IMGs, Reitz (2005) pointed out that the issue of skill underutilization of immigrants belonging to racial minorities was more common than with European immigrants with equivalent qualifications. Bourgeault et al. (2010) stated that most IMGs believe that “being nonwhite” is a significant challenge to obtaining a residency position. Moore and Rhodenbauh’s (2002) quantitative research compared IMGs’ and US Medical Graduates’ (USMGs) surgical skills by surveying 112 program directors of surgical residency programs. Seventy percent of the survey participants accepted that USMGs were favored during the selection process despite no differences in surgical skills. The findings of these studies are compelling; it would be interesting to more deeply explore their meaning through qualitative methods. For example, it would be interesting to ask program directors to describe specific situations and contents in which they favoured USMGs to explore the reasons for different treatments.

2.4.4 Institutional and policy barriers

Despite the potentially important role of IMGs within the Canadian health care system, much of the research identifies that IMGs have limited access to residency training programs and need to undergo a series of assessments at the federal and provincial levels. Similar types of assessments and limited residency opportunities were also found in Australia and the Netherlands (Huijskens et al., 2010; Louis et al., 2010). Bourgeault and colleagues’ (2010) qualitative case study compared the barriers and facilitators encountered by Internationally Educated Health Professionals (IHEPs),

including physicians, nurses, and midwives residing in Quebec, Ontario, British Columbia, and Manitoba. The comparisons were made among the IEHPs as well as across the four provinces. The main similarities were the limited number of spots in bridging and integration programs, difficulties in steering through the licensing process, and finally, the time and money-consuming nature of the process. The main differences were the integration procedure and the availability of a number of provincial bridging programs. For example, midwifery training programs that were available in Ontario were not available in Manitoba. The authors pointed out that the transferability of the findings of this research to other provinces should not be assumed due to the unique characteristics of the study participants, hence additional research is needed.

Researchers have identified several gaps in government policymaking and policy implementation related to IMGs, which further aggravates the IMGs' relicensing process (Bauder, 2003; Dauphinee, 2005; Esmail, 2006). For example, Bauder (2003, p. 713) pointed out that many skilled labor immigrants have been "tricked" by Canadian immigration policies that did not reveal prior to the arrival that immigrants' skills will be "devaluated." Dauphinee (2005) compared the IMG integration procedure in Canada with that of the US. In the US, the federal government coordinates the pre-migration verification and assessment process of IMGs and provides more opportunities for postgraduate training positions. In contrast, Canada does not have a coordinated approach for IMGs at the federal level because health and education are the responsibilities of provincial governments. For example, Dauphinee (p. 26) elaborated: "the funding of physician training posts and paying of practicing physicians in Canada is a monopsony: there is essentially one payer and predominantly one funder of training posts, the

provincial ministries.” Due to the incompatibility among immigration, education, and health policies, individual provinces offer a limited number of residency positions, and it is very competitive for IMGs to integrate into the Canadian medical stream. For example, 1,920 IMGs applied for a 2011 CaMRS match, but only 380 were successful (CMA, 2012).

2.4.5 Barriers during residency training

Research on IMGs’ experiences during residency training have identified that IMGs do not have sufficient knowledge related to Canadian hospital settings, and emphasized the importance of introducing additional training modules (Lockyer, Fidler, Gara, & Keefe, 2010; Wong & Lohfeld, 2008; Zulla, Baerlocher, & Verma, 2008). Wong and Lohfeld’s (2008) phenomenological qualitative study was conducted using in-depth individual interviews with 12 IMGs in Ontario; they identified three phases of IMGs’ adjustment during their residency training period. During the first phase, IMGs lost their original identity as physicians; the second phase showed disorientation, “feeling like aliens” (p. 56) and during the final phase IMGs adapted to the system. One weakness of this study is that country of origin, age, and gender of IMGs was not considered, thus reducing the transferability of the study. Similarly, Zulla and colleagues’ (2008) quantitative study identified the challenges encountered by IMGs from the perspective of both IMGs and the program directors at the University of Toronto. Results revealed that the IMGs preferred to have more knowledge of the Canadian health care system. By contrast, program directors indicated that IMGs need to give preference to communication skills. Though the findings from the two study groups are not convergent, they provided an overview of the situation of IMGs in residency programs. The research

would have been strengthened by a qualitative study using another set of study participants; for example, a group of patients or co-workers to collect more evidence to explain why the IMGs and the program directors provided differing views.

2.4.6 Resetting barriers

IMGs face numerous challenges during their re-settling process in Canada. Many IMGs are middle aged and have dependent children. This context creates added personal and social challenges to integrating into the Canadian health care system (AIMGA, 2002; Bourgeault et al., 2010; De Carvalho, 2007; Huijskens et al., 2010; Kohn, 2010). Huijskens and colleagues (2010), in their Netherlands study, identified religion and appearance as additional barriers, and De Carvalho (2007), in her mixed methods study, identified self-esteem, quality of life, health status, experience of discrimination, and stress as additional barriers for resettling. She concluded that without their license, IMGs are unable to regain their professional and socio-economic status.

2.5 Relicensing and Resetting Facilitating Factors

IMGs immigrate to Canada with diverse backgrounds and variable needs. To integrate into the Canadian health care system IMGs need to update their clinical and communication skills. Licensing of IMGs in Canada is a complicated process (Masalmeh, 2009); however, many resources and up-skilling programs are available to facilitate the integration of AIMGs into the Canadian health care system (Couser, 2007). I found ten articles that focused on relicensing and resettling facilitators. In the following, I categorize facilitators under two major headings: personal and institutional.

2.5.1 Personal facilitating factors

The IMGs relicensing process is a time-consuming, depressing, exhaustive, and expensive process requiring individual patience and dedication (Statistics Canada, 2007). Outgoing personality, family support, young age, financial support, flexibility, resilience, emotional support, and adaptability to the Canadian health care system are some of the personal facilitating factors that expedite the relicensing and resettling process (Bourgeault et al., 2010; Kohn, 2010; Huijskens et al., 2010). For example, Kohn (2010) interviewed six practicing IMGs in Ontario, analyzed the data using the tenets of grounded theory, and identified factors leading to the successful licensure of IMGs into the Canadian system. Kohn found that financial support, social support, and resilience were facilitating factors.

2.5.2 Institutional facilitators

Many federal and provincial governments have taken initiatives to integrate more IMGs into the Canadian health care stream (Baumann & Blythe, 2009; Bourgeault, 2010; Colette, 2011). Bourgeault et al. (2010) identified a number of federal and provincial initiatives, including an attempt to improve the transparency of the licensing process, establish a number of bridging programs, and commence language courses. Considerable research has been conducted to assess the effectiveness of various bridging programs, both locally and internationally (Curran, Hollett, Hann, & Bradbury, 2008; Lockyer, Hofmeister, Crutcher, Klein, & Fidler, 2007; Lockyer et al., 2010; McGrath & Henderson, 2009). McGrath and Henderson (2009) conducted a qualitative phenomenological study using nine IMGs attached to the Observer Program (OP) at the Redland Hospital (Australia), in collaboration with Central Queensland University. The

OP allows IMGs to interact with patients and become familiar with the clinical setting under the supervision of a practicing physician. The authors found that the OP is beneficial for IMGs entering into the Australian health care system, and the participating IMGs favorably commented about the self-confidence they gained after participating in the OP.

Two studies involving IMGs with restricted licenses working in rural Alberta revealed the importance of maintaining mentorship programs to facilitate fast integration, acculturation and higher retention of IMGs in rural Alberta (Lockyer et al., 2010; Lockyer et al., 2007). A restricted license allows some international physicians to practice while they prepare for MCC examinations. Lockyer et al. (2010) interviewed 23 IMGs and 10 medical leaders, and researchers found that learning and supporting programs related to patient management, referral practices, and investigation were needed for effective integration of IMGs. The inclusion of both groups' views enhanced the credibility of the research, but this study only involved IMGs with restricted licenses. In another study conducted by the same authors (Lockyer et al., 2007), 20-minute individual telephone interviews were conducted with 19 IMGs to determine their perceptions about the mentorship program. Both studies recommended a mentorship program for IMGs. In another scenario, Curran et al. (2008) evaluated the effectiveness of an orientation program for IMGs practicing in rural areas of Newfoundland and Labrador. They concluded that effective orientation programs are important to reduce professional isolation and support new IMGs' smooth transition into rural communities. The authors suggested that an effective orientation program should provide opportunities for IMGs to

reflect on their own cultural biases and to learn about the cultural backgrounds of Newfoundland and Labrador communities.

In Alberta, in 2006, AIMGP commenced the Medical Communication Assessment Project (MCAP) to increase the language proficiency, communication skills, and cultural understanding of IMGs preparing for Objective Structured Clinical Examinations and the QEII. In 2006, MCAP enrolled 26 participants, and had the maximum number of participants (64) by 2009. In 2011, MCAP enrollment dropped to 38 participants (CIC, 2012). The integration of 70% of MCAP participants into the Alberta health care system justifies the effectiveness of MCAP (CIC, 2012). Recently, the University of Calgary introduced a new online communication program called Communication4Integration to assist AIMGs to prepare for OSCE and MMI. Another bridging program is the Alberta Clinical and Surgical Assistant Program (ACSAP), which is a six-month orientation, clinical assessment, and evaluation program functioning in Calgary and Edmonton (Alberta Health Services, 2012). During the assessment and evaluation phase, participants are integrated into existing programs. The program provides opportunities to actively participate in supervised interactions and receive hands-on experience. I could not locate any research identifying the weaknesses and strengths of MCAP and ACSAP programs.

2.6 Rationale for the Current Research

In this literature review several themes stand out. Much of the research was conducted on the relicensing of Ontario IMGs and only a few studies were focused on Albertan IMGs. In addition, most of the previous research utilized IMGs who were either practicing or already in residency training. None of the research incorporated two

categories of AIMGs: non-practicing and practicing AIMGs. Furthermore, researchers to date have not examined both relicensing and resettling of AIMGs. In this research, I conducted a study at the provincial level to include the views of two categories of AIMGs, to gather information about both relicensing and resettling to construct a theory using Charmaz's (2014) approach to explain how AIMGs negotiated barriers and facilitators during their journey to licensure.

Furthermore, two theories were incorporated into this study: Berry's (1997) acculturation theory and institutional theory (Scott, 2001). The application of these theories provides different lenses to examine complex data and also provides a framework within which to conduct analysis (Reeves, Albert, Kuper, & Hodges, 2008). For example, the use of acculturation theory helped to explore the work and lifestyle changes of individual AIMGs during their journey to achieving Canadian medical licensure. The institutional theory guided me in describing how institutional challenges imposed by different professional associations affected the relicensing of AIMGs.

2.7 Summary

Much of the research to date has focused on the challenges faced by IMGs undergoing residency training and IMGs practicing on restricted licenses. The challenges faced by non-practicing AIMGs require further study. I firmly believe that the resettling and relicensing experiences, barriers, and facilitators encountered by two categories of AIMGs (currently practicing and non-practicing) need to be incorporated into my research in order to draw a comprehensive picture of the AIMGs' relicensing process. Much of the research has been focused on Ontario IMGs, and only a few studies have

focused on the AIMGs. The socio-political and economic situation in Ontario is very different from that in Alberta. For example, many facilities and bridging programs for IMGs are available in Ontario, but not in Alberta. Given that the provinces have autonomous control over licensure, it is a valuable exercise to assess the provincial context. In the last few years, Alberta attracted a large number of IMGs due to its relatively strong economy, but the number of residency positions for the IMGs was not increased at the same rate.

The next chapter explores the details of the research design based on a constructivist grounded theory approach. It discusses the specific methodology used to explore the impacts of barriers and facilitators of relicensing and resettling of AIMGs.

CHAPTER THREE: RESEARCH DESIGN

The purpose of this chapter is to articulate the research design that I used to understand the barriers and facilitators to AIMGs' resettling and relicensing. This chapter begins with a discussion of the philosophical underpinnings of my chosen methodology, followed by a description of the theoretical and conceptual framework, personal situatedness and reflexivity, a description of the design and rationale for use, setting, sampling, recruitment, inclusion criteria, data collection, interviewing the study participants, transcribing, data preparation and analysis, ethics, trustworthiness, and finally, the summary.

3.1 Philosophical Stance

Creswell (2013) defined philosophy as a set of abstract ideas and assumptions which informs the research. Denzin and Lincoln (1994) outlined three fundamental philosophies of science (ontological, epistemological, and methodical) used to construct the qualitative research question. Furthermore, Creswell (2013) noted that the three philosophies overlap and build upon each other.

The ontological assumptions explain our perceptions of the nature of reality (Denzin & Lincoln 1994). The research reported here revolved around AIMGs and explored the barriers and facilitators that influenced the resettling and relicensing process. Creswell (2013) noted that qualitative research includes a number of realities, and a researcher uses multiple pieces of evidence from study participants to explore these realities. To explore these multiple realities from different perspectives, I recruited two categories of AIMGs. Furthermore, I used thick descriptions to display the existing multiple realities (Creswell, 2013).

The epistemological question refers to “what is the nature of the relationship between the knower or would-be knower and what can be known?” (Denzin & Lincoln, 1994, p. 108). The aim of this assumption is to make explicit the relationship between the researcher and the study participants. For the present research, as Creswell (2013) stated, I developed a close relationship with my fellow AIMGs during the interviews in order to generate thick descriptions about their individual experiences on resettling and relicensing. Being an AIMG myself helped me to create rapport with the study participants while helping me to be recognized as an “insider” among them (Creswell, 2013, p. 21). On the other hand, as the researcher I needed to follow a neutral stance to minimize researcher bias. More details about my personal stance are provided in section 3.3.

The methodological assumptions refer to the processes a researcher uses to find answers to his or her research question (Denzin & Lincoln, 1994) and it is highly dependent on the previous two philosophies (Hays & Singh, 2012). For the present study, I collected information by interviewing study participants a (“ground up” approach) and then generated a theory based on emerging themes to describe the impacts of barriers and facilitators on resettling and relicensing of AIMGs (Creswell, 2013, p. 22). As Creswell (2013) described, I incorporated the experience I gained from the first few interviews to guide subsequent interviews.

Denzin and Lincoln (1994) introduced four alternative inquiry paradigms: positivist, post-positivism, critical theory, and constructivism. Paradigms are a group of ideas which guide the research (Guba, 1990). Positivism refers to formulating common rules in order to describe certain phenomena (King & Horrocks, 2010), and it dominates

quantitative studies. It uses only provable hypotheses and assumes that a general reality can be arrived at by observations and experiences (Hays & Singh, 2012). Post-positivism focuses on the existence of general reality and assumes that it is not possible to completely comprehend the truth (Hays & Singh, 2012). Critical theory is a comprehensive expression used to describe a set of alternative paradigms, which includes a “value-determined nature of inquiry” (Denzin & Lincoln, 1994, p. 109). Constructivism is a belief that research is a collaborative exercise guided by perceptions of both the researcher and the study participants (Padgett, 2008). Constructivism posits that multiple realities exist and researchers try to understand the world in which they exist and survive (Creswell, 2013). In this research, I believed that multiple realities existed among the two categories of AIMGs, and I explored these multiple realities and theorized the barriers and facilitators for relicensing and resettling.

3.2 Theoretical and Conceptual Framework

The conceptual and theoretical framework of a research project consists of “a number of concepts, assumptions, expectations, beliefs, and theories that supports and informs the research” (Maxwell, 2013, p. 39). The conceptual and theoretical framework of my study is shown in Figure 2. The main components of the conceptual framework were the two theories, the barriers, and the facilitators encountered by the AIMGs. The two main theories that were incorporated into this research as explained in the literature review section were acculturation and institutional theories. As the research progressed, the basic conceptual framework developed when AIMGs’ views and issues were gathered and analyzed.

In order to understand how the barriers and facilitators shape the regaining of professional identity of AIMGs, I explored the experiences of two categories of AIMGs in different stages of their relicensing and resettling process. Furthermore, this research offered an interpretation of what is happening, rather than unveiling an absolute reality using Charmaz (2014) constructivist grounded theory approach.

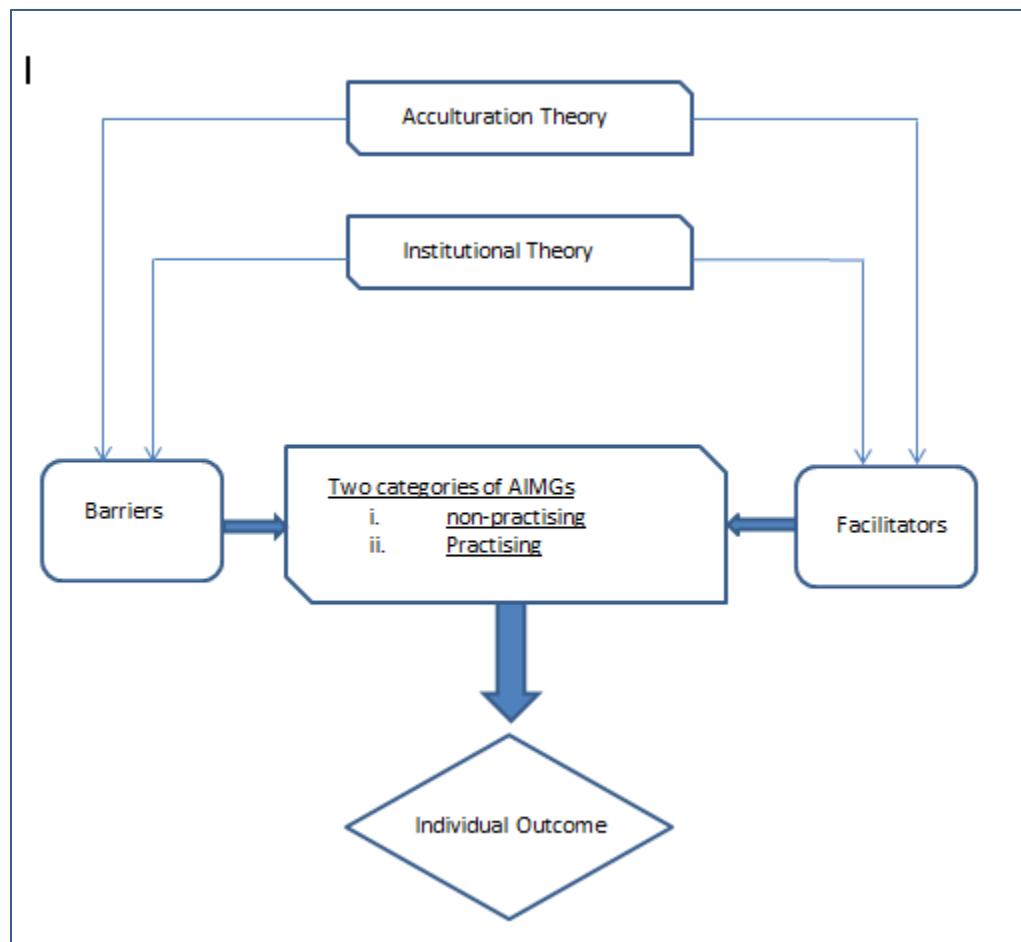


Figure 2. Conceptual Framework of Barriers and Facilitators for Relicensing and Resettling

3.3 Personal Situatedness and Reflexivity

The personal experience, perception, and background of a researcher may have an influence on his or her research, and this influence needs to be acknowledged

(Liamputpong, 2013). In the following paragraphs, I am sharing my experiences and perceptions that may have affected the topic, data collection, and analysis of the research.

The research phenomenon of this study has extreme value and sensitivity to my personal career goals. I am an internationally-trained physician from Sri Lanka who immigrated in 2007, currently living in Lethbridge and pursuing a Master's Degree at the University of Lethbridge. Like many other AIMGs, I also encountered many challenges during my journey to Canadian medical licensure. In my case, I immigrated to Canada as my spouse's dependent so I was not "tricked," but I knew many of my colleagues who had filed for immigration by themselves and were under the impression that they would obtain licensure upon arrival in Canada. I came in 2007, and completed all the required exams by 2009, but did not receive a residency spot due to the lack of funding. I believe that this is not due to racial discrimination, but due to government and institutional policies. Upon reflection, I decided to change my career goals and started to pursue a Master's degree in Health Sciences.

Being an AIMG, it is a privilege and an honor for me to undertake this research. The current research environment is familiar to me. I have experienced and witnessed a number of barriers and facilitators toward Canadian medical licensure, and have heard many heart-wrenching as well as successful stories from and about my fellow IMGs. Because most IMGs could not withstand the professional and social challenges, I personally know a number who have given up their dreams of becoming physicians in Canada and moved towards other career paths for their survival. Furthermore, I have seen many television programs and read many newspaper and journal articles describing the deteriorating situation of IMGs. My own curiosity about how the barriers and facilitators

impact AIMGs' journey to licensure inspired me to do this research. According to McCracken (1988, p. 18), the qualitative researcher acts as an "instrument" in both data collection and analysis. For example, I believed that my IMG status guided me to identify rich informants and thereby to collect high quality data. Furthermore, it also helped me to freely interact and to establish rapport with the study participants.

Though my professional background inspired me to do this research, I did my best to remain neutral when I was researching a topic that has a personal significance, in order to minimize personal bias. I interacted with my fellow AIMGs during the interviews, and being an IMG myself improved my interaction, but it might have introduced bias. However, during the research, I carefully monitored how my previous experiences as an IMG subjectively shaped the flow of this research. I was aware of what it meant to be both the main researcher and an IMG, and how this dual nature affected my research. In a number of situations, I faced stressful situations when satisfying dual identities. For example, study participants who suffered immensely wanted to express their views on barriers more than on facilitators. Even when I prompted them to talk about facilitators they ended up talking about barriers. In such situations, I had to divert the discussion back to the original topic without hurting the study participant's feelings.

I made my own judgment in managing the margin between closeness and distance when collecting and analyzing data. For example, during interviews, I minimized sharing my own experiences with the study participants, and it prevented leading the participant down a particular path. In some situations, even sharing just a few of my ideas initiated a more in-depth discussion and built rapport with the participant, but it showed me how my nearness to the topic influenced the interview process. Hence, I maintained journals and

dialogues with my supervisor and used these dialogues to remain conscious of my relationship with the topic and to balance my perceptions.

3.4 Description of the Design and Rationale for Use

There are two types of research designs: qualitative and quantitative. The quantitative research paradigm uses a deductive or top-down approach, and it is experimental and scientific and is dominated by numbers (Creswell, 2009). The main aim of quantitative research is to verify a pre-determined hypothesis to quantify the findings, and therefore to generalize the results. Quantitative studies often have pre-determined study plans and step-by-step procedures. Quantitative research methods cannot be used to explore human experiences and perceptions.

On the other hand, qualitative research is subjective, descriptive and inductive in nature, and it collects, analyzes, and interprets data by observing human behavior and by listening to human voices (Creswell, 2009). The inductive approach flows from specific observations to a general theory often referred to as “a bottom-up approach” (Patton, 2002, p. 351). Furthermore, qualitative researchers want “answers to questions that stress how social experience is created and given meaning” (Denzin & Lincoln, 2013, p. 17). Qualitative research begins with one or two phenomena of interest and while the research progresses, more concepts emerge (Creswell, 2009). The selection of quantitative or qualitative research for a project is determined by the type of research question. The resettling and relicensing experiences of AIMGs are difficult to quantify, and the literature search lead me to use a qualitative approach to explore the resettling and relicensing experiences of AIMGs. Furthermore, I believe that the qualitative research

method is best suited to tell the untold stories of AIMGs, highlighting the barriers and facilitators they encountered during their relicensing and resettling process.

Padgett (2008) described six types of qualitative designs: ethnography, narrative study, case study, phenomenology, action research and community-based participatory research, and grounded theory. Out of these six approaches, I used the grounded theory research design to explore the impacts of barriers and facilitators on AIMGs' journey toward licensure. I was attracted to grounded theory because this approach allows the researcher to construct a theory from data. The theory I developed in this research can be tested by someone else in the future. Furthermore, grounded theory allows researchers to move into unknown areas while research progresses, because data are gathered and analyzed simultaneously (Charmaz, 2014). The relicensing and resettling of AIMGs is multifaceted and the use of grounded theory is suitable to analyze multifaceted issues, since grounded theory is based on a "detailed, rigorous, and systematic approach" (Jones & Alony, 2011, p. 793).

Two sociologists, Barney G. Glaser and Anselm Strauss, developed grounded theory in 1967. Grounded theory is "a social scientific theory construction" (Charmaz, 2013, p. 293). It employs "an emergent iterative" procedure to collect and to analyze data (Charmaz, 2013, p. 293). For example, findings from the first interview guide subsequent interviews as well as data analysis. Its aim is to discover or construct theory from data.

The three main traditions of grounded theory are: emerging design (Glaser), systematic design (Strauss and Corbin), and constructivist approach (Charmaz) (Creswell, 2012; Liamputpong, 2013). These three traditions are based on the three major principles (theoretical sampling, constant comparison of data, and theory development)

characteristic of grounded theory design. However, the three traditions of grounded theory differ in their implementation of principles (Liamputpong, 2013). Table 2 compares the theory development of the three categories of grounded theory approach. I used Charmaz's (2014) constructivist grounded theory for the current research.

The philosophical stance of constructivist grounded theory

Charmaz believes that constructivist grounded theory lies between the more “positivist stance of Glaser and Strauss and Corbin and postmodern researchers” (Creswell, 2012, p. 429). Constructivist grounded theory assumes an epistemological position of subjectivism. For example, in my research I acknowledged that a relationship existed between me (as the researcher) and the two categories of AIMGs (Mills, Bonner, & Francis, 2006).

Table 2. Features of Three Categories of Grounded Theory Approach

Systematic design (Strauss and Corbin)	Emerging design (Glaser)	Constructivist approach (Charmaz)
This allows for more research and “subjectivity, existing theory, and potentially related conditions in explaining a phenomenon” (Hays & Singh, 2012, p. 49).	This allows a theory to “emerge from the data rather than using specific, preset categories” (Creswell, 2012, p. 428).	The theory is constructed rather than discovered and it is “situated within time, location and environment” (Liamputpong, 2013, p. 222)

On the other hand, constructivist grounded theory takes an ontologically relativist position, which means that we can only understand the reality and truth within a context

of time, place, and culture (Charmaz, 2006). Methodologically, constructivist grounded theory is interpretivist, and it is based on the idea that reality arises from the interactive process and its temporal, cultural, and structural contexts (Charmaz, 2006). These philosophical concepts improved my understanding of how AIMGs negotiated and manipulated social structures, how a shared reality was created, and how meaning was developed through the social interactions towards AIMGs' licensure (Gardner, Fedoruk, & McCue, 2013).

Constructivist grounded theory emphasizes the importance of social interaction during the research and how themes are generated through this interaction (Marvasti, 2004). Unlike classic grounded theorists who promote discovering theory from data, Charmaz (2014) emphasizes that "we construct our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices" (p. 17). For the present research, I gave priority to exploring how barriers and facilitators impacted IMGs, and assumed that both data and analysis were generated from the shared experiences with AIMGs (Charmaz, 2006). The constructivist approach helped me not only to explore AIMGs' individual experiences, but also to see how AIMGs view their own situation. The theory generated from this research is a mixture of my own views as well as my fellow AIMGs' perceptions (Charmaz, 2006). I carefully listened to AIMGs' voices and tried to understand how the AIMGs negotiated barriers and facilitators during the relicensing and resettling process (Charmaz, 2006). The study findings were my interpretative understanding of the barriers and facilitators to IMG licensure in Alberta.

3.5 Ethics

Because this research included human subjects as study participants, I followed the three core principles as stipulated in the Tri-Council Policy Statement prepared by the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada (CIHR, NSERC, & SSHRC, 2010). The three core principles of respecting human dignity are respecting for persons, concern for welfare, and justice.

Before starting the interviews, I applied for ethical approval from the Human Subject Research Committee (HSRC) at the University of Lethbridge. After a number of revisions and updates, I received ethical approval. A copy of the certificate of approval is included in Appendix A.

Furthermore, I obtained ethical approval from the Institutional Research Information Services Solution (IRISS) of the University of Calgary and Research & Ethics Management Online (REMO) of the University of Alberta. Appendix B contains a copy of the approval certificates from IRISS and Appendix C includes a copy of the approval certificates from REMO.

Prior to the interviews, I asked study participants to read, sign, and date an informed consent form. I provided a copy of the signed consent form to the study participant for his or her own reference (Health Canada, 2013). Samples of consent letters are shown in Appendix D for non-practising AIMGs and Appendix E for practising AIMGs. Regarding respect for persons, I honored the autonomy of study participants, and accepted their perceptions and freedom to choose options without interference. I did not lead the participants to answer in certain ways, but remained open to novel perspectives.

To avoid distress and emotional harm, painful and sensitive life events were not discussed gratuitously. For example, one study participant revealed that she had experienced postpartum depression during the relicensing process. She was highly emotional when talking about postpartum depression. In situations like that, I spoke carefully and empathetically and gradually changed the topic to ease the tension. I treated all the study participants with equal respect. I felt that all the study participants were honest and willing to disclose their resettling and relicensing experiences.

Ethical issues may arise in different stages of the research. Marshall and Rossman (2011) posed a number of ethical issues that may arise during transcribing. For example, cleaning up words, sentences or phrases, correcting incomplete sentences, and even correcting grammar might harm the participant's dignity. Therefore, during transcribing, I did not alter the informants' words and carefully placed punctuation marks as accurately as possible.

Another ethical issue is protecting the confidentiality of the study participants. I concealed the true identity of the study participants from all documents by using pseudonyms (King & Horrocks, 2010). Furthermore, inconsequential facts were not disclosed, and videotaping was not done in order to protect the identity of study participants. In addition, I obtained the consent from the study participants to record the interviews.

Audio files, transcripts, and data generated in this study will be kept in a secure locked cabinet in my supervisor's office at the University of Lethbridge for three years past the completion of all data collection. Furthermore, electronic versions of data will be stored on a password-protected computer for three years past the completion of all data

collection. In addition, contact details and the master lists will be kept on a password-protected restricted drive (provided by the University of Lethbridge's IT department) separate from the transcribed data.

3.6 Setting

This study employed two categories of study participants: non-practising and practising AIMGs. The majority of the non-practising AIMGs are concentrated in Edmonton, Calgary and the surrounding areas, and most of them are members of the Alberta International Medical Graduate Association (AIMGA). AIMGA was formed in 2000 with a vision to “integrate IMGs into the Alberta Health Care System, thus working towards the benefit of the growing population of Alberta” (AIMGA, 2014, para. 2). The AIMGA is a non-profit organization and it is funded by Citizenship and Immigration Canada (CIC) and Alberta Health. Currently, AIMGA members are connected by an e-mail and file sharing service. A mail message sent by a member to another group member is automatically copied to all the members. The current non-practicing AIMG population in Alberta is not precisely known. At present there are 6,750 physicians linked with Alberta Health Services (Government of Alberta, 2011). It is estimated that 32% of practicing physicians in Alberta are IMGs (CIHI, 2009). It is difficult to estimate how many AIMGs are within this group.

3.7 Sampling Strategies

The goal of qualitative research is to explore the procedures or the significance that individuals provide to their own social circumstances (Patton, 2002). Therefore, qualitative studies greatly depend on purposeful sampling techniques to select information-rich study participants. There are four types of purposive samplings:

sampling to achieve representativeness, sampling special or unique cases, sequential sampling, and sampling using a combination of purposive techniques (Teddlie & Yu, 2007). Snowball and theoretical samplings fall under sequential sampling techniques. Snowball sampling relies on initial informants to locate the rest of the study participants who have shared the similar experience of research interest (Bailey, 2004). In theoretical sampling, the researcher recruits study participants as the theory leads the research (Teddlie & Yu, 2007).

3.8 Sampling

I attempted to use purposive sampling to collect data from two study groups: non-practicing and practicing AIMGs. The use of purposive sampling provided in-depth understanding and insights, and it allowed me to learn extensively how barriers and facilitators impacted AIMGs' relicensing and resettling processes (Liamputpong, 2013). According to Patton (2002), purposive sampling allows a researcher to recruit information-rich cases. For example, interviewing practicing AIMGs who have been in the process of relicensing for some time provided extensive information about barriers and facilitators in the past. On the other hand, non-practicing AIMGs who are currently attempting to secure a residency position could provide a current picture of the relicensing process. Information-rich cases enhance the power and quality of a qualitative study (Patton, 2002; Schatzman & Strauss, 1973).

3.9 Recruitment

Once I received ethical approval from the HSRC, I employed purposive sampling and recruited AIMGs known to me who belonged to different cultural and social backgrounds to explore how their backgrounds were affected when securing a residency

position. I also used snowball sampling to recruit a sufficient number of practicing and non-practising AIMGs. Contact information of AIMGs who were willing to participate was forwarded to me by known AIMGs. Then, in turn, I contacted them by sending them an invitation letter. Appendix F includes a copy of the invitation letter. First, I recruited six non-practicing AIMGs and then recruited seven practising AIMGs for a total of 13 participants.

Although I posted a copy of the invitation letter on the AIMGA web site to recruit non-practicing AIMGs it was not helpful in securing participants. Appendix G shows a snapshot of the web page containing the invitation letter. A copy of the poster I used to recruit study participants is shown in Appendix H; unfortunately this strategy was also not helpful.

3.10 Inclusion Criteria

According to the Agency for Healthcare Research and Quality (AHRQ, 2014), inclusion criteria are used to determine whether an individual can participate in a research study. I introduced the following inclusion criteria to select participants who could provide in-depth testimony of being an IMG. The inclusion criteria for non-practicing AIMGs were having resided in Alberta for at least a year, and have either completed or were in the process of completing the Medical Council of Canada (MCC) examinations. The inclusion criteria for practicing AIMGs were having resided in Alberta at least for two years before the residency training, and have completed their residency training either at the University of Alberta or University of Calgary.

3.11 Data Collection

Since grounded theory studies “have frequently been interview studies” (Charmaz, 2013, p. 293), this study also relied on individual interviews as the sole source of data collection. According to Kvale and Brinkman (as cited in Marshall & Rossman, 2011, p. 145), an interview is “literally an inter-view, an interchange of ideas between two persons. Since the barriers and facilitators for relicensing and resettling were multi-faceted, I used individual “dialogic interviews” (Padgett, 2008, p. 103) with open-ended in-depth questions for both categories of study participants, allowing them to freely express their feelings and experiences (Charmaz, 2014; Patton, 1980).

I used an interview guide to outline the main topics that I wanted to explore with the study participants; however, I used a flexible approach when phrasing the questions and in the order in which they were asked. In addition, I gave freedom to the study participants to freely express their ideas in their own words and to take me in unexpected directions (King & Horrocks, 2010). Hays and Singh (2012) suggested using certain types of questions when creating an interview guide: background or demographic questions, behavior or experience questions, opinion or value questions, knowledge questions, feeling questions, and probing questions. I followed this guideline to frame interview questions when covering the two research questions. The main questions included in the interview guide were home country details, reasons for migration, resettling experiences, relicensing experiences, present status, and residency training experiences. A copy of the interview guide is included in Appendix I. Furthermore, the paper copies of interview transcripts were assessed by my thesis supervisor and she provided suggestions to improve the framing of questions and stressed the important

points that I needed to discuss with future participants. After the assessment, she returned all the paper copy transcripts to me.

Although I used the interview guide, when new themes emerged I elaborated and collected more information relevant to the emerging themes using probing questions such as tell me more, why, how, where, and when as needed to collect additional details about important facts and events from the study participants. When the interviews became longer, the study participants showed more confidence and were anxious to provide more in-depth details. When the study participants were emotionally expressing their experiences, I listened to them carefully to grasp their ideas and to use probing questions. In this type of situations, the interview guide helped me keep the questions on track.

A good interview question must be clear, singular, and open-ended; and the purpose of the interview is to go into other person's experiences and collect information in their own words (Patton, 1980; Patton, 2002). I followed certain interview qualities. The first quality was the preparation before an interview, the second quality was the "ability to ask follow-up elaborating questions," the third quality was "superb listening skills," and the fourth quality was being "skillful at personal interactions" (Marshall & Rossman, 2011, p. 145). My previous communication and interaction skills that I had acquired as a medical officer helped me immensely during the interviews. After conducting a couple of interviews, I learned "when to ask more questions or to make more focused observations" (Charmaz, 1996, p. 37).

3.12 Interviewing the Study Participants

I started interviewing in late July 2013 and completed interviewing in late January 2014. I conducted face-to-face interviews at places preferred by the study participants.

Based on their preferences, for practicing AIMGs, I interviewed five at hospitals and clinics and two at their residences. For non-practicing AIMGs, I interviewed two at the library, one at a restaurant, and another three at their residences. The interviews were conducted in English. The inclusion criteria guaranteed the English language competency of the study participants.

I initiated the interviewing process with non-practising AIMGs. I did the preliminary analysis of the first interview before commencing the second interview. After analyzing the first interview, I added additional probing questions as required for future interviews. After interviewing six non-practicing AIMGs, I started interviewing practising AIMGs. For the non-practising AIMGs, the interviews lasted 60 to 90 minutes. Due to the busy scheduling of the practising AIMGs, their interviews only lasted 45 to 60 minutes. With the permission of the participants, I recorded their interviews. Furthermore, after each interview, field notes and observations were added to the interview data to express my reflective thoughts. Field notes and observations helped me to generate introspective data in different perspectives. Furthermore, before the formal interviews, I asked study participants to sign an informed consent form. I gave a signed copy to them and kept a copy for my own records. In addition, I asked study participants whether they needed any clarification or whether they had any concerns about the research. I also collected participants' demographics (see Appendix J). The collected demographics details are summarized in Chapter 4. I continued interviewing until I achieved data saturation. Data saturation refers to the situation where interviewing new study participants sheds no further light on the properties of the identified theoretical categories (Charmaz, 2008; Patton, 2002).

3.13 Transcribing

Just after interviewing the first study participant, I started transcribing. The transcribing is “interactive and engages the researcher in the process of deep listening and interpretation” (Hesse-Biber & Leavy, 2011, p. 305). Furthermore, to protect the originality and integrity of data, the transcriber should have the “same level of familiarity with the data as the interviewer” (King & Horrocks, 2011, p. 119); therefore, I did not hire a transcriptionist and I transcribed the interviews verbatim. I listened to the interview records at least four times during transcribing to clarify any word ambiguities and to understand the study participant’s perceptions about the resettling and relicensing processes. In addition, transcribing is not “passive;” the way I transcribed the data was “crucial to analysis and interpretation” (Hesse-Biber & Leavy, 2011, p. 302). During transcribing, I took extra precautions about the pitfall of this process. For example, placing a comma, semicolon, or a period in a written sentence is complex and may change the meaning altogether; also, the nonverbal clues in the audio recordings were very difficult to reproduce (Marshall & Rossman, 2011). Transcribing helped me to immerse myself in the data, which heightened my familiarity with the data as well as helped me gain a deeper understanding of study participants’ perceptions about the resettling and relicensing process.

3.14 Data Preparation and Analysis

The main steps of grounded theory analysis are simultaneous data collection and analysis; creating analytic codes and categories; identifying the social process in the data; collecting more data on the identified categories; going back and reading earlier data for new categories; framing new questions; constant comparison of events, codes, and

categories; writing memos about codes, categories, and ideas; theoretical sampling; and integration of categories into more abstract ideas (Charmaz, 1990).

3.14.1 Simultaneous data collection and analysis

The objective of data analysis is to progressively narrow down the voluminous amount of data to identify key themes (Creswell, 2013). It involves simultaneous data collection and analysis. Just after transcribing the first interview, I commenced the analysis. Early data analysis helped me in my subsequent interviews and also facilitated me to gather more in-depth information on identified themes about the resettling and relicensing of AIMGs. In addition, data analysis and data interpretation were conducted simultaneously (Hesse-Biber & Leavy, 2011).

3.14.2 Coding the data

Grounded theory is characterized by coding, sorting, and organizing data (Liampittong, 2013). Coding means “categorizing segments of data with a short name that simultaneously summarizes and accounts for each data,” (Charmaz, 2014, p. 111) and coding allowed me to identify the important patterns within the data, which eventually guided me to conduct the subsequent interviews. Coding is the “pivotal link between collecting data and developing an emergent theory to explain the data” (Charmaz, 2014, p.113). In Charmaz’s (2014) constructivist grounded theory, there are two types of codes: initial and focused.

Initial codes

According to Liampittong, (2013, p. 229), initial coding is the “first run” at coding data and it facilitates researchers to scrutinize data from different angles and to find links between different events. Initial codes help to break the original data into

categories and to see the processes. Initial coding involves naming each word, line, or segment of data, and provokes the researcher to scan and detect areas where needed data is lacking (Charmaz, 2014). During initial coding, I examined transcripts to identify main codes by answering the following questions as suggested by Charmaz (2004, p. 507): “what is going on, what are people doing, what is the person saying, what do these actions and statements take for granted, and how do structure and context serve to support, maintain, impede, or change these actions and statements.” By following the above procedure, I reviewed interview data line-by-line and assigned initial codes to incidents in order to define the actions or events that occurred in each incident. The names of the initial codes were either directly taken from the interview scripts or my creations to reflect study participants’ experiences and perceptions about barriers and facilitators to resettling and relicensing. Charmaz recommends using “codes with words that reflect action” Charmaz (2014, p. 116). I used active and specific words as initial codes. For example, I coded the details about lack of financial support to resettle and relicense as “experiencing financial difficulties.”

Then, to maintain consistency, I compared each topic of the interview. The comparison helped me to understand the main themes of the interview as revealed by the study participants, and to draw a holistic picture of the study participant’s perceptions and experiences. I followed the same procedure to analyze subsequent interviews. Line-by-line coding helped me to minimize my personal biases about the collected data and guided me to make decisions about my subsequent data collection (Charmaz, 1996).

Focused coding

Data analysis is a non-linear iterative process (Charmaz, 2014; Creswell, 2013). For the current research, after finalizing initial coding for the first study participant, I identified which of the initial codes made the “most analytic sense and categorized the data most accurately and completely” (Charmaz, 1996, p. 40) and used them to sort, synthesize, integrate and organize data into theory (Denzin, 1997). I compared and located the instances where the study participants described similar resettling and relicensing experiences, which had significance, by writing them down as initial codes. By doing this type of comparison, I was able to interpret data which described similar themes and to assign the same names for similar themes. As the interviewing continued, some study participants made some events “explicit,” which was “implicit” in previous study participants’ statements (Charmaz, 1996, p. 40). For example, the first study participant only implicitly mentioned the observership program; however, subsequent study participants highlighted the importance of this program. In this type of situation, I revisited the earlier data, reexamined it carefully, and added new codes as required. Focused coding refers to taking codes “that continually reappear in initial codes and use those codes to sift through a large amount of data” (Charmaz, 1996, p. 40). As Charmaz (1996) recommended, I kept my focused codes active and brief in order to create sharp and clear categories. While making the focused codes I recognized the variation of data within a category and among categories. I did comparisons between data, incidents, and contexts. In turn, this helped me to see the relationships and patterns among focused codes. This process of collecting data and comparing it to emerging categories or focused codes is called constant comparison, a unique feature of grounded theory data analysis.

(Charmaz, 2014; Creswell, 2013). After completing the analysis, I identified a number of overarching themes and the identified themes led me to identify the relevant factors. Both of the aspects are discussed in Chapter Four.

3.14.3 Memos

According to Charmaz (1996), memo writing is taking categories apart by breaking them into components. In other words, memos are a “specialized type of written records” (Corbin & Strauss, 2008, p. 117) and “part of the analysis” (Corbin & Strauss, 2008, p. 117). I started writing memos from my first analysis and continued throughout the analysis. I refined my thoughts by developing the previous memos, which helped me to reflect my analytic thoughts. According to Charmaz (2014, p. 162), “memos catch your thoughts, capture the comparisons and connections you make, and crystallize questions and directions for you to pursue.” Birks, Chapman, and Francis (2008) described memo writing as facilitating the researcher to deeply engage with the data. Writing memos enabled me to immerse myself in the data (Charmaz, 2014; Birks et al., 2008; Liamputpong, 2013), guided me to search for supplementary data to draw a holistic picture to answer the research question, and assisted me in the development of theoretical codes (Strauss & Corbin, 1998). Memo writing helped me to express my own views as well as to formulate my ideas about the AIMGs’ resettling and relicensing process and to document the history of developing the theory.

3.14.4 Theoretical sampling

As the study progressed, while analyzing interviewed data, I identified new themes, and these new themes guided me to conduct further interviews to collect more data to confirm the identified categories (Charmaz, 2014). According to Charmaz (2014,

p. 197), “initial sampling in grounded theory gets you started; theoretical sampling guides where you go.” Theoretical sampling is one of the unique features of the grounded theory method and memo writing guides theoretical sampling (Charmaz, 2014). For example, after analyzing the first 10 interview transcripts, networking to find references and intrapersonal characteristics emerged as two new concepts. Then, in subsequent interviews, I elaborated on these two concepts to collect more in-depth details to develop the themes. Theoretical sampling helped me to refine the research and made it more complex and holistic.

3.14.5 Theoretical sensitivity

Theoretical sensitivity is a personal quality of a researcher and it refers to an “attribute of having insight and the ability to give meaning to data, the capacity to understand and the capability to separate the pertinent from that which isn’t” (Strauss & Corbin, 1998, p. 42). According to the same authors, theoretical sensitivity comes from literature, personal experience, professional experience, and analytic process. Being an AIMG and having similar experiences as the study participants, helped me immensely to be theoretically sensitive to the data. For the current research, I not only conducted the interviews but also transcribed and analyzed the data myself. This greatly facilitated me to immerse myself in the data and to understand the study participants’ experiences and perceptions about the resettling and relicensing process. Furthermore, simultaneous data collection and analysis aided my theoretical sensitivity.

3.14.6 Integrating categories into theoretical framework

The final step is integrating categories into a theoretical framework. The theoretical framework I developed using the literature search was updated to include

findings from the constructivist grounded theory analysis. I constructed theoretical categories from the data to construct a theory to describe how AIMGs negotiated barriers and facilitators during the relicensing and resettling process as a co-product between me as a researcher and AIMGs as study participants (Charmaz, 2014). These categories depended on my interaction as a researcher with the data and my interpretation of them.

When I was creating the final theoretical framework, I received guidance and confirmation from my thesis supervisor. I met with her regularly and spent time discussing, analyzing, and formulating the final theoretical categories during my analysis process. I drew a number of diagrams, maps, and other visuals to examine the relationships between and among these theoretical categories. As the analysis progressed, with the finding of more abstract ideas, I redrew these diagrams after discussing them with my supervisor, committee members, and fellow graduate student colleagues.

3.14.7 Use of NVivo

I understood that using computer software like NVivo can expedite the data analysis procedure. However, I did not solely depend on software for data analysis. I did the preliminary analysis manually. Manual analysis helped me to immerse myself in the data and to identify the main category and subcategory. After doing the preliminary analysis I used NVivo for subsequent analysis. I used the attribute function to record a description of the study participants and created nodes to represent main categories from the interview scripts. There are two types of nodes: parental and child. For example, I created parental nodes for finances, language, family, institutional rules, culture, networks, and intrapersonal characteristics. These nodes represent categories or factors. Each factor can serve as either a barrier or a facilitator. Situations where the above factors

are lacking are termed as barriers. For example, lack of finances was termed as financial difficulties. For another example, I created child nodes of first employment, low income, and expenses for the parental node of financial difficulties. Each time I created a node I also created a memo linking to that node, to describe the ideas and concepts behind creating the node. Furthermore, I used NVivo to visually present my data and display the relationships between and among parental and child nodes. Figure 3 shows the preliminary model of nodes I created using NVivo. I understood the importance of both manual and NVivo analysis. I do not want to prefer one over the other but wanted to be open and make use of the benefits of each.

3.15 Trustworthiness

According to Lincoln and Guba (1985), the conventional criteria for trustworthiness are: credibility, dependability, transferability, and confirmability.

3.15.1 Credibility

Credibility is the believability of the research. It examines the agreement between the opinions of the study participants and the representation of these opinions by the researcher (Padgett, 2008). It is based on constructivist assumptions about the existence of multiple realities (Carpenter & Sutto, 2008). Furthermore, “credibility is achieved when the multiple realities held by the participants are represented as accurately and adequately as possible” (Liamputpong 2013, p. 25). I believed that being an AIMG myself helped me to understand the different and similar views of AIMGs and to document these views precisely.

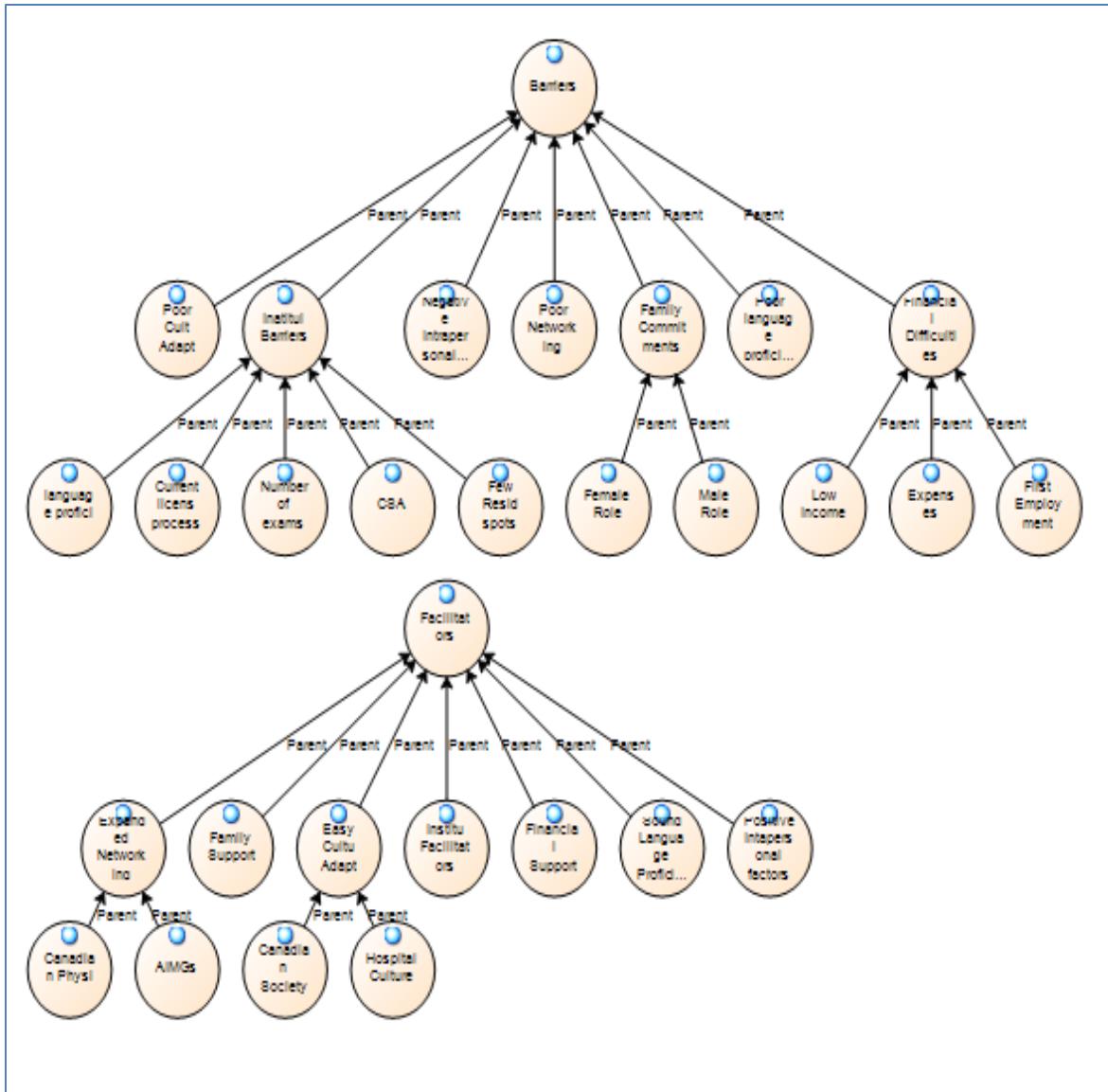


Figure 3. The Preliminary Model of Nodes Created Using NVivo

Furthermore, Lincoln and Guba (1985) noted that credibility depends on prolonged engagement, persistent observation, triangulation, member checking and debriefing. Peer debriefing is the process by which a researcher discusses the research work and emergent findings with peers (Marshall & Rossman, 2011). I regularly debriefed with my thesis supervisor about my research to improve the credibility of the research. In addition, after

the preliminary analysis of the interview transcripts, I conducted member checking with five study participants over the telephone, and each conversation lasted approximately 10 to 15 minutes. During the member checking, I shared the data and interpretations with study participants (Marshall & Rossman, 2011) and received their feedback and consent. All the study participants agreed with my interpretations and were satisfied with the preliminary findings. On the other hand, member checking requires additional time from the participants and some participants were reluctant to re-engage. To achieve data triangulation I incorporated the views and perceptions of two groups of study participants.

3.15.2 Dependability

Liampittong (2013) compared dependability to reliability and says dependability can be achieved by a good auditing process. According to Carpenter and Suto (2008), dependability checks whether the study findings agree with the data. In order to achieve dependability, I carried out my research in a consistent manner, documented my data collection and analysis strategies, and maintained “coherent linkages between the data and the reported findings” (Liampittong 2013, p. 26). Furthermore, my documented records helped me to critique and review my own research actions (Shenton, 2004).

3.15.3 Transferability

Transferability refers to the generalizability of the research findings to other similar situations and similar questions (Padgett, 2008; Marshall & Rossman, 2011). For example, transferability criteria of the current research are to indicate to what extent barriers and facilitators encountered by Albertan IMGs can be applied to IMGs in other provinces. Since qualitative studies are specific to a certain number of study participants,

it is difficult to show the applicability of research findings to other situations (Shenton, 2004). On the other hand, some researchers argued that if the situations described in a particular study are similar to other situations, then findings from that research may be applied to the similar situations (Lincoln & Guba, 1985; Firestone, 1993). To compare similarities of situations, thick descriptions of the research phenomenon need to be provided to the readers (Shenton, 2004). Therefore, to ensure transferability, I provided thick descriptions of the research events and the processes, including the details of the settings, interviews and analysis procedure.

3.15.4 Confirmability

Confirmability refers to the demonstration of genuineness of study findings (Liampittong, 2013). The research findings must be the ideas of study participants and should not be altered or modified by the researcher (Padgett 2008). Confirmability is “comparable to objectivity or neutrality” (Liampittong, 2013, p. 26). During my research, I listened to the range of views of AIMGs, and reported the AIMGs voices as accurately as possible by including direct quotes from study participants (Hays & Singh, 2012), to minimize my biases, motivation, interests or perspectives (Liampittong, 2013). In addition, throughout the research I remained open and reflexive to ensure confirmability.

3.16 Summary

This chapter provides a detailed description of the constructivist grounded theory methodology utilized for the current research. I recruited two groups of study participants using snowball sampling and conducted semi-structured face-to-face interviews to gather

resettling and relicensing experiences of AIMGs. Details of data analysis, ethical considerations, and trustworthiness were also explained.

CHAPTER FOUR: RESULTS

This chapter presents the interview findings and analysis with non-practising and practising AIMGs. The purpose of this study was to construct a theory following the constructivist grounded theory approach (Charmaz, 2014) to explain how AIMGs negotiated the barriers and facilitators to obtain their license to practice medicine in Canada. The incorporation of views and perceptions of two categories of AIMGs enhanced the research findings. The interview questions were framed to find answers to the following two main research questions:

- i. What is the process for resettlement and securing a residency position?
- ii. How do AIMGs negotiate the facilitators and barriers for securing a residency position?

The data generated during the research guided me not only to inquire about obtaining a residency position but also to generate details of securing and completing residency training as one step toward licensure. Furthermore, analysis of the initial data prompted me to extend my study to include how AIMGs negotiate the resettlement process. Therefore, I reframed the second research question as follows: how do AIMGs negotiate the resettlement and relicensing process? This change in direction of the original research questions complemented the constructivist grounded theory approach because this research method provides flexibility to the researcher to collect additional data and related to the research focus (Charmaz, 2014).

4.1 Demographics of the Study Participants

To avoid the risk of identification, I referred to study participants by pseudonyms and have not included their country of origin or current employment status in the

discussion. Of the 13 interview participants, six were non-practising AIMGs and seven were currently practising AIMGs. The pseudonyms of the participants are presented in table 3. The aim of interviewing two groups of AIMGs was to generate a holistic picture of the resettling and relicensing process of AIMGs. Non-practising AIMGs were not employed at the level for which their education and post graduate training had prepared them, and they were unable to work as physicians. At the time of interviewing, two of the non-practicing AIMGs were working in temporary positions (medical office assistant and seniors' home assistant), two were working as professionals in the health sector, one was enrolled in a health-related degree course, and the remaining one was working in a medical laboratory. Though they are currently working in different fields, they were all still trying to obtain their license to practise medicine.

Table 3. Status and Pseudonyms of Study Participants

Status	Pseudonyms
Practicing	Peter, Mark, David, John, Nick, Amanda, and Tanya
Non-practicing	Nancy, Anna, Emmy, Bill, Olivia, and Hanna

The study participants included both women and men. Of the non-practising physicians, five were females and one was male. Of the practising physicians, two were females and five were males. The non-practising AIMGs ranged in age from 35 to 50 years, and the age range for practising AIMGs during their licensure process was 35 to 45 years. In addition, study participants represented a wide spectrum of the international community, which helped to understand how the resettling and relicensing process differs for AIMGs who arrive from different parts of the world. Of the non-practising AIMGs,

three were from South Asian countries, two were from East Asian countries, and one was from a West African country. Of the practising physicians, one was from Eastern Europe, two were from the Middle East, one was from South America, one was from East Asia, and two were from South Asia. Four non-practising physicians were married, and had immigrated to Canada families. Four female non-practising AIMGs had children after immigrating to Canada. For the practising AIMGs, six were married and one married after immigration. Five AIMGs had children during their resettling and relicensing process and two AIMGs had children after completing their residency training. Table 4 summarizes the details of the two categories of participants.

Table 4. Details of Study Participants

	Non-Practising	Practising
<u>Continent of origin</u>		
• East Asia	2	1
• South Asia	3	2
• Eastern Europe	0	1
• South America	0	1
• Middle East	0	2
• West Africa	1	0
<u>Age range (years)</u>		
• 35- 45	5	7
• 45- 55	1	0
<u>Gender</u>		
• Male	1	5
• Female	5	2
Children		
• Yes	6	5
• No	0	2
<u>Medical Specialty</u>		
• General Practitioner	5	4
• Specialist	1	3

4.2 Identifying Themes

My findings will be presented within a constructivist grounded theory framework that will culminate in a model highlighting the factors that impact the licensure of IMGs. I identified the following five themes to represent the experience of the IMGs as they worked toward becoming licensed in Alberta: arriving with dreams; trying to make a home when you cannot find a house; relationships make the difference; new rules; and making a new reality. In the following section, I discuss each theme with examples of quotes.

4.2.1 Arriving with dreams

Participants immigrated with dreams of practicing medicine in Canada. On AIMGs' immigration papers, their occupation was listed as a skilled labourer; therefore, they thought they could work as physicians. Unlike other categories of immigrants, AIMGs not only needed to become accustomed to the new Canadian social environment but also needed to adjust their career goals to match the reality of employment in Canada. Olivia expected that the IMG licensing process in Canada would be similar to that in the US where IMGs need to complete only three exams to apply for residency: United States Medical Licensing Examination (USMLE) Step1, USMLE Step 2 Clinical Knowledge, and USMLE Step 3 Clinical Skills to apply for residency. The following quote illustrates Olivia's dreams.

There should be couple of exams, and I never thought it would be so difficult. I thought after taking exams, after I get licence, at least I could be able to work in rural areas so I had a plan, even if it is not something like a big city so I can be able to work in rural areas. I was willing to go to even rural areas once I passed the licensing exams.

Like Olivia, Peter, Nancy, Bill, and Emmy had similar thoughts. This is how Nancy explained her dreams.

I thought that after passing barrier exams, I will be able to practise so I did not think that it is going to be really a long process. I think I was hoping, I wanted to believe I can practise.

This is how Bill expressed his unawareness about the Canadian medical licencing process.

I didn't know, totally I didn't know, even I didn't know that after passing exams I cannot practise. I didn't know that until I came here.

In addition, Bill did not have a clear goal about his future in Canada. The main purpose of his immigration was to have a better life in Canada; he was not aware of the details about the licencing process in his adopted country. In some situations, IMGs received incorrect or misleading information about the licencing process before their migration. Based on such information from one of his relatives, Nick drew an incorrect picture about Canadian medical licensure.

She said to me, you just have to write one English exam. If you pass that, you have to write medical exams and if you pass that you can work so knowing that in the US, you have to write step 1, 2, and 3 and wait and see how things go. I thought this is easier, but until I finished my ESL which was a year that I realized. Oh! My goodness, the information that told me was not even the ten percent of the whole process.

4.2.2 Trying to make a home when you cannot find a house

Participants came to Canada with differing origins but a common decision to make new homes here. Participants who received their Canadian medical licence thrived in their new homes. On the other hand, participants who did not receive their Canadian medical licensure encountered substantial challenges. For this group of participants, even their desire and dedication to make a new home in Canada was thwarted by the number of challenges they faced. This was described as *trying to make a home when you cannot*

find a house mainly because of the financial challenges associated with their transition.

After immigrating to Canada, IMGs need to take survival jobs to find finances to cover their day-to-day and medical licensing expenses. Many IMGs faced financial issues during their resettling and relicensing process because the earnings from survival employment were barely enough to cover these expenses. Bill expressed the financial difficulties he faced this way:

My wife didn't have a job so she stayed at home and we relied on my research income which was very minimum so we lived in one single bedroom apartment for three and half years and without a vehicle. In 1996, that year was extremely cold and we never experienced minus eight before we came to Canada. That year was -30 for months so it was extreme difficult.

In addition to finances, there were several key challenges: differences in culture and language were two main ones. For many IMGs Canadian culture is very different from their homeland culture. Some participants were nervous and frightened about the differences between their homeland cultural values and the Canadian values. Furthermore, English is not the first language of all the study participants. After immigration, AIMGs needed to spend time and money to improve their language skills. Many AIMGs struggled to achieve the language competency levels demanded by the regulatory agencies to apply for residency spots. Emmy explained her feelings about cultural adaptation during the early stages of her immigration this way:

Initially, it was tough because we were not used to different things. I think there was a shock like when we came to Canada. There is different culture wise, different everything, different food, but we managed it. Once you make a mind that you have to live, we can manage it.

Finally, Hanna described the initial difficulties she encountered by saying:

First, you need to find a place to live and you have to get into the culture and you have to learn the language. Also the most challenging thing is you have to find a

job to survive. First few years, I found like pretty hard. You have to find a place to live.

The above quote summarizes the main idea of this theme.

4.2.3 Relationships make the difference

The immigration process meant that the participants did not have physical closeness to extended family members and had to rely on their immediate family, i.e., spouse and children, for support. Making friends was essential for their support system. Even in solid, loving relationships the resettling and relicensing processes are stressful and can lead to inter-personal challenges. There were a number of examples from the interviews about the impacts on relationships. Bill had to sacrifice some of his family commitments to find time to study; he felt sorry about not spending as much time with his son as he wanted. Bill praised his wife for taking care of the family.

She did all those house works mainly. She didn't like the idea that to sacrifice the family life to achieve career goals. She thinks that after marry first thing is to focus on family life.

Nancy had an understanding husband who was very supportive and looked after their children, providing her with the time to study. Another participant, Emmy, received support from one of her fellow AIMGs to prepare for the exams.

I was seven months pregnant and same year I did OSCE and my son was one month old when I was doing OSCE...my study partner helped me a lot. She always visited my home and we studied together. She helped me a lot. Luckily, I got a very good study partner.

Mark described the support he received for his studies.

I met somebody in my working place, she was also a foreign doctor, she was ahead of me and she had that information what to study so she gave me the name of the book and I was reading that for several months for that exam.

AIMGs migrated to Canada leaving behind their relationships with family and friends. To secure employment in Canada, AIMGs needed to develop relationships with Canadians. One study participant, Anna, stated that it was difficult to survive after immigration without someone else's support. She said:

If you don't really find a good person to help you to go through, even it gets harder."

Furthermore, all of the study participants stressed the importance of having expanded professional relationships to receive a residency position. Peter emphasized this idea in the following quote:

If you get friends and neighbors, you live with them. They understand you, but get into the medical field is the key question and you need somebody to get you there.

Amanda explained the support she received from study groups.

For Evaluation, I joined AIMG group here. We used to have regular classes every Saturday. There were some excellent people who were organizing and doing volunteering. I joined that group that gave me the encouragement for studies. First I used to study my own, and then I joined friends. So there were four or five people from different countries. We started studying together.

This is how Tanya disclosed the help she received from a friend.

It was very tough. Then, I don't know how I came to know about this lady, through one of our friends. You know, she told me to read that book. Sometimes I was pretty backward, but she was pushing. She said let's do this and let's do the art.

4.2.4 New rules

The AIMGP regularly introduces new rules and policies and amends the existing rules and policies to regulate the selection of AIMGs for residency positions. Most participants negatively commented about the frequently-changing rules. Some perceived the hidden government motives behind the changes. Bill believed that policy makers wanted to keep AIMGs in a labour pool from which to pick when needed. Another

participant, Mark, showed his displeasure because his homeland's medical qualifications were not automatically accepted in Canada. Nick realized that the Canadian medical system is different from his homeland's medical system in many aspects, but he also knew that Canada needs more physicians. He therefore could not understand why Canada is reluctant to absorb IMGs into the Canadian health care system. Peter commented about the changes in the rules and how it personally affected him:

Usually they come in and they bring rules with them and those rules are affecting you. For example, I was one time I didn't apply for residency for the whole year because I was short one mark on bench mark English. The year before was okay. I thought everything was okay because year before was the same exam and same thing. They came up with no you have to have minimum mark on the bench mark. They put your EE, QEI, and QEII into garbage and because of your English test which was one mark short you are not qualified to apply.

Hanna argued for the necessity to have a set of transparent static rules and standards to assess AIMGs:

I think they should have a tool or a better program to assess the IMGs. I think what we have is very useless criteria for selecting IMGs for residency, and also it is not transparent. You don't know what criteria they use. They should give something everybody can see.

Frequent change of rules and regulations hamper AIMGs chances to receive residency positions.

4.2.5 Making a new reality

This theme explains the distinction between participants' prior immigration dreams and their experiences after immigration. IMGs are attracted to Canada due to many push and pull factors. Once the participants faced different challenges and experienced how other IMGs suffered, they realized that their dreams did not match reality. Participants believed that they had given up a better life in their homeland and that they suffered because they could not obtain their Canadian medical licence. Many

participants were underemployed and had to do any work for their survival and this situation tattered their self-esteem and self-confidence. One of the main factors affecting AIMGs' disappointment was the difficulty in receiving a licence to practice medicine in Canada. As participants attempted to salvage their dreams, they tried to find survival strategies. Anna believed that IMGs, including herself, immigrated to Canada with unrealistic expectations and a narrow understanding about the relicensing process of IMGs. She believed that it was time for her to look back, understand the realities, and adjust to existing realities. Leaving everything back home and starting all over in Canada was too much for Anna to handle. She began to question many issues related to her application for licensure:

Why am I here? That question pops up every single day. Why did I come here? What is better about this? Why are we here? It was very hard at the beginning, but you just have to keep talking to yourself: things will get better, things will get better, we will make it better, and that was the only way.

A number of participants shared a similar frustration. Bill said:

I assumed I need to pass their licensing exams. I did the exams but I cannot get the residency due to all kinds of barriers and due to the limited seats available.

Like Bill, Peter faced number of disappointments.

It was tough to get through those periods. It was just ridiculous. You feel going back at one point and just depends sometimes. Every opportunity comes after you. You start hoping okay you might get through this time apply and try to get through and keep up mind for residency, and lots of disappointments.

For an AIMG receiving the Canadian medical licensure is difficult. It requires time, finances and hard work. Nancy understood this reality and was determined to work hard in order to achieve her goal.

I don't know that how I faced. When I think about, that was really tough. I was so determined because I knew that there was no other way out. So I did have no other options. I had to do that.

For all of the participants, the combination of these themes impacted their experience of the licensure application process. In addition, these themes also led to the identification of factors that impact the licensure process. The next section addresses these factors in details and includes a diagram to visually illustrate the process.

4.3 Negotiating Factors for Securing a Residency Position

The data were analyzed based on the principles of constructivist grounded theory; the original data were filtered and arranged into categories using initial and focused coding. The themes discussed in section 4.2 facilitated the identification of the focused codes. Seven focused codes (factors) were selected by identifying codes which made the most analytical sense to comprehensively categorize the data. Figure 4 illustrates how AIMGs negotiated various factors to obtain licensure.

The seven identified factors were finances, language, family, institutional rules, culture, networks, and intrapersonal characteristics. All these factors were important and influenced each other. Their successful negotiation was the key to obtaining licensure. In addition, each factor served as either a barrier or a facilitator, depending upon the context, the individual participant and his/her unique circumstances. Situations where the factors are lacking are termed barriers; where they are present, the factors are called facilitators. For example, financial factors can both facilitate, when resources are sufficient to meet all needs and obstruct, when resources are inadequate. While all study participants faced barriers and facilitators in one way or another, some participants encountered greater challenges. These differences will be discussed in detail to provide contextual understanding of all of the issues faced by AIMGs.

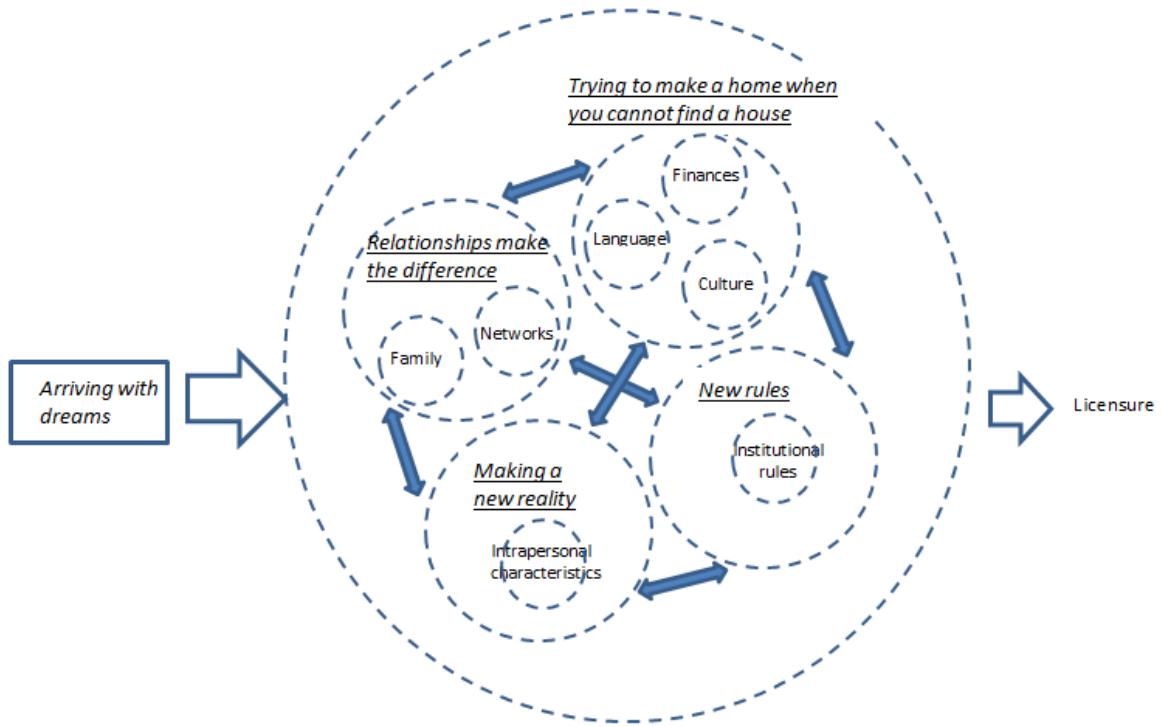


Figure 4. Theoretical Model to Explain How AIMGs Negotiate Factors

The identified factors that facilitate the success of the participants influence each other. For example, competency in language helped the adaptation to culture while also facilitating the individuals to create professional networks and pass examinations. In another example, an AIMG whose spouse had pre-arranged high-paying employment at the time of immigration had financial stability and was able to devote more time and resources to obtaining the licensure.

Similarly, the factors that were identified in this research were also noted to be inter-related with one another and to serve as barriers. For example, family commitments may lead to financial difficulties as well as limiting the available time for study. To obtain medical licensure, the barriers need to be negotiated. Some of the barriers are

easier to negotiate than others. For example, financial difficulties are within individual control and easier to manage than institutional barriers such as access to the few residency spots which are beyond individual control. In another example, language skill acquisition is easier to negotiate than gender (family commitment). For a female AIMG, pregnancy and taking care of children are difficult to negotiate. However, by spending more time and resources it is possible to receive language proficiency. On the other hand, sometimes a barrier can become a facilitator. For a female AIMG whose husband has a highly-paid job, his financial strength becomes a facilitator and helps her in obtaining licensure. The following section describes each of the main categories presented in the theoretical model.

4.4 Emergent Categories

In the following sections, the seven emergent categories (factors) are explained using direct quotes from the study participants and are accompanied by my perceptions and interpretations. Charmaz (2014, p. 148) recommended developing “subcategories of a category and show the links between them.” I identified subcategories for the seven main categories. For example, for the category of finances, I identified first employment, low income, and expenses as subcategories. The identified subcategories are used to explain the main categories in the following sections.

4.4.1 Finances

Finances are one part of the negotiating process to gain licensure; however, finances are a significant two-edged sword that includes both financial difficulties and financial support. Financial difficulties refer to the situation where an individual does not have sufficient finances to cover his or her expenses. On the other hand, financial support

is the condition where an individual is receiving financial help from other sources, for example, from a spouse or relatives.

All AIMGs had upper or middle-class economic status in their homeland and expected a better life in Canada. However, after immigrating to Canada, the majority of them faced financial difficulties and experienced low economic status. Canada is known for its high standard of living. However, living costs are quite high for new immigrants. The foreign savings they brought with them were only enough to survive for a couple of months. Study participants revealed in detail how hard it was for them to manage their finances during the initial stages of resettling and relicensing. All but two female participants experienced financial difficulties during the resettling and relicensing process; their spouses had high-paying, stable employment, which allowed them to spend time negotiating for their license.

To fully comprehend the impact of finances, this section will focus on four subsections, including quotes to illuminate the participants' perspectives: first employment; low income; expenses; and financial support.

First employment

Since AIMGs' educational credentials were not sufficient to secure employment in the health sector, it was necessary to find any kind of employment to ensure survival. The male participants talked about taking odd jobs like being a labourer or a security guard. Both male and female participants revealed how hard it was for them to find their first employment because of a lack of Canadian references, employment networks, and Canadian experience in relevant fields. One way to acquire Canadian work experience

and ultimately networking and references is to work as a volunteer. However, to start volunteer work, an AIMG needs to be economically established.

David recounted the types of odd jobs he initially did and how difficult it was for him to find jobs with his non-Canadian medical qualifications.

We came here and worked. We worked in everywhere; we worked in group homes; we worked in security. It is not easy to find a job because medical speciality, very difficult to find. If you show your diploma, nobody likes you because it is overqualified for many positions so you just hide your diploma and apply to simple jobs.

Another participant, Olivia supported David's ideas.

It was not easy at all. So I didn't know where to work, and I didn't understand where to work. I went for couple of places looking for works. They said I am overqualified to do some survival jobs. So I don't know where to start and how to start. Few times, I got rejected, and I got depressed. This is not the way. I didn't understand what to do next.

She further elaborated on her frustration and how she became depressed because she had to struggle when looking for a job due to her overqualification with having a medical degree.

It was like so depressing because we can't work as a doctor. Though we have license, knowledge, and we have everything, we cannot work as a doctor. Even we cannot do lower level job because they say we are overqualified so it was very depressive.

Another study participant, Hanna, explained the difficulties she faced when even finding a lower level job at a nursing home.

The most challenging thing is you have to find a job to survive. First few years, I found like pretty hard. After that I also got a job in a nursing home as a nursing home assistant. I needed some earning at that time so the first two years were quite challenging.

New immigrants cannot obtain employment without Canadian experience and immigrants cannot get Canadian experience without a Canadian job. The following quotes from Anna further supported the existence of this barrier.

Of course for us getting work was kind of difficult because where ever you go they require Canadian experience which we don't have and it meant that we had to work like just random jobs.

She further elaborated.

And part of my first job, I remember I worked in a department store. They had like a demonstrator, yes that was the first job I did in Canada. That was something along that line that was most I did for first few years in Canada.

Low income

One study participant, Anna, explained how hard it was for her to manage her finances, since she did not bring sufficient savings.

I remember, because we did not have really much savings when we arrived it was just that minimum that was required to get into Canada. That's all the money we had so it was pretty important to find a job for both of us.

She further elaborated:

Yes, definitely, money was a big issue how we spent and the way we earned because at that time it was just me who had a job; I was working and you know like having a young child, diapers.

Unlike other categories of immigrants such as refugees and unskilled labours, the main aim of AIMGs is to obtain their professional identity to work as a physician in Canada. AIMGs need to earn not only to cover their day-to-day expenses but to spend money on items such as books, exams, and other related activities to obtain their medical license. Studying in Canada is quite expensive. For many AIMGs, simultaneously working, learning, and looking after children were daunting tasks. This is how Peter explained his experiences.

It was usually tough and we were expecting that to be tough with the beginning. And you know as you go you face problems. Sometimes you hope to have problems solve easier, but it was not easy to us it was tough from the beginning. It is including all kinds of financially and support with studies.

Emmy also expressed her financial difficulties and how her husband supported her success. She described the difficulties she and her husband faced to finance their exams and to manage day-to-day life.

I remembered initially, we didn't have much money. One time we have only the amount for rent so my husband said no you go and pay for your exam fees and I'll get some money because he was working in longer shifts and at that time it was very difficult.

Financial dependency on her husband was a significant emotional struggle for Olivia.

I have to depend on my husband for all the exam fees and for my regular expenses like basic living expenses. I was depending on my husband so that was stressful for him too because like back home in my country, we both used to work and financially we could be able to afford everything. It was not much stressful. Here, only he was working and all the time I was depending on him for financially so it was stressful for him and I was always feeling guilty all the time to make him stressful and to depend on him.

Nancy described how difficult it was to work (doing night shifts) and to study at the same time.

But handling the day to day life was really a problem because financially both my husband and I were not in work so we had financial problems. Definitely, it was hard on him too because studying and doing nightshifts. Still I don't think we earned a lot, doing those two jobs; it was a struggle.

Expenses-housing

For many new AIMG immigrants, finding a place to live during the first few months after arrival was a big challenge. Many new AIMGs choose to live in apartments in city suburbs due to the availability of good schools, services and reasonable transportation services. However, renting an apartment is not easy. Many landlords check credit history before renting to determine the applicants' capability to pay the rent. Since new immigrants do not have any credit history or employment, landlords demand that applicants pay three months' rent in advance. On top of this large expense, the

applicant also needs to place a security deposit, usually an additional month's rent, to cover any damage to the property. For new immigrants who come with minimum savings it is challenging to afford rent for an apartment.

Anna described the difficulties she faced renting an apartment and her experiences in sharing a house.

We didn't have a vehicle at that time because we couldn't afford a vehicle. We just used public transportation. When we were trying to apply for renting a place, it was that we did not really; first we didn't have jobs so they wouldn't rent a place for us so we have to stay with her (sister) in her place until we both had jobs and we both could provide references to the like the property management and stuff so yes it was kind of difficult.

Similar to Anna, financial difficulties forced Olivia to share accommodation, and sharing accommodation eventually led Olivia to return to her homeland with her children, leaving her husband in Canada.

So first we landed in his (friend's) house so it was like sharing accommodation so it was a new experience sharing accommodation. Staying in someone house, sharing the same kitchen. It was a new experience and so we have to share for a couple of months and then I didn't like that much so I went back to my country again, but my husband stayed here, and me and my children went back to my country.

Hanna is like many immigrants who lived in a basement suite for two years because it was the only realistic choice for an AIMG without a steady income.

First, you need to find a place to live and you have to get into the culture and you have to learn the language. Also the most challenging thing is you have to find a job to survive. First few years, I found like pretty hard. You have to find a place to live. First, we lived in a basement for almost two years.

Expenses-exams

The MCC exams are time consuming and expensive. The MCC official web site (2014) lists the current exam fees as follows. The EE costs \$1,695 with the QEII noted as \$950. Though it is not required to complete the QEII to apply for residency, many

AIMGs also take QEII to boost their credentials. This QEII exam costs \$2,260. To obtain a residency position, AIMGs need to pay a non-refundable application fee of \$300 (AIMGP, 2014) and need to pass the NAC-OSCE, which costs \$2,190. In addition, English language proficiency tests are also expensive. The cost of an International English Language Testing System (IELTS) test in Calgary is \$285 and the costs of TOEFL iBT in Calgary is \$240. Altogether AIMGs need to spend a minimum of \$7,380 on exam fees.

Anna did not have enough finances to apply for exams. She postponed her exams until her husband found a suitable job to finance her endeavor to become licensed and pay for her exams.

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He was still studying so my plan was to wait for him until he finished and get a good job and at least pay for my exams because my exams were really expensive and we couldn't afford that. So that was the reason. As soon as he got into a job, I registered for the exams. He was hired in March and I registered for the September exams.

Hanna explained the extra expenditure she paid due to the lack of an exam centre in Calgary.

I first took the exam in Saskatchewan, and we had to fly there. Exam was quite challenging because Calgary didn't have exam sites so we had to go either Vancouver or Saskatchewan. That was lots of expenses. If you want to take the exam, travel expense, also the exam fees also expensive too.

She further explained the reasons for postponing her exams:

We don't know how much we have to pay for schools. So I thought I should do the job and he can do the full time course. After his graduation, I can pursue something.

When both husband and wife were AIMGs it was much harder to prepare for licensing as explained by David:

All exams of course very difficult to go through; when we are applying paying double for everything, also travelling, at least books for two of us is easier. It is a lot of pain; we didn't get anything during the first five years. We were renting very cheap, not the best areas, just to survive, minimally working and spending money for exam preparation.

Financial support

Nick praised his wife for the financial support he received from her.

I was just staying and doing things at home. She was working and studying and we were living on a salary of \$1,300 per month for the first nine months until I got my work permit. Once I got my work permit, I started working and I could make some savings and preparing for the exam same time.

Like Nick, Mark also showed his gratitude to his wife for her financial support.

She has to work. Back home she was not working. When we came here, because I cannot work full time and I am studying, so she has to take the other full time jobs while I was trying to take my exams.

Furthermore, Mark gratefully admired the support he received from his brother and parents.

It is mainly my family who gave the support for me and my family, including a place to stay, our food. Me and my wife worked and supported the other things we need in our lives, but mainly my family who supported what we needed. It is much easier because my brother and my parents were here and we lived with my brother for a while and he didn't allow us to buy anything. He take care every expense while I was trying to re-certify myself.

Unlike other study participants, Tania and Amanda had financial security because of their husbands' employment and therefore did not experience financial difficulties like the other study participants. Tania expressed her satisfaction in the following quote:

No, because my husband did a job; he got a job in seven months. That's why I am saying that I know for some people have to struggle for those things. I didn't have to do those things.

Amanda agreed that she was financially secure:

We didn't struggle for anything or any job here because my husband got a transfer so the company gives a lot of benefits so no problems.

4.4.2 Language

Language skills are another factor to negotiate in the process of obtaining licensure. Communication is the key to the physician-patient relationship. Language proficiency is part of the communication ability of an individual and proficiency is described in terms of the four basic language skills: listening, speaking, reading, and writing. AIMGs need to undergo language assessment to demonstrate their proficiency in these skills. AIMGP only accepts International English Language Testing System (IELTS) or Test of English as a Foreign Language Internet Based Test (TOEFL-iBT) marks. Participants recounted their experiences in fulfilling the language proficiency requirements.

The majority of participants spoke about the different language challenges they faced. Nancy struggled to understand certain colloquialisms and the informal language used.

When it comes to language, some terms, and some sentences sometimes; after learning I was ok, but sometimes if I hear it for the first time, I won't get it. It takes sometimes get used to Canadian English because English is different.

For Bill the most difficult thing was the English language in general.

The most difficult thing is the language. Then I started to study, prepare for the exams. We were totally trained in my native language so medical terminologies are so different as not like people who trained in English. Medical terminology, specially, anatomy, anatomical names, bacteria, microbiological names and drug names were so different so it took me a little while to prepare for the exams.

His spouse abandoned pursuing her licensure due to poor language skills.

She didn't want to do anymore because her English language knowledge is not excellent so she had some English problem so for her studying was too difficult. She didn't do anything.

For Hanna the most difficult part is the speaking and listening.

So and also, my husband and I had to go to the English course to get the language training. So for us because speaking and listening, it was the most challenging part. May be rather reading and writing we didn't have problems, but for the speaking and also the listening. That's the most challenging: communication part for us.

Peter spent time in an Eastern European country, and lost his English language skills. For Peter, reading was not an issue but understanding slang was difficult and needed time.

I had a background of English, but when you work in a different country that doesn't speak English; you lose your second language. I lost my English. English became my third language and I almost lost English. When I came in, I had to learn English. I thought I know English. When you read you understand, but when you come in and start to talk with people slang is different and don't catch what they say. It took for a year to be able to communicate and understand well.

Peter explained how he improved his language skills.

I didn't go because I didn't have time. I had to study and I had to work. Later on there were some classes for IMGs. They were full time classes and I cannot quit the job and go for the classes full time so I had to refresh English by myself practising with people. I think I went to a course for TOEFL. We had to write for TOEFL so I went to a TOEFL preparation course, and that was the class I went.

Nick first completed the English proficiency test and then started the medical exams.

No English at all so what I did I wrote ESL with the saving I had working in my country. I studied intermediate, high intermediate and advance. I couldn't fail any because I was paying from my pocket so I had to push my English. As soon as I finished the English, I challenged the MCC-EE.

Interestingly, at the university, Nick faced difficulties even in filling out application forms. For him, some of the questions were confusing. He described how difficult it was to complete forms and had to ask his teacher for this basic help before he proceeded. Like Peter, Nick attended an English class and within one year he became competent in English.

One thing that helped me a lot in English class was out of seventeen students 15 were Chinese, one Korean, and me so I had to speak English. There was no question. I was full time English one year. That worked. I think I had headaches for first three months because it was so intense. Starting point it was difficult, but

once I started enjoying it, it was easy and I did it. That was the first time in my life that something I did completely unrelated to medicine so it was fun.

For some participants there was not enough time to learn English due to the many other demands in their life, while other participants self-studied and were successful in passing the TOEFL. Amanda had little difficulty in understanding and speaking, and she described how she improved her weaknesses.

Little bit, but didn't affect much. I used to listen to radio and talk just to improve my vocabulary.

Four study participants; Emmy, Olivia, Mark, and Tanya, each had good English proficiency. In their homeland, they had studied medicine in English. This is how Mark explained why English was not hard for him.

No problem with the language because English was our medium of instruction, in school they teach in English so it was not hard.

4.4.3 Culture

Cultural adaptation can be referred to as “changes that take place in individuals or groups in response to environmental demands” (Berry, 1997, p. 13). This adaptation is a key to obtaining licensure. This section includes details about AIMGs’ adaptation into both Canadian national and hospital cultures. I will provide details about AIMGs’ cultural adaptation under two subheadings: Canadian society and hospital environment.

Adapting to Canadian society

Canadian culture is not a single culture. It is a combination of multiple cultures. Canadian society is composed of multiple cultures and the immediate physical and social surroundings in which people interact with each other. Participants revealed the challenges they faced in adapting to Canadian society and how they negotiated this process. For all study participants, their homeland society was very different from

Canadian society. Bill commented about the difficulty he faced when establishing friendships with Canadians, which forced him to build relationships with immigrants who shared common cultural values. When he needed something, he went to his homeland friends. Nancy revealed that she faced a number of cross-cultural conflicts which impeded her integration into Canadian society.

I don't know, but it may be the culture or it may be the things that we focused on the day to day life. For example, I don't go to pubs, I don't drink, I don't go to musical shows, I don't play golf, and even I don't watch hockey, so there are so many things that I don't do. I don't say that I am not interested.

A number of AIMGs like Amanda, Nick, and Anna immigrated with an open mind. They faced fewer challenges when adapting to the Canadian society. Amanda was open and willing to become a part of the new culture.

There were little bit of challenges. New people, new friends, but I think if you are open, and if this in your heart and mind that this is you belonged to this country now. You are not a stranger here. This is a lot in your mind like I used to cover my head when I was doing observerships; I wore hijab. Sometimes, I feel awkward because I am the only one. It was in my mind. Nobody cares it. May be some people, but like different things and different responses, but I still feel not done bad.

Like Amanda, Anna immigrated with an open mind and expected both good and bad things.

I don't know, it was a big difference by all means it was a big difference a lot to get accustomed to, but I think, I came in open and expecting controversy, expecting difficulties, I did not expecting to be all rosy like generally.

For AIMGs who were previously exposed to other cultures for some time before immigrating to Canada, adapting to the Canadian society was not a difficult task. Tanya described her homeland culture as a family culture and Canadian culture as a personal culture. However, she pointed out that living in the Middle East, which is a multicultural society, helped her adjust to Canadian society. Through the familiarity of living in

Europe for some time, John disclosed that adapting to Canadian society was not difficult. Furthermore, his cultural adaptation was facilitated by interacting with people from his homeland community.

It is a different culture, but I lived in Europe for four years before this so there was like a transition there so it wasn't hard plus there is communities from Middle East. Not hard.

David and Mark agreed that Canadian culture was different; however, for them adapting to Canadian culture was not a big issue because the ways people interact in Canada are similar to their homeland. In addition, David got the opportunity to interact with people from his homeland and Mark believed that the family bond is tighter in his culture than the Canadian culture. This is how Mark explained his perceptions.

It is not really hard to adapt to Canadian culture because we have similarities with our cultures except that family bonding seems to be tighter with our cultures rather than Canadian culture. The way of life I think similarity being friendly to other people. You know, you find the Canadians being also friendly similar to our culture without discriminating any other cultures.

Olivia believed that to understand Canadian culture you need to immerse yourself in it. Hanna and Emmy believed that doing a job facilitated learning Canadian culture. Hanna learned about Canadian culture through language, and working helped her to mingle with Canadians.

Of course, culture is different. First thing is language. Language is a big obstacle. How to move with the culture? I think first thing is you have to get a job, if you want to get into the culture. Because if you are just staying home or just stay in the class room, you learn something from there, but actually you are not getting into the society or community.

Canada announced a policy of multiculturalism in 1971 and the goal of the policy was to improve the quality of intercultural relations (Berry, 2013). According to the Government of Canada's (2014, para. 2) official web site, "Canadian multiculturalism is

fundamental to our belief that all citizens are equal. Multiculturalism ensures that all citizens can keep their identities, can take pride in their ancestry and have a sense of belonging.” By promoting multiculturalism, Canada helps immigrants to keep the cultural values of their homeland and still integrate into Canadian society.

Peter emphasized the importance of identifying the multicultural nature of Canadian society when adapting to Canadian culture. He believed that in a multicultural society, one can survive while protecting his or her own cultural values. This is how he explained the details:

It is different, but I aware of it. It was more like one person. Our cultures like family cultures. Here it is like one person culture. So that way it was pretty different. Actually, what happened from my country we went to Middle East? There also it was pretty multicultural so it was a sort of transition for me. It was not a straight shock for me.

Anna filtered out Canadian cultural norms that were not compatible with her homeland’s cultural values and only accepted what was compatible with her homeland’s values. She further elaborated the ways she learned about Canadian culture:

Just being around young moms with children my child’s age, listening to the way they talked about their lives, what they do during their day, what things they do for fun that helped me a lot.

Hospital culture

Five of the practising physicians (Amanda, Tanya, Mark, John, and David) revealed that they faced a number of challenges during the residency training. They linked these challenges to the differences between Canadian hospital culture and their homelands’ hospital cultures. This is how Amanda saw the differences between the two hospital settings.

Number one total system, number two medications, names, and number three how to manage things.

Residency training was a struggle for Tanya. She never used a pager in her homeland, so it was a novel experience for her. Tanya also noticed a number of differences in clinical settings:

In our country, you have a room, you are sitting over there, patient comes and then examine. Here, it is very different. We have consulting rooms and you go from one room to another and the patient is ready so one big difference and what patients expect from you is very different and the way you have to communicate very different from back home... Like here you cannot tell about one person to their family. In our country, family comes first and they want to know and it doesn't matter. Here, if you tell the family, they can sue you so it was a bit different.

John admitted that Canadian medical residency is quite challenging compared to his homeland residency, due to the differences in expectations, hours of work, and patient concerns. Residency training was a stressful exercise for David. He had a fear of being expelled from the residency and having to go back to being a security guard. To ensure his survival in the program, he worked as hard as he could. He advised other AIMGs to keep other avenues open (like pursuing a master's degree) in case something goes wrong during the residency training.

Oh! Very difficult, every time you should pass assessment. Every two months you should go, you might not pass the assessment. It depends on who is your preceptor. Who might like you? This might be a bias. You don't know ever. Every two months you go through the assessment. You don't know you are continued to be a doctor or you back out of residency and you are security guard again. This is very stressful two years. You are a doctor or security guard. This is why I am talking about master degree some background you have. If you are not a doctor, you are doing something descent, not again security guard something related to your education you are doing.

Amanda emphasized the importance of having an open mind in order to be successful in the residency training.

If you are open and if you observe them and you try to learn instead of having your own mind set, I think you are successful. You should learn what other things

they want in their system and culture. It was different compared to our health care system, but it is not hard and for sure, I tell lot of my colleagues and people who are struggling. I know there are challenges, but we have to have this open mind in order to be successful, we should learn their system. Some people try to impose their ideas. That doesn't work at all. They made the system and they know what it is and you have to go with that. Throughout my residency I learned that. For sure, we all are doctors and we have clinical skills. Nobody challenges that; only trouble is learning the culture, accepting the culture and try to merge into that.

Mark and Tanya both experienced uncertainty when they were dealing with their preceptors. Mark believed that preceptors expected more from AIMG residents than from the same level of Canadian residents because preceptors knew that AIMGs already had previous residency and clinical experience. Below is Tanya's perception of preceptors.

What I found was very tough because the preceptors they will be nice, they won't say any word, but when they give evaluation seems that it is not the same situation. I think they should keep telling this is not the way; this is the way, and what is lacking. It should be ongoing and I think preceptors should be more empathetic to the residents. Not just for us, even for Canadian graduates whoever it is.

On the other hand, two practising physicians (Nick and Peter) revealed that they did not face any challenges during the residency training. Nick enjoyed residency training and believed that his homeland medical knowledge was beneficial in successfully completing the Canadian residency training. Due to the clinical experience Peter received in other countries and Canada (as a clinical assistant), residency training was not a challenge for him.

Even I had than my senior resident. I didn't have any problems and pass the exam right away.

4.4.4 Family

Living with family can have both favorable and unfavorable consequences for an AIMG while navigating towards licensure. Living with family becomes a burden when an AIMG needs to spend time and energy to support his or her family instead of working

towards obtaining licensure. On the other hand, living with family becomes a support or morale booster when an AIMG receives emotional and financial support from a spouse or family members to prepare for his or her licensure. Family factors are discussed under two sub-categories: family commitments and family support.

Family commitments

When AIMGs do both work and study, it is hard to find time for both. On top of this, to find references AIMGs need to observe or job shadow a doctor. When both husband and wife are professionals, both need to spend time and money to obtain their medical licenses. This situation becomes even more challenging when they have children. Male and female AIMGs played different roles as described in the following section.

Male role

As bread winners, male AIMGs faced additional challenges compared to their female counterparts. In some situations, male AIMGs had to do labor jobs which required physical work. In some cases, the wives could not work because they had to look after children. John struggled to find time to study due to various family commitments.

I had to bring bread to the table and at the same time I had to take the evaluating and qualifying exams. At the same time, I had to do some job shadowing and get Canadian reference letters so it was very tough.

Peter explained his family responsibilities. He needed additional finances because they were expecting a third baby during their early years of immigration. Peter added how he found time to study while working.

I did two things. After my EE exam, which was after eight months, I started looking for a job and I got a security job. That helped me to do night shifts. Night shifts usually, they put you in a place that and sit somewhere else and you keep going every hour. Practically, I sit and every forty five minutes, I get up and walk around, do my job, come back and sit again. This was kind of nights. This was a

kind of job that gave me some money and some time to study, and the same time sits and do the job.

Bill postponed his exam preparations until he was financially established.

When we came here, initially, I fixed onto establish the family here to get back to normal life. At that time, I was quite young and I think I still have time so I didn't start to prepare for the exams by I came here. I focused on to get a good career or get a good job first so I initially worked as a researcher at the university because of the lack of funding so at last I lost my job and there I studied computer programming at the university trying to get a good job. I cannot leave my family in one bed room apartment suit for ever and my son never gets a gift of ten dollars so I tried to make money to support the family.

Some AIMGs believed that family commitments impeded their journey to licensure.

They have purposefully postponed having children. For example, David and his wife postponed having a baby until they re-established their careers and were financially secure.

We couldn't afford children because we were preparing we were thinking if we get a child done, our medical goal kind little bit of suffering this way not having children early.

David explained how he studied while working.

But those jobs, during security, you read, and group home jobs you have time too, when disabled people sleep, I used all these time to prepare.

Female role

Females had different roles which affected their attempts to become licensed. In several cases, the female participants had to stay home to provide child care. As a result, Anna, Hanna, and Emmy postponed exam preparation. This is how Olivia explained her experiences.

That's the reason, I became very slow. I couldn't concentrate on my studies . . . my children were small and I had to take care of them too. No other support to take care of them so it was always hard.

Nancy had to do night shifts, because she needed to look after her children while her husband was at work.

It was really stressful because I worked after five o'clock. I had to wait until my husband comes home because kids need to be looked after. When he came home I went to work. I came at 10 o'clock. In the weekends my husband worked doing night shifts.

Pregnancy affected financial status as well as studies. As newcomers, AIMGs had limited social networks and underwent the ante-partum and post-partum periods without any external support. This is how Hanna explained her post-partum experience.

I think most stressful time in my life. When I had my first kid, actually, I experienced serious challenges because my husband was at full time studying, and I stayed at home with my first kid, and I had C-sections for my kid. All the things happened, when I ended up with infection. I consider I had the post-partum blue, because I knew, I was quite stressful and I had quite weird thoughts.

In addition, she had lactation problems. When her incision became infected, she did not know where to go for help. Fortunately, after a month, her parents visited and helped her. Like Hanna, Anna also experienced postpartum depression. This is her story.

I just came out giving birth to a child and had to go through depression and it was a tough time. I had postpartum depression and this result came on top of it and it was bad. It was a bad time.

In some situations, female AIMGs like Anna sacrificed their time and labour by allowing their spouses to continue their studies. Reflecting about her spouse, Anna said:

He was working and doing his exams at the same time while I was working part time just to get by. Because, like I said, I have to work and my child was very young.

Family support

For AIMGs, preparing for licensing while struggling to survive was emotionally draining. Many study participants appreciated the support they received from their spouses. They elaborated on how this support gave them the time and freedom to focus

on their studies. Emmy acknowledged the support and love she received from her husband.

He was very cooperative he helped me a lot. Sometimes, his exams were there and my exams were there. That was a tough time. We put our son to bed and we both studied. That was tough.

Anna received support from her husband as well as from her son.

Well, during my first and second exams, my husband and older son, they were pretty cool and they were very supportive like my husband was very good and he did everything when I was studying.

Emmy's husband motivated her to do exams and encouraged to obtain her licensure.

My husband wants me to work as a physician as well and he said why you are wasting your time, and I think that's right I should be working as a physician and so how I started and I wanted to do my exams.

Nick recounted the support he received from his wife.

At that time, I have my wife there. Things were so easier because my wife helped me a lot, in terms of English application, support as a friend and as a wife. She encouraged me a lot. I am thinking that without her I wouldn't have made it. That was a big support having said that I am very stubborn and it wouldn't happen without her.

Peter recounted the stresses he had dealt with and believed without support from his wife he could not have obtained his license.

Without family support, you cannot get through this because this is a very big stress. If you get stress from the family you get double stressed. But my wife understood and she always helped me and supported me.

John suffered from stress and anxiety during his journey to licensure; support from his wife was the key to his recovery.

Again as I mentioned it was very tough and I had periods of stress and anxiety and depression and all of the above, but with the support of my wife, family, and friends, I was lucky to go through those difficulties.

4.4.5 Networks

For an AIMG, networking is a deciding factor in obtaining a residency position. The Oxford online dictionary defines networking as “interacting with others to exchange information and develop professional or social contacts” (“Network,” n.d.). Networking helps AIMGs to connect with fellow AIMGs and also with Canadian physicians. An individual with an expanded network can receive more benefits than an individual who has a poor network. An AIMG who studies and works alone faces professional isolation. On the other hand, an AIMG with an expanded network can connect with colleagues to receive up-to-date information about the relicensing process. In addition, networking is useful in forming and joining study groups, and also in boosting morale. Furthermore, connecting with Canadian physicians helps AIMGs to find observership positions and thereby to obtain Canadian references. In the following, I will present two sub-themes: networking with fellow AIMGs and networking with Canadian physicians.

Networking with fellow AIMGs

For an AIMG, the AIMGA user group is a vital channel and a safe place to share information and connect with fellow AIMGs. Furthermore, the AIMGA is used as a platform to make demands for more residency spots, and to discuss challenges faced by AIMGs within the AIMG program. One of the study participants, Tanya, believed that AIMGA strengthens the bond among AIMGs. She added that the work done by AIMGA cannot be achieved by members working individually. The electronic group forum run by the AIMGA is a useful way to make contact with fellow AIMGs. This is how Nancy explained the benefits of this forum.

AIMGs communicate through emails most of the time so there is a common Yahoo group. Yahoo group is very useful. For example, let say, if I need to buy

some books, sometimes they advertised about books and sometimes they email about study groups and like generally those things.

John explained that networking is talking to people, introducing yourself, learning others' details, and offering and receiving help. Many AIMGs believed that networking and sharing experiences amongst themselves was very useful. Social networking allowed Peter to develop friendships with other AIMGs who received residency positions and to follow their steps to obtain his medical licensure. Amanda explained how she benefited by interacting with fellow AIMGs.

It is helpful. We learn from others' experiences; people are successful; people are not successful; see what is going on; what is wrong; something wrong in your resume; something wrong in your personal letter; something wrong in your communication. You can learn because we all are in same boat. We all are. Some are behind; some are there; some are not.

Other benefits of networking are to obtain study materials and to form study groups to prepare for tests like the OSCE and QEII. Mark believed that the best way to socialize was to join groups of foreign physicians and study together. John and David emphasized that joining study groups helped them to keep their spirits up by witnessing how other AIMGs were struggling to achieve the same goals. In addition, study groups not only helped David to study medicine, but also provided support. For Bill, study groups helped him to know how other people were preparing for exams and put pressure on him to study hard. Emmy received study materials from one of her friends to prepare for the MCC exams.

One of the girls I met when I was in my work place, I told her that I don't have MCQs and she told me to come and she gave me. The only resources I was using. She gave me everything pass papers and some assessment papers and these kind of things.

Like Emmy, Amanda got help to prepare for QEII.

We are all here to help other. Like, I came here because somebody helped me. There were one of my friends, I never forget her. For QEII, I have no experience so I talked to her. She said come over, do some cases with me and I did cases and she told me this is wrong; do this way. So I looked at those people who give time and helped me. There are people already to help. Newcomer should have that; one should get the feedback, improve to have that enthusiasm. They learn things. It is not impossible.

Networking with Canadian physicians

Networking with Canadian physicians is useful for AIMGs to find observerships and to collect the three Canadian reference letters needed to apply for residency positions. As a newcomer it is a crucial requirement, and most AIMGs work hard to build up links with Canadian physicians. In the following, I provide findings under two sub-headings: observerships, and Canadian references.

Observerships

Many study participants highlighted the importance of networking to find observerships. To obtain references, all AIMGs must do observerships or doctor shadowing with a Canadian physician. As newcomers, it was hard for them to find physicians willing to offer observerships. At present, there are no formal provincial observership programs, although some positions are provided by the MCAP and the AIMGA. After passing the exams, John focused on networking and observerships to obtain the required references. He attended half days with residents and did observerships with physicians at the hospital. Nancy believed that a good network would help her to find observerships and thereby the Canadian references, but it might take time. Amanda participated in a number of observerships. She did her first observership with her family physician and did the second with a friend's family physician. Her roles during the

oberverships were to show her interest and to learn. Mark recounted how he began on networking with Canadian physicians and the benefits he received.

Like the first time when I came to Canada, I didn't know anybody, I didn't know any physicians so what I did was as a specialist in my country, I approached one of the specialists related to my field here and he was so good enough. He entertained me; he gave me the information and luckily he was a foreign doctor too before he practised in Canada. He was the one who introduced me to the clinical assistant program. Nobody tells you that so it is very important to get information from what's going on around you so you know options.

Anna felt badly about not living in a major city where the main hospitals and universities are located. These cities have more opportunities for networking and observerships. In some cases it is even possible to do observerships with examiners. She believed that recruiters tend to select applicants who are familiar to them. She felt that this familiarity made the difference. To find an observership, Nick personally contacted an emergency physician and the physician helped Nick to complete oberverships in gynecology, surgery, psychiatry, internal medicine, and family medicine.

On the other hand, some study participants faced difficulties finding observership positions. For Peter and John, it was hard to believe that a Canadian physician offered observerships to AIMGs without any knowledge of the AIMG. To find oberverships, an AIMG needed to contact a physician through a third person who had some contacts with the physician. This is how John explained his experience.

Because in many occasions, I was not allowed to join for job shadowing or to attend because they don't know me, but if I introduce through somebody, then it is easy to overcome that obstacle. But, if you come from the door and introduce yourself, nobody knows you then probably that won't help.

Olivia asked for observerships from many physicians but only a few physicians offered her observerships.

I asked from so many places, but only few people gave me.

David could not find an observership on his own.

I didn't like to go to everybody and ask for observerships and everybody says no. So it was very difficult for long time. MCAP program helped to find out an observership. I myself couldn't find an observership.

Observerships help AIMGs become familiar with the Canadian medical system. Emmy disclosed how she became used to the Canadian clinical environment and subsequently her mentor built up his confidence in her.

But in my case, initially, he wasn't because initially I went there he expects me to do know each and everything because it was long time so I missed few things. He was not very happy. With time he got confidence on me. I see him how he is doing and I worked with him for three to four years. He helped me a lot and now he knows how much I know.

Unlike other study participants, Anna and Olivia expressed their displeasure about observerships. For Olivia, observerships were not useful in improving her skills and knowledge. It only generated negative memories. Similarly, Anna expressed her negative feelings this way.

I don't think observerships are helpful. They are not helpful at all because in an office setting they are always rushing and like time constrain. I didn't feel like I really got lot of it. Even if I did get a chance of examination, it was a very quick examination, just listen to this and do that because they are always time constraints and depending on the person I working with some of them even didn't take time to discuss things. Some of them are really good; take time to discuss and motivate you to go back read and bring new information, but most of them didn't really care. So I didn't really feel that is very helpful in terms of clinical experience it wasn't.

Canadian references

Study participants explained the meaning of "a good reference" in number of ways. Nancy assumed that good references made a big difference when all the candidates had equivalent qualifications. Nancy further believed that when hiring, recruiters favored those applicants who had worked with recruiters or worked with persons known to

recruiters. Bill believed in the “right reference” and not the “good reference.” This is how Bill defined the “right reference.”

Right reference means you have to get into the field. You have to know somebody or you have to have somebody in that field and give you the reference. For example, if you apply for pathology, if you know a pathologist, if he or she can give you a reference, you can get in easily or if he or she is a medical directors there may be much easier to get in. So it is not a good reference, it is a right reference. That’s the difference between these two.

A number of study participants—John, Peter, and Mark—stressed the value of having a Canadian reference. Peter claimed that many AIMGs make the mistake of taking reference letters from doctors of the same ethnic background. He assumed reference letters received from physicians with the same ethnic background had a lower value. This is how John explained the need for a Canadian reference:

References are very important because if you bring a reference from outside Canada, nobody can verify this reference letter. But, if you bring a reference from here somebody in Canada, usually the program directors and decision makers pick the phone and phone whoever wrote this letter. They ask specific questions so they can verify things.

David thought it was unfair to compare references brought from different sources. He wanted everyone to get the references from the same source. David felt sorry for his wife. She had better exam results than he did but she could not get a good reference. He perceived that Canadian references are more powerful than the exam marks.

You don’t know references are a little bit kind of luck. I understand it is important. You are failing in everything is fine, but mean time it should be fair like same people give references to everybody. If it is that, it would be fair, but if everybody comes with different references don’t know it is fair to compare those references. I would find twenty referees in one city. They should see everybody write down then you can compare it really would work like otherwise it is just luck I don’t know how lucky you are and how many connections you have that you can help you.

Amanda disclosed the secret of receiving good references.

People are good. Some might say no we are busy. You are not imposing yourself on them. Always I was there on time. I have seen some observers don't come on time. How can they get a good reference? I was always there before my doctor, 15 minutes before. You can do something small simple which was helpful. It seems that you are interested. Everything has its own way to do things.

4.4.6 Institutional rules

Institutional rules can be either facilitators or barriers. Unlike other factors, institutional rules are difficult to negotiate because these factors are beyond the control of the AIMG. In Canada, licensing of physicians and the delivery of health care services is the responsibility of the provinces (Wong & Lohfeld, 2008). In Alberta, selection of AIMGs for residency training is the responsibility of the Alberta International Medical Graduate Program (AIMGP), which was established in 2001. Study participants identified some of the rules and regulations introduced by the AIMGP as barriers. On the other hand, different bridging programs conducted by government institutions act as facilitators. The barriers are discussed under five sub-headings: current selection process; language proficiency requirements; Canadian Studying Abroad (CSA); limited residency spots; and number of exams. The facilitators are discussed under three sub-headings: Medical Communication Assessment Project (MCAP), Calgary Clinical Assistant Program (CCAP), and study groups at Bow Valley College.

Institutional barriers

Current selection process

All of the non-practising and four practising AIMGs revealed their displeasure with the process and procedures adopted by the AIMG program to select candidates for residency positions. They believed that the selection process itself is a major barrier. They noted that AIMGP was not helping them to find residency spots; instead, AIMGP

imposed more obstacles by bringing in new rules or changing the existing rules. The following quotes provide some of the participants' perceptions about AIMGP.

Peter expressed his displeasure about AIMGP's regularly changing rules and introducing new rules.

They kept coming up with new rules. In Alberta, every year, something comes up with new changes. We need to get support, stupid sometimes.

He was frustrated about the selection procedure adopted by the AIMGP and believed that the current process was unfair. He implied that AIMGP was trying to filter AIMGs in unfair ways. Hanna had similar perceptions about the selection process of AIMGs for residency positions.

I think what we have is very useless criteria for selecting IMGs for residency, and also it is not transparent. You don't know what criteria they use. They should give something everybody can see . . . they should implement some sort of tools to assess IMGs. The tool should be individual because your background is different.

Bill believed that the government was not sincere in its effort to integrate AIMGs into the Canadian health care system. He charged that AIMGP wants to keep AIMGs as a labour pool. Nancy expressed her unhappiness about the lack of clarity of the selection process and complained that AIMGP does not have an appeal process.

I do not understand how the program works. For example, no appeal process, no explanation given. If I take an example, if somebody pay application fees and submitted the application, they have right to know why their application is rejected, but they don't give explanations for that. It is a huge barrier.

On the other hand, Amanda, David, and John were happy about the selection process of the AIMGP. Though John received a residency position only in his second attempt, he believed that AIMGP is a good program. This is how Amanda recounted her pleasure about the AIMGP.

It was good. We have spots. We are competing with own people: all AIMGs. I think it is easier, I think CaRMS is difficult because you are competing with Canadians. But AIMG program was good.

Language proficiency requirements

Study participants showed their displeasure with the language proficiency policies of the AIMGP. In general, IELTS or TOEFL test results are valid for two years. However, AIMGP required AIMGs to take the language proficiency tests every year. They also commented about the wasting of money and time required to redo the exams. Study participants were also not happy about the AIMGP decision not to accept TOEFL after 2016. This is how Emmy disclosed her displeasure about AIMGP's language policy.

I think AIMGP is not very good because though I have valid ILETS, they don't accept it. Now they are saying that within few years they are going to stop accepting TOEFL and only do the ILETS. That's okay, but they should accept IELTS, if it is still valid. That's everywhere in Canada only AIMGP said, or if you give ILETS like I did in January, but they are not going to accept it.

Nick argued that individuals who reside in an English-speaking country improve their language skills daily. He asked, as an AIMG who had once passed the language proficiency test, why he would need to retake the test.

I can challenge an English speaker to do the TOEFL, they don't get hundred percent. I remember when I was taking the Canadian bench mark exam, they can increase little bit more and that is what you are exactly doing. Why they need TOEFL? Who is behind that? You have to pay over and over for those exams, though you pass, it is only valid for two years. I wonder why you have to write English exams frequently, if you are living in an English speaking country. Do Canadians have to do it all the time? If you pass it once, you keep learning every day. You have to pay for that; you have to travel to do that.

Canadian Studying Abroad (CSA)

At present the AIMGP uses the same assessment and recruitment policies to award residency spots for both immigrant AIMGs and CSAs. Study participants believed that it is unfair to use the same assessment scheme. They charged that the AIMGP

favoured CSAs over AIMGs because of their younger age, cultural background, and English proficiency. The CaRMS estimated that 3,500 Canadians are currently studying medicine in countries like Ireland and Poland and are seeking residency training in Canada. In 2012 more than 200 CSAs were successfully matched to a Canadian residency position (Canadian Medical Association, 2014).

To alleviate the situation, Emmy suggested:

For CSAs and IMGs, there should be separate programs. If they prefer CSA, they should set the program differently, but handling them as IMGs then it would be difficult for those who are living in Canada for long time like me, you, and other people. CSAs come and take our seats. What's the point and they might say you away from practise for seven years. I think they should do something about that. Like either make their programs separate from IMGs.

This is how Bill saw the advantages experienced by CSAs.

What I can see is they have better chance to get in. First of all, they don't have a language problem so they don't need to pass the English exam and English exam is one of the barriers for IMGs and second, they have better networking skills because they have families as far as I know according to an article published in Medical Post, 20% of those Canadian born IMGs their parents either one or both are doctors here. So they can easily get observerships and they can do some clinical rounds with their parents, friends or relatives and also very importantly they have better financial supports from their family so they are easily get in and yes that what I can see. They have high ratio of opportunities, better opportunities to get in.

Limited number of residency spots

To obtain the medical license, AIMGs are required to receive postgraduate medical training at either the University of Alberta or the University of Calgary. A number of study participants commented about the lack of residency spots available for AIMGs to complete their postgraduate training. They understood the existence of monetary obstacles to increase the number of residency spots, but believed that government needs to take meaningful steps to integrate AIMGs into the Alberta health

care system. The number of available residency spots has not increased in proportion to the number of AIMGs living in Alberta. This is how Emmy described her frustration.

I think it may be difficult for them to increase the residency seats, but there should be something they should do. I know it is hard for them to, but now we have new hospital opened, but there are no residency positions there. They do not increase residency seats. Instead, they decreased the seats last year. I think government should do something about those things. Also like clinical assistant program, is very good, but if they increase the seats and increase the pay. That would be very good.

Due to the lack of residency spots, many talented AIMGs cannot obtain residency training. Bill believed that AIMGs need to work extra hard to stand out from the others and receive a residency spot.

The issue is seats for IMGs are very limited. So if you look at the big picture, there can be many IMGs cannot get back into their career for sure because the number of seats available for them. Individually, you need to work diligently, study hard, and marked in the little bit and get to know the persons you supposed to know then you increase your chance to get in.

Number of exams

The present licensure includes a set of costly and time consuming exams: EE, QEI, QEII, and NAC-OSCE. All are conducted by the MCC. Some AIMGs have questioned the need to do similar exams twice:e.g. NAC-OSCE and QEII. They believe that it is a waste of time and money. Peter questioned the need for Mini Mental Interviews (MMI).

Then they came with MMI. These are ridiculous. What use of those; AIMGP is supposed to facilitate the process, but not to complicate this.

Emmy compared the number of exams in Australia to Canada, and pointed out that the lengthy exam process is one of the reasons why AIMGs in Canada lack recent clinical practice.

In Australia, they have just two exams. One is like QEI. One is clinical. I think two exams are enough. They don't need to have EE. They don't need to have QEI, QEII then OSCE, which is almost as QEII. I think this is a waste of our money and time. And then by the time we finished every exam then they say, you are away from practice for long time. They don't take us for residency just because we are away from practice for more than four years so because of their process they are having. I think they should at least give one written exam one clinical exam which is enough to assess a person.

In contrast, two participants, Bill and John, agreed that exams are needed to filter AIMGs. They believed AIMGs are a heterogeneous group and it is necessary to have a system to filter AIMGs.

The exam is necessary because as far as I know there are big variations in medical education across the world so we cannot assume that medical graduates from other schools should able to practise here that's not the case so exams are necessary to get qualified.

Institutional facilitators

During recent years, the Alberta government has introduced a number of bridging programs to improve AIMG integration into Alberta health services. Participants discussed the details of these bridging programs. Although these programs have made some progress, there remains much work to be done. The following sections provide the current resources and programs that helped AIMGs to obtain their licensure, as revealed by the study participants.

Medical Communication Assessment Project (MCAP)

The Medical Communication Assessment Project (MCAP) began started in 2006 and is funded by four organizations: Citizenship and Immigration Canada, Alberta Employment and Immigration, Alberta Health and Wellness, and Community Programs in Advanced Education. According to its official web site, the main objective of MCAP is to improve the language and communication skills and cultural understanding of AIMGs.

Study participants disclosed that MCAP helped them find networks and observerships, and pass the OSCE. MCAP helped Nick to locate fellow AIMGs and to learn more about the Canadian health care system.

But the MCAP that was an eye opening because I understood that Canadian medicine is just more than what I knew. I understand the concept of patient centered care: how to break bad news, famous five things in patient management. The other thing is that you realized that you are not the only one go through this whole process. There are a lot of people who are in the same situation at different levels. They are going through the same situation. That helped a lot because at same time while we are doing this, the MCAP also prepare for you to understand the Canadian medical culture.

This is how Amanda benefitted from the MCAP.

MCAP was very good. We did lot there. Lot of discussions and I think may be in that program got good recommendations because we used to do case base. There were few cases, they recorded my cases and we used it afterwards and other program...one thing for sure I did whatever the feedback I got I tried to improve myself every day, every time, and every minute.

Calgary Clinical Assistant Program (CCAP)

The Calgary Clinical Assistant Program (CCAP) was intended to develop qualified applicants for the Alberta residency programs. Clinical Assistants (CAs) were given the freedom to actively participate in clinical interactions with patients and receive hands-on experience. A number of study participants (John, Peter, Mark, and Emmy) positively commented about the CCAP. For John, the CCAP was a stepping stone for residency.

I think that was a very excellent program because it was like a stepping stones for me from out of practice to go into residency. I worked as a clinical assistant basically, like a resident under supervision of a head physician.

Bow Valley College study groups

Some study participants positively commented about the study groups organized by Bow Valley College in Calgary to help AIMGs prepare for their licensure exams.

Nancy believed that AIMGs can understand and become familiar with the Canadian health care system by attending the study groups.

It gave opportunities to meet other IMGs and there were like practising Canadian doctors came for the lectures and programs. That was helpful because being IMGs most of us are not working in the real hospital setting or Canadian health care system and it wasn't easy to enter the system so we did not know what it was. So we understood the Canadian health care system through those doctors.

This is how Hanna described the program.

Yes, I did participate last year. Actually, idea was quite good. There were some physicians who were previous IMGs. They come over to the class and do little bit practical questions, and they have little bit of discussions. There are two classes. One is preparing for QEI and other one is for the OSCE.

4.4.7 Intrapersonal characteristics

For an AIMG, intrapersonal characteristics or personality traits play a dominant role in obtaining a residency position. The Oxford online dictionary defines intrapersonal as “taking place or existing within the mind” (“Intrapersonal,” n.d.). According to Feeney (2006), intrapersonal characteristics are individual differences in personality. The intrapersonal characteristics were identified using the study participants’ actions, words, and facial expressions. Some examples include resilience, dedication, positivity, persistence, and flexibility that were helpful during the process to obtain a Canadian medical license. Study participants revealed that for an AIMG with intrapersonal characteristics like giving up, meaninglessness, and confusion, made it difficult to navigate licensure successfully.

Many study participants revealed details of hardships they underwent during their journey to licensure. They believed that resettling and relicensing were two major life events occurring in both psychological and pragmatic perspectives. The majority of participants were positive with their subjective experience. They had future-oriented

positive feelings like optimism, hope, and faith. Furthermore, study participants also had positive individual traits including courage, perseverance, self-determination, and self-esteem. The words used by the study participants showcased their traits. These traits helped AIMGs to negotiate barriers and facilitators in a state of equanimity. In the following, I will provide direct quotes of AIMGs. Though Anna faced financial and cultural challenges during her initial settlement as a new immigrant, she opted to think thoughts which uplifted her morale and analyzed situations constructively.

It was very hard at the beginning, but you just have to keep talking to yourself: things will get better, things will get better, we will make it better, and that was the only way.

Olivia had hopes about her future, which were the main driving force for her survival.

Like all AIMGs, my hope, my dream, my life, and my everything is getting into residency.

While working and preparing for exams, David looked for other choices such as a master's degree. Similar to David, Peter also tried different options: clinical assistant, surgical assistant, and residency. Peter had high self-esteem and did not want to put all his eggs into one basket.

Somebody did it, I can do it. That's my goal like. If saw somebody did it, I can do it. Might take some time . . . The most of the doctors gave up, but I never thought of giving up . . . I was the guy who tried everything on me by myself.

John did not lose his determination, even after seven years of trying when he finally received a residency.

It was a tough journey. It was hard, but with the perseverance, at some point, after seven years passing the exams and not getting anything . . .

In another case, Nancy's hopes kept her alive.

First, it was a surprise, but I understood over couple of years that it was not like sudden. I think I was hoping, I wanted to believe I can practise so I passed the first exam and I was keeping my hopes high and I passed the second exam and

then when I applied to the residency process, may be the first time, I was still hoping high after the second year . . . I am still hopeful.

In many societies around the world, physicians experience high social status. After immigration, Nick had to work as a labourer to survive. He had terrible feelings after his first day of work. After lengthy deliberations, he continued to work as a labourer.

My first day of the work, it was the hardest. I worked in where I required to work. I came out and I sat on my little truck. I looked at myself and I was full of dust and all the fumes and everything. I looked like slept inside of a muffler. When people are sad they say that they feel like an apple in their throat so I felt like having a watermelon in my throat that I couldn't swallow. It was really bad. I felt sad. But how I overcame this feeling was that I knew that I have to work hard.

Nick did an observership at a hospital, but could not continue his observership due to objections from a staff member. However, being resilient and being optimistic helped him to forget that incident and prepare for his exams. He wanted to do his best.

“Why would I escape? Only thing that I did is believe in myself with lot of faith and tried to do my best. The best I could do.”

Some study participants, like Tanya, learned from their mistakes and looked for the bright side in everything they did and recognized the surprising benefits within them.

Because I had to do everything by myself, I got confidence. When you have challenges, you overcome them. You know, you get confidence...Persistence means there will be challenges and keep trying if you don't get it. Try next time. Don't give up. Sometimes people say, this is not going to work for me. You don't get it once; you don't pass the exam once. If you can't do once, try again. Maybe something was missing. Read more; you learn more . . . don't give up. If you don't pass exam, accept it and work harder and then you will find oh! I didn't know; so many things can be positive.

Rather than blaming the system, Amanda followed the system and moved forward by identifying and correcting her weaknesses. She focused on exams and identified her deficiencies, and made improvements. Receiving negative feedback is not easy because it hurts one's feelings. However, Amanda wanted to be good and believed that receiving negative feedback was an incredible opportunity to learn and grow.

I got feedbacks. I never criticize my feedbacks. Even sometimes, when you were doing fine, but somebody told you; no, this was not right; you didn't do this way and you need to do this way so I learnt. Every moment I learnt. I didn't argue. I think these are the ones I don't know . . . things will work out very well and just listen to, when I was doing residency, my preceptor was so sure, may be ten years younger than me. Fresh graduate, but I have to do what she thinks and what she says. I have to accept the positive feedback, the negative feedback. Change your ways. What feedback you give, people get feedbacks and improve your way. That what is in my mind and I think it helped me a lot.

The members of strong families stand by each other during times of hardships and have a sense of loyalty towards other family members. Both Emmy and her husband were dedicated, believed in themselves and assumed they could frame a bright future. They uttered “can” more than “cannot.”

I was telling my husband that if someone else meets this, he or she might go back. My husband was very dedicated. He said no we can do this like that.

In another example, when Anna's husband became depressed, she motivated him.

I stopped him; we came so far; we don't go back; you are going to make it; we are going to make it; things are going to get better so I think I always talking positive, thinking positive, we are getting better, you are making it, we are not going to give up now; here we are not going back.

In addition to the intrapersonal characteristics described above, one AIMG (Hanna) described how she felt in the following quote:

Now I am thinking of quitting. I decided that I am not going along this pathway. I don't know how other IMGs think. I know some of them. They are still quite young or they don't have a big family to consider. They might consider getting into the system. For me, I am thinking I do not like to continue...all your money, all your time, all your family time, and to do something, where there is no hope.

4.5 Summary

The study participants revealed that seven key factors played dominant roles when preparing for licensure. These key factors play dual roles. The availability of factors acts as facilitators, and unavailability or lacking of factors acts as barriers. The following summarizes the key findings of the seven factors.

i. Finances

For the majority of the study participants, low income, difficulties in finding first employment, and expenses acted as financial challenges for relicensing. On the other hand, financial support received from spouses or family members acted as facilitators.

ii. Language

The majority of interview participants spoke about different language challenges they faced. To improve English proficiency, some of the study participants attended English classes and the others did self-studies.

iii. Family

For an AIMG, living with family had both advantages and disadvantages. On one hand, preparing for licensure was a challenge because AIMGs had to spend money and time to interact with their families. However, the emotional and financial supports they received from their families were useful because the journey to licensure was an emotionally and physically draining process.

iv. Institutional rules

The AIMGP is the organization responsible for selecting AIMGs for residency positions. Study participants revealed that the current selection process, English proficiency requirements, competition, limited residency spots, and the number of exams were seen as barriers. On the other hand, the number of bridging programs like MCAP, CCAP, and study groups organized by Bow Valley College acted as facilitators.

v. Culture

AIMGs needed to adapt to two cultural settings: Canadian society and the hospital setting. Interacting with local people and doing a job helped AIMGs to learn about Canadian society. Strenuous work, being open, Canadian clinical experience, and self-confidence helped AIMGs to become accustomed to the Canadian healthcare setting.

vi. Networks

AIMGs with an expanded network connected with fellow AIMGs to receive current information about the relicensing process, to form and join study groups, and to develop self-confidence. In addition, networking with Canadian physicians helped AIMGs to find observership positions and thereby to obtain Canadian references necessary to apply for residency positions.

vii. Intrapersonal characteristics

Positive intrapersonal characteristics like optimism, hope, faith, courage, perseverance, self-determination, and self-esteem helped AIMGs to obtain medical licensure. On the other hand, negative intrapersonal characteristics like giving up, meaninglessness and confusion impeded the licensing process.

4.6 Conclusions

This chapter discussed the perceptions of both practising and non-practicing AIMGs. Seven key factors emerged after analyzing the interview data using Charmaz's (2014) constructivist grounded theory. The identified factors were financial, language, family, institutional, cultural adaptation, networking, and intrapersonal. Quotes from the study participants were used to explain how AIMGs negotiated the above seven factors to work toward medical licensure. The next chapter compares the meaning of the research findings with the available literature.

CHAPTER FIVE: DISCUSSION, RECOMMENDATIONS AND CONCLUSION

This chapter provides details about the meaning of the study findings in relation to the current literature; in addition, the significance of the findings is also discussed within the context of the two theories: acculturation and institutional were used in the research. Finally, the remaining topics that will be discussed are the limitations of the study, recommendations for future research, education and policy development, the process of dissemination that will be used to distribute the research findings, and conclusions.

5.1 Research Findings Related to the Current Literature and Research Questions

This research identified five themes: (1) arriving with dreams, (2) trying to make a home when you cannot find a house, (3) relationships make the difference, (4) new rules, and (5) making a new reality. These themes symbolize the resettlement and relicensing experiences of AIMGs. The five themes led me to recognize seven factors which AIMGs needed to negotiate to receive their medical licensure. In this section, the process for resettlement and relicensing and ways in which the AIMGs negotiated the seven factors to obtain Canadian medical license are examined in relation to relevant literature. The identified themes and factors affect both the resettlement and relicensing processes. The answers to the two research questions cannot be separated from each other but are embedded together. In the following sections, identified themes are discussed in the context of the available literature while also incorporating the factors that needed to be negotiated by the participants for successful licensure.

5.1.1 Arriving with dreams

Immigrants believe Canada is a “land of opportunity” (Khan & Watson, 2005, p. 313). AIMGs immigrated to Canada with a wide set of dreams to practice medicine in Canada. Some of the dreams were similar to, and consistent with, the research findings in the literature. Many IMGs misjudged the Canadian medical licensure process before coming to Canada (De Carvalho, 2008). According to Choudhry (2001), immigrants bring educational and training opportunities with them; however, there are several threats against these opportunities. Choudhry’s findings are congruent with my research findings. Other researchers have shown that a main stimulus for immigration was to achieve a bright future for newcomers and their families (Maraj, 1996). The notion of IMGs coming with dreams has received little attention in published literature. More research needs to be conducted in the future to explore the immigrants’ unawareness about ground situation in Canadian job market.

The factors identified in my study helped to explain how the AIMGs negotiated barriers and facilitators during the resettling and relicensing process after arriving to Canada. Therefore, arriving with dreams does not neatly fit with the factors but is a precursor to the resettling and relicensing process. The other themes however are more amenable to linking them with the factors associated with licensure as the following discussion notes.

5.1.2 Trying to make a home when you cannot find a house

After immigration, participants faced a number of challenges when they were trying to establish their new Canadian home. According to Khan and Watson (2005), immigrants expect a thriving future; however, in many instances, these expectations are

not immediately fulfilled. I identified three key factors that participants had to negotiate in order to positively affect their resettling and relicensing process: finances, language, and culture. These three factors are discussed in the following sections.

Finance

The current study findings revealed that both financial difficulties and financial support were relevant during the licensure process. Low income, difficulty in finding initial employment, and expenses created financial difficulties and negatively impacted the licensing of AIMGs. Some of the AIMGs had to postpone their licensing process until they achieved financial stability. A number of AIMGs in the sample worked as labourers and security guards in order to finance the licensing process and to support their families. Statistics Canada (2007) identified a lack of Canadian experience as the most common barrier for newcomers searching for employment. A number of recent studies demonstrated similar findings. A cross-sectional survey conducted using a group of 21 IMGs in Ontario who were in the process of licensing showed that the limited financial resources of IMGs negatively impacted the licensing process (Sharieff & Zakus, 2006). Another study conducted in Ontario with eight IMGs revealed that a significant number of IMGs did not work at their professional level and faced financial challenges during relicensing (De Carvalho, 2007). Similar findings were revealed by a study using 176 IMGs, internationally-educated nurses and midwives who were recruited from four Canadian provinces (Bourgeault et al., 2010). The authors found that the exorbitant expenses required to finance preparation for a series of professional examinations were a huge barrier. Furthermore, the amount of money IMGs brought to Canada as skilled workers was inadequate and forced them to acquire low level employment while

studying. This impacts IMGs' economic status while illustrating the positive relationship between their economic status and type of employment which is not paid well. In a similar study, a lack of finances was also found to be a barrier for IMGs who wished to undergo costly evaluations and assessments (Masalmeh, 2009). The IMGs' financial situation deteriorated due to the lack of employment opportunities which matched IMGs' qualifications and the reluctance of employers to recruit IMGs to other available employment. The current study findings also revealed that the financial obligations of the study participants towards their family were also significant. According to CaRMS (as cited in Walsh & Banner, 2011) IMGs have more social and financial obligations including spouses and children than Canadian medical graduates.

On the other hand, according to the present study findings, financial support from one's spouse or family members acted as a facilitator. Another study conducted with six practising IMGs from three major cities (Toronto, Montreal, and Vancouver) revealed that having financial support was very important at the initial stage of the IMGs' licencing process (Kohn, 2010). Based upon the findings of another study, loans, scholarships, and lines of credit would improve IMGs' financial status (Masalmeh, 2009). Furthermore, this author recommended providing financial incentives to employers who hire IMGs and subsidizing some of the fees required to absorb IMGs into their workforce.

Language

The study participants in the current study were a diverse group of physicians who emigrated from a number of countries. The majority agreed that the English language presented a challenge for them in terms of medical terminology, passing

English proficiency exams, and day-to-day communication. While working and preparing for Canadian medical licensure, study participants had to find the time and finances for their English exam preparation. For most, finding time to study English was the hardest part. On the other hand, the current study revealed that some of the participants had sound English language skills, which facilitated their licensing processes.

Similar to the current study results, a number of other authors have revealed that language was a major challenge for IMGs, and that IMGs who have competency in the English language faced fewer challenges. A qualitative study conducted in Calgary with ten practising IMGs who emigrated from four different countries revealed that IMGs who studied medicine in English in their homelands did not have many challenges compared to IMGs who studied medicine in other languages (Eyford, 2011). Furthermore, the author stressed that language competency is important for IMGs to pass the OSCE and MMI exams, and also noted that it is important for IMGs to master not only the technical language skills, but also day-to-day conversation. Likewise, another author revealed that language incompetency was a challenge for IMGs in Ontario during their initial settlement (De Carvalho, 2007). Citing the findings of Chur-Hansen, Khon (2010) claimed that passing English proficiency exams does not guarantee the effective communication skills that are required during the residency training.

A study was conducted at in the US with 20 IMGs in the internal medicine residency training program to understand the relationship between English language skills and success as a medical resident (Eggy, Musial, & Smulowitz, 1999). Language skills were assessed using two tests, and success as a medical resident was evaluated by patient satisfaction surveys, colleague and faculty evaluations, and an objective test of

clinical medicine. The results of this study showed that IMGs' language skills were significantly correlated with patient satisfaction. Despite IMGs receiving high scores for language proficiency tests, faculty members, patients, and colleagues who interacted with the IMGs gave poor scores for their languages skills. Furthermore, the researchers found that there was no relationship between the IMGs' language scores and their clinical skills.

In the current study, five participants revealed that the MCAP helped them to improve their verbal and nonverbal communication skills. An IMG-patient communication study conducted at the University of Toronto with program directors of residency programs and IMGs identified that IMGs' communication difficulties with patients and with team members were the most pressing needs for improvement (Zulla, Baerlocher, & Verma, 2008). Other authors noted that preceptors need to understand the communication barriers faced by IMGs and identify strategies that may help in training future IMGs (Jain & Krieger, 2011). Furthermore, two other research teams noted that IMGs have difficulty understanding the nonmedical and colloquial language and the process needed to disclose medical issues to patients (Hall et al., 2004; Walsh & Banner, 2011).

Bourgeault et al. (2010) revealed that passing the English proficiency exams does not guarantee IMGs' effective workplace communication. Qualitative research conducted in Ontario with 15 IMGs who were in the process of licensing and three educators affiliated with interview support, language, and cultural bridging programs revealed that IMGs with poor English language skills encountered considerable difficulties in passing English proficiency exams and facing residency interviews (Colette, 2012).

Culture

Another important factor underpinning the licensing process is cultural adaptation. During the research, it was revealed that AIMGs need to adapt to two cultural settings: Canadian society and the hospital setting.

Adapting to the Canadian society

A number of facilitators were identified that helped the study participants' adaptation to Canadian society. Language proficiency and obtaining employment helped study participants to interact with Canadians and to learn about Canadian society. Furthermore, existence of multiculturalism and living with their own homeland people put less cultural stress on AIMGs and helped them to survive by maintaining their own cultural integrity. For some study participants, previous exposure to European cultures helped with the adaptation to Canadian culture. In addition, personal attitudes (flexibility, openness, and willingness to change) helped to ease their cultural adaptation. On the other hand, AIMGs who lacked those qualities were slow in cultural adaptation. A review of the literature yielded only a few studies about IMGs' adaptation to Canadian society. Therefore, more research needs to be conducted on AIMGs' adaptation to Canadian society. The findings of the available literature supporting the current research findings are detailed below.

Austin (2007) noted that international pharmacists in Ontario needed to adjust to two different cultural settings: national and professional. He used the term "double-culture shock" to describe the experiences encountered by the international pharmacists during their adjustment to two different cultural environments (p. 239). He further pointed out that adjustment to national culture is facilitated by living with one's own

cultural community and proficiency in the dominant language. Interviewing eight non-practising IMGs who lived in Ontario found that acculturation into Canadian culture was a dramatic experience for IMGs due to their lack of language proficiency and poor understanding of Canadian culture (De Carvalho, 2007). In another study, it was found that for IMGs to achieve their ultimate licensure goal, it is important for them to become accustomed to Canadian society (Kohn, 2010). The study further revealed that IMGs who were proficient in English easily adapted to Canadian culture.

Adapting to hospital culture

Findings from my research demonstrated that there were numerous challenges faced by the AIMGs during their residency training. These challenges were attributed to the differences in Canadian and AIMGs' homeland hospital cultures. The identified differences were: patient management, medical terminologies, training expectations, disclosing confidential information, use of technology, and patients' and preceptors' expectations. Study participants disclosed that being flexible, prior Canadian and international clinical experience, and good communication skills helped them to become accustomed to the Canadian hospital culture.

A narrative study of the acculturation experience of ten practising IMGs who came from four different countries concluded that previous experience and having certain personality types (determined, bossy, tenacious, optimistic or flexible) were important in the IMGs' acculturation into the Canadian health care setting (Eyford, 2011). These conclusions complement the current research findings. The lack of cultural competency in a Canadian clinical setting is a challenge when integrating internationally educated health professionals into the Canadian health care system (Bourgeault et al., 2010).

Another research study highlighted a number of issues affecting externally funded (by foreign governments) residents in Canada (Hall et al., 2004). The researchers identified that IMGs were lacking knowledge about the health care system and specific patient management skills. They also emphasized the importance of educating the faculty and staff about cultural challenges faced by IMGs. In contrast, another study revealed that the majority of IMGs did not feel that they lacked skills and competence but rather they felt that “they are differentially perceived and treated in the application and assessment” (Foster, 2008, p. 12).

5.1.3 Relationships make the difference

Study participants identified relationships as a key to resettling and relicensing in Canada. Whittebrood and Robertson (1991) emphasized the need of supportive relationships during resettlement. Relationships can be broadly divided into relationships among family members and relationships among professional members. These relationships are discussed under the two relevant factors: family and networks respectively.

Family

According to the current study, living within a family can be either a barrier or a facilitator. My findings revealed that each gender has different family obligations. The majority of the male AIMGs had to provide sufficient funds so that their family could be supported and hence they had to work while studying. This limited the time available for their licencing as well as providing an additional burden on them. Similarly, some of the female AIMGs postponed their licensing process to allow their husbands to complete

their professional exams. Pregnancy and child care were other family burdens faced by female AIMGs.

A few authors have discussed IMGs' family commitments. For instance, the majority of IMGs who immigrated to Canada with their families and had other numerous family commitments which further aggravated their financial difficulties and hence affected the time available for exam preparation (Bourgeault et al., 2010). These authors also noted that gender played an important role among females during their licencing process. In some instances, female IMGs were not receiving adequate support from their families to obtain a Canadian medical licence. Another study conducted using CSAs and immigrant IMGs registered for 2002 CaRMS match revealed that immigrant IMGs were older and had more family obligations than CSAs (Szafran, Crutcher, Banner, & Watanabe, 2005). CAPER (2012) also noted that in 2010/11 family medicine IMG residents were 7.6 years older than Canadian family medicine residents.

My research revealed that living within a family is an advantage because income and emotional support received from spouses facilitated AIMGs' journey to licensure. Immigrating with their family is beneficial for IMGs because living with the family is helpful to relieve stress and to receive emotional support from the family (Bourgeault et al., 2010; Khon, 2010). Other research has stressed the importance of receiving support from family members during major stressful periods (Bloom, 1990).

Networks

All of the study participants in my research accepted the fact that AIMGs with an expanded network can connect with peers to receive up-to-date information about the relicensing process, to form and join study groups, and to develop self-confidence. In

addition, participants stated that networking with Canadian physicians helps them to find observership positions and thereby to obtain the Canadian references to apply for residency positions. An AIMG with poor networking ability lags behind.

To date, limited research has been conducted on IMGs' professional networking. Those who were successfully integrated into the Canadian medical stream believed that professional networking was one of the key facilitators to their success (Bourgeault et al., 2010). The authors used the term "professional diaspora" to describe the networking with people who belonged to the same profession (p. 113). They also noted that when forming a professional diaspora, one's ethnic background is not essential; however, shared values and meaning play an important role. Research on international pharmacists revealed that a lack of connection with one's professional community may cause professional marginalization and impede the licencing process (Austin, 2007). Statistics Canada (2011) supported the perceptions held by the study participants of my study regarding networking to find employment and other opportunities. Statistics Canada also stated that immigrants relied on friends and internet to find employment. IMGs' current entry into clinical observerships was based on factors such as networking skills and luck (Colette, 2012). These study participants believed that doing observerships would enhance their chances to receive a residency position. This is in congruent with the opinions of my study participants. Furthermore, I found that Canadian reference letters are essential to obtain a residency position. Colette (2012) was not clear about how relative preference an IMG would receive for a reference letter obtained by completing a short duration observership compared to a professional reference letter from the IMG's homeland.

5.1.4 New rules

The medical profession in Canada is regulated by each province individually. Participants disclosed their displeasure with the introduction of new rules that overrode existing rules, believing that the changes would affect their journey to Canadian medical licensure. One of the barriers was the re-evaluation of foreign credentials. Guo (2009, p. 1) also noted that foreign credentials of immigrants were “devaluated and denigrated.” The high educational and professional background of the participants gave an added a psychological burden to professionals who felt that they were “uprooted and dislocated from their place of origin” (Khan & Watson, 2005, p. 314). The theme, *new rules* symbolizes the institutional rules that affected the licencing process.

Institutional rules

In Alberta, the AIMGP is responsible for assessment and placement of AIMGs for residency positions. During the interviews, seven participants in my study revealed a number of drawbacks of the AIMGP, including a lack of transparency in the current selection process, regularly changing rules and procedures, competition from Canadian Studying Abroad (CSA), and limited residency positions. However, six of the study participants expressed their pleasure about the procedure adopted by the AIMGP to recruit AIMGs for residency positions. In addition, a number of bridging programs (MCAP, CCAP, and study groups organized by Bow Valley College) were identified as institutional facilitators.

There are similar findings from other studies. For example, the selection process in Ontario was not transparent and ambiguous because the selection body did not publish the selection criteria (Colette, 2012). This author further stressed that the applicants were

not provided any feedback to improve their performances. Another study identified a number of institutional barriers in the Ontario licensing process: exam expenses, number of exams (EE, QEI, QEII, and NAC-OSCE), few numbers of residency spots, and length and lack of transparency of the licensing process (De Carvalho, 2007).

Bourgeault et al. (2010) found that the selection process was not transparent and noted the lack of communication between the IEHPs and the stakeholders of the integration process. In another study, Brotén (2008, p. 5) revealed that the present selection process was a “cookie cutter approach” and emphasized the need to form a new assessment protocol where candidates are individually assessed for skills and educational qualifications. Similar to the perceptions of the current study participants, two other researchers noted that CSAs have preference when being awarded residency positions (Colette, 2012; Foster, 2008). Furthermore, they pointed out that every year, the number of CSAs applying for residency position increases. For example, in the last three years, the number of CSAs who applied for the CaRMS matches has doubled (Walsh & Banner, 2011). This further dilutes the chances of IMGs’ absorption into the residency training program. Furthermore, the authors noted that at present, though a significant number of IMGs are absorbed into the Canadian residency programs, the number of unmatched applicants remains high relative to the matched applicants. Masalmeh (2009) urged authorities to take meaningful steps to accommodate IMGs into residency programs without allowing IMGs to accumulate.

The literature search also revealed that little research has been conducted on bridging programs. Participants from two different studies had positive perceptions about different bridging programs (Bourgeault et al., 2010; Colette, 2012), leading the authors

to conclude that bridging programs were useful to enhance communication skills and the cultural competency of IMGs.

5.1.5 Making a new reality

According to Guo (2009), due to the existence of multiple barriers, foreign professionals faced additional challenges when integrating into Canadian system. Once they realized the existing reality of the licencing process, participants tried to remap their professional expectations. During the remapping, participants' intrapersonal characteristics play an important role. The *theme making a new reality* leads to identify intrapersonal characteristics.

Intrapersonal Characteristics

Participants identified a number of positive intrapersonal factors (optimism, resilience, hope, faith, courage, perseverance, self-determination, and self-esteem) which helped them to face challenges and to obtain medical licensure. However, negative intrapersonal factors such as giving up, meaninglessness and confusion also impede the licencing process and were noted by participants.

These findings are supported by a number of other authors. IMGs who successfully integrated into the Canadian medical stream were “being proactive,” a key facilitator for their success (Bourgeault et al., 2010, p. 94). Being proactive included self-initiative, determination, and self-confidence. One of the IMGs’ preceptors admired the “flexibility and determination” of IMGs undertaking residency training at the University of Saskatchewan (Greenberg, 2006, p. 718). He further praised IMGs’ courage: “the struggles of these courageous men and women to obtain a residency spot in a Canadian department of medicine are worthy of legend” (p. 718). Being resilient is an important

factor for IMGs to successfully complete the licensing process (Khon, 2010). He further stated that IMGs should see the whole licensing process in positive sense to successfully work toward Canadian medical license. Another research study explored the strategies which facilitate IMGs' integration into the Australian health care system, and noted that during the licensure process IMGs need to hear the supporting messages of "keep positive, hopeful and not to give up" (McGrath, Henderson, & Phillips, 2009, p. 846). An Australian cohort study included 479 family practitioners and identified resilience as a key component of "well-being is an important factor in medical training to help doctors learn to cope with challenges, stress, and adversity" (Eley et al., 2013, p. 1). The findings of Eley et al. appear applicable not only for practicing physicians but also to the IMGs who are pursuing residency positions because for IMGs, receiving residency positions and completing the residency training are two equally daunting tasks. A similar study conducted in the Netherlands with 32 IMGs noted that their intrapersonal qualities of persistence and flexibility had helped them to shape their careers (Huijskens, Hooshian, Scherbier, & Horst, 2010).

In summary, the majority of my study findings are congruent with past research. For example, many researchers have identified finances, language, family, culture, networks, institutional rules, and intrapersonal characteristics as keys to receiving Canadian medical licensure. On the other hand, two unique findings have emerged from the current study: the importance of Canadian reference letters to receiving a residency position and the value of openness during assimilating into the Canadian hospital culture.

5.2 Research Findings in the Context of Acculturation Theory

In this section, Berry's (1997) acculturation theory is used to describe the multidimensional interactions between AIMGs who emigrated from different parts of the world and Canadian society. Acculturation theory has its roots in anthropology and is extensively used in sociological analysis (Berry, 2001). The process of acculturation is complex, and information available in the literature is inconclusive (Berry & Sam, 1997). Acculturation involves cultural and psychological changes due to contact between two or more cultural groups (Berry, 2005). Normally, during acculturation, the minority group becomes adapted to the cultural patterns of the dominant group. However, acculturation is a reciprocal process: "everyone is involved, and everyone is doing it" (Berry, 2005, p. 700). The discriminating attitudes of the host society may negatively affect the acculturation of new immigrants (Padilha & Perez, 2003).

Each individual follows acculturation in a unique way and four distinct acculturation strategies exist: assimilation, separation, integration, and marginalization (Berry, 1997). During the assimilation, individuals leave their original cultural values behind and integrate into the host culture. Separation appears in situations where individuals want to keep their original cultural values and refuse to integrate into the host culture. Integration is used to describe situations where individuals integrate into the host culture while keeping their own cultural identity. Integrated individuals experience lower acculturation stress (Zeng & Berry, 1991). According to the same authors, acculturative stress is a psychological stress that is linked to acculturation. Finally, marginalization is the situation where individuals neither keep their original cultural values nor participate in the activities of the host culture, and this often results in exclusion or discrimination.

The choice among the above four strategies is based on the political, economic, and demographic backgrounds of the original and hosting societies (Eyford, 2011).

Study participants revealed their acculturation experiences. Once they immigrated to Canada, AIMGs underwent acculturation in different stages. The information provided by the study participants clearly illustrated their acculturation strategies. In the following two sections, I will explain AIMGs' acculturation strategies for adapting to Canadian society and hospital culture.

5.2.1 Adapting to the Canadian society

The ultimate goal of almost all AIMGs is to obtain Canadian medical licensure to practice medicine in Canada. To achieve this goal, immigrant AIMGs need to interact with individuals at different levels of Canadian society to achieve cultural competency. The study findings revealed that the study participants followed two main acculturating strategies: integration and assimilation.

Integration is only possible in multicultural societies (Berry & Kalin, 1995). Because Canada is a multicultural society, the majority of AIMGs preferred integration as their acculturation strategy. Furthermore, for an individual to give up his or her own cultural values is not an easy task and the adaptation strategy of an immigrant is partly dependent on the policies promoted by the society (Van Oudenhoven, Prins, & Buunk, 1998). An individual can have high self-esteem by keeping his or her own cultural values during cultural adaptation (Tajfel & Turner, 1979; Zeng & Berry, 1991). Therefore, in choosing the integration strategy, study participants could maintain high self-esteem. In addition, learning about Canadian society was crucial for their survival.

A number of examples can be drawn from the current study participants to illustrate cultural integration. Peter chose integration, as he believed that Canada is a multicultural society; he would survive while protecting his own cultural values. Another study participant, Anna screened out Canadian cultural values that were not acceptable to her and only accepted what was right to her. Amanda was willing to become a part of the new culture and she integrated into Canadian society with an open mind. However, she did not forget to wear her hijab. By wearing a hijab she showed her connection to her homeland culture. Although integration is the preferred adaptation strategy of AIMGs, only one study participant used assimilation. He set aside his homeland cultural values; religion, language, and customs, and assimilated into Canadian society.

5.2.2 Adapting to the hospital culture

The importance of cultural competency in health care settings is well recognized (Eyford, 2011; Flores, 2000; Koehn & Swick, 2006). Adapting to Canadian hospital culture is a type of assimilation. AIMGs who emigrate from all over the world need to leave their homeland hospital cultures behind and assimilate into Canadian hospital culture. As one of the study participants, Amanda noted, residency training is a period of cultural adaptation and she described her adaptation experiences as follows:

Some people try to impose their ideas. That doesn't work at all. They made the system and they know what it is and you have to go with that. Throughout my residency I learned that.

To receive a license to practice medicine in Canada, AIMGs need to pass four exams and need to complete a minimum of two years of residency training. The residency training is a form of cultural orientation and the timeline required to pass the

exams and complete the residency training is “reasonable proxy” to measure adaptation to Canadian hospital culture (Eyford, 2011, p. 6).

In summary, my research findings compliment Berry’s (1997) acculturation theory, and the findings illustrated that AIMGs followed two different acculturation strategies when adapting to Canadian society and Canadian hospital culture. AIMGs were more positive toward integration when adapting to Canadian society, because many AIMGs wanted to keep their own cultural values while interacting with Canadian society. For AIMGs, assimilation was the only choice when adapting to Canadian hospital culture. The current research findings are similar to those of Van Oudenhoven, Prins, and Buunk’s (1998) research conducted in the Netherlands with Turkish and Moroccan immigrants. They stated that immigrants to the Netherlands prefer to the integration because integration provides low acculturation stress and high self-esteem. The context of the present study is insufficient to document marginalized and separated AIMGs, because in general marginalized and separated groups might have returned to their homeland rather than staying in Canada.

5.3 Research Findings in the Context of Institutional Theory

In this section, I discuss the application of institutional theory to explain why it is highly competitive for AIMGs to obtain their medical license in Alberta, Canada. Institutional theory is not “a coherent system of rules—it is rather a collection of ideas that together form a somewhat consistent, perspective of the mechanisms supporting and restricting social behaviour” (Bjorck, 2004, p. 1). Some ideas in the context of the present research are: number, content and structure of exams; selection procedure for residency spots; number of residency spots; duration of residency training; and language

competency requirements. Institutional theory views the definition and structure of professions as “following socially constructed patterns” (Salaff & Greve, 2003, p. 444).

The Canadian professional regulatory institutions and the state used institutionalized processes to exclude immigrants from upper segments of the labour market and give preference to Canadian born and Canadian educated workers (Bauder, 2003).

The current barriers encountered by AIMGs during their licensing have deep roots in policies and procedures adopted by many government, medical, and professional institutions. The majority of AIMGs migrate to Canada either as skilled labourers or as spouses to a skilled immigrant. CIC uses a point system based on education and training qualification to select skilled labor immigrants. However, the education and training skills recognized by the federal government institution (CIC) to grant landed immigrant status to AIMGs is not recognized by the provincial professional associations. Because of this mismatch, to receive Canadian medical licensure, AIMGs need to successfully complete a number of exams and residency training. Participants revealed that passing the exams was not difficult. However, receiving a residency spot is highly competitive because only a limited number of residency spots are offered to AIMGs.

Many North American professions define recruitment standards for their employees (Collins, 1979). The medical profession has the toughest regulations (Bauder, 2003). At present, Canada only accepts medical degrees from a few selected countries: Australia, the United Kingdom, Ireland, Switzerland, Singapore, Hong Kong, New Zealand and South Africa (CPSO, 2014), and closes its doors to medical graduates from other countries. Ultimately, the country of education becomes a criterion to receive a Canadian medical license. The MCC, created in 1912, is responsible for the evaluation of

physicians and maintains the Canadian medical registry which contains the details of physicians who are qualified to practice medicine in Canada. To receive a medical license, MCC requires AIMGs to pass four exams. In addition, provincial professional bodies demand additional requirements for IMGs to satisfy in order to receive a residency position (Bauder, 2003).

In Canada, professional associations control the decentralized accreditation system (Collins, 1979; Johnson, 1972). For example, the College of Physicians and Surgeons of Alberta (CPSA) regulates the practice of medicine in Alberta. Alberta's Health Professions Act granted the CPSA the privilege of self-regulation. Furthermore, AIMGP is responsible for the assessment and recruitment of AIMGs for residency positions. As discussed in the section 4.4.4, the study participants commented on the institutionalized actions of AIMGP, which limit the access of many talented AIMGs who want to integrate into the Alberta health care system. Bauder (2003) identified the professional organizations as "gate keepers" (p. 703). When professional associations control the labour supply through certification and licensing, they create monopolies (Salaff & Greve, 2003).

It is generally accepted that post-secondary and higher education qualifications provide better employment opportunities (Alboim, Finnie, & Meng, 2005). However, institutionalists noted that immigrants' level of education "symbolizes" and does not "equal the competence or the labor market value" (Salaff & Greve, 2003, p. 452). AIMGs receive their educational and clinical qualifications (cultural capital) from homeland institutions. The cultural capitals shaped by the homeland institutions are often mismatched with the cultural capital needs of Canadian institutions. This mismatch

causes numerous difficulties during AIMGs' licensing process. The authors further argued that migration alters the career paths of immigrants, and it is hard to connect a foreign career to an institutionalized career in a host country; former physicians have the most barriers to receiving a medical license to practise. For example, only five percent of IMGs receive their Canadian medical license (Bauder, 2003).

The current study findings support the institutional theory. Study participants in the current study believed that the policies and procedures adopted by the professional associations controlled the relicensing of AIMGs. In many situations, these policies and procedures act as barriers for AIMGs to receive residency spots. At the same time, the policies and procedures of professional bodies are adesigned to maintain the standard of Canadian medical practice.

5.4 Limitations of the Study

The current research was conducted in a credible manner; however, there exist a number of limitations as discussed below.

Although there are different sampling procedures that can be employed in qualitative research, it is vital to choose a sampling that ensures participants are meaningfully and strategically recruited (Liamputpong, 2014). Due to the busy and tight scheduling of practicing AIMGs, it was difficult for me to recruit practicing AIMGs. I used snowball sampling and relied on the study participants to help me recruit both practising and non-practising AIMGs. However, this may have resulted in homogeneous sample with limited diversity of perspectives.

Another limitation of this study is the generalizability of results, which is common to all qualitative research. According to Glaser (1992, p. 106), "generalizing to a

larger population is a unit orientation that is not appropriate to grounded theory.”

Furthermore, according to Todres (2005, p. 109), the intention of qualitative sampling is about “quality but not size.” Though it is difficult to replicate the findings of this study, it can be used as a platform for other research because other IMGs might possess similar experiences.

The credibility and confirmability of the research findings can be improved by the method of triangulation (Patton, 1990). Triangulation is the term used by land surveyors to locate a point by using two known points (Bitsch, 2005). There are four types of triangulation: data, investigator, theory, and methodological. One method of data triangulation is collecting information from diverse informants (Shenton, 2004). This study only employed data triangulation by incorporating views and perceptions of two groups of informants: practicing and non-practicing AIMGs. Thus credibility and confirmability of the research findings are limited.

To provide a holistic picture of the licensure process of AIMGs, it is beneficial to incorporate views from a number of stakeholders including non-practicing AIMGs, practicing AIMGs, AIMGs currently in residency programs, AIMGP steering committee members and AIMG preceptors into the study. This study only incorporated the views of practicing and non-practicing AIMGs. If I had incorporated more categories of stakeholders into the current study, the data might have generated richer findings.

5.5 Recommendations for Future Research

The present research examined how AIMGs negotiated barriers and facilitators during their journey to obtaining medical licensure. The findings of the current research can be used as a platform to conduct further research as outlined below.

One of the disadvantages of qualitative research is the lack of generalizability. Generalizability is defined as the degree to which the study results can be generalized from the study sample to the entire population (Polit & Hungler, 1991). Since qualitative research studies collect data from selected study participants, the research conclusions are unique to them. It is not correct to extrapolate research findings to other situations and people unless they have similar or comparable conditions to the specific group of individuals used for the study. To overcome this, I recommend developing a questionnaire to conduct a quantitative study with a larger random sample covering the whole province to quantify the challenges faced by AIMGs. The results of this type of quantitative study might be more representative of the population of AIMGs.

I recommended that a qualitative study be conducted involving the members of the management teams of different professional bodies to explore the impacts of institutional policies and procedures adopted by professional bodies on the relicensing experience of AIMGs. The current research did not incorporate the perceptions and views of members of the management team of different professional bodies. This type of study may be useful in furthering our understanding of the design, purpose, and implementations of the current policy framework.

The barriers and facilitators faced by the AIMGs are dynamic and may not be valid for future situations. Therefore, a similar study should be conducted in the future, and those study findings can be compared with the current study findings to identify how the barriers and facilitators change over time.

Canadians Studying Abroad (CSAs) and AIMGs compete for residency positions through the same pathway. The study participants of the current study revealed that this

competition is an additional challenge for them. Conducting a qualitative study to explore the barriers and facilitators faced by CSAs would generate information about the similarities and differences faced by IMGs and whether the journey to licensure is the same for both groups.

Participants in the current study positively commented about the effectiveness of bridging programs. Therefore, to enhance our understanding of acculturation theory, we need to conduct a mixed methods study that investigates the effectiveness of bridging programs and the inter-relationship with acculturation. A mixed method study provides both qualitative and quantitative data. For example, to find out the effectiveness of the bridging program, a paired sample t-test can be used. In addition, face-to-face individual interviews with open-ended questions can be used to assess the acculturation strategies of study participants.

5.6 Education and Policy Development

The goal of this research was to identify how AIMGs negotiated barriers and facilitators during the relicensing and resettling process. The findings of this research led to recommendations for developing policies and procedures to facilitate successful integration of AIMGs into the medical profession. Over the time, many positive changes have taken place, but to date, there are still some gaps and challenges.

1. Observerships

At present, there is no province-wide organized way to provide observerships for AIMGs. Observerships facilitate AIMGs' acculturation into Canadian hospital culture to obtain references and to keep in touch with clinical work. On the other hand, clinical observerships are not considered training or work experience and do not provide any

monetary benefit to participants. Furthermore, at present, only a limited number of observership spots are available through the MCAP and AIMGA, and these observerships are offered only in major cities. To cover the above shortcomings, study participants suggest that the observership programs need to:

- allow AIMGs not only to observe, but also to actively engage (for example, provide opportunities for AIMGs to take histories and to do physical examinations) in clinical practices under the guidance of a mentoring physician.

In addition, based on my experience, I would like to suggest following

- be provided throughout the entire province, and last at least once a year,
- use the EE certificate as an eligibility criterion to offer observerships, and
- be rotational observerships covering different disciplines such as family medicine, gynecology and obstetrics, surgery, pediatrics, internal medicine, and psychiatry.

2. Institutional barriers

Many study participants expressed their frustration with existing policies and procedures of the AIMGP Program. The study participants emphasized that AIMGP frequently changes existing policies and introduces new policies without prior notice. For example, English proficiency requirements (cutoff marks and validity period) and Alberta residency requirements are frequently changed. Furthermore, at present, AIMGP does not provide any reasoning when applications for OSCE are rejected and there is no transparent appealing process. Currently, AIMGs need to compete with CSAs for limited residency spots, and AIMGs believe that CSAs have more chances to receive residency

positions due to CSAs' sound English language skills and cultural competencies. Study participants proposed the following. The AIMGP needs to:

- provide more residency spots and clinical assistant spots for AIMGs,
- maintain a transparent selection and appealing process,
- provide adequate time periods to change rules and regulations before implementing any changes, and
- establish a different pathway to recruit CSAs.

3. Alternate pathways

AIMGs' Canadian medical council credentials (EE, QEI, and QEII) are only good to receive either clinical assistant positions or residency positions and these credentials have limited value when applying for other positions. Only a few AIMGs receive residency or clinical assistant positions and the remainder are forced to work in other fields. To cover the above shortcomings, study participants suggest that to:

- establish a physician assistant program in Alberta (like in Manitoba).

In addition, I would suggest the followings:

- create a special after-degree medicine program (2-3 years long) for AIMGs, similar to the University of Lethbridge's Bachelor of Nursing (BN) after degree program. AIMGs who successfully complete the medicine after degree program will be considered for the same residency positions as for the Canadian medical graduates, and
- MCC credentials (EE, QEI and QEII) should be used as added qualifications to do graduate degree programs in other health-related fields.

4. Database of AIMGs

I would suggest to conduct a survey on AIMGs to identify their issues and to prepare an AIMG database. The information collected can be used to develop policies to integrate AIMGs into the Canadian health care system. The AIMG database should include the following information about AIMGs:

- country of origin,
- current status (practicing, non-practising, or moved to different professions),
- education credentials and clinical skills,
- gender, age, and marital status, and
- number of years since immigration

5.7 Process of Dissemination

So far, to disseminate preliminary research findings I have made two presentations at the Meeting of the Minds, University of Lethbridge (Spring 2014 and Spring 2013), one presentation at the first Campus Alberta Student Conference on Health, Banff (CASCH) (Fall 2013) and a poster presentation at the third Annual Research Poster Day, Faculty of Health Sciences, University of Lethbridge (Fall 2013). During the presentations, I shared research findings with conference participants. I plan to share research findings with AIMGP and AIMGA officials. Finally, I am in the process of preparing an article to be published in a peer-reviewed journal to disseminate my research findings within the scientific community to foster greater awareness and show the challenges faced by the AIMGs, and to urge authorities to undertake meaningful steps to integrate more AIMGs into Alberta Health Services by improving the current licensing process.

5.8 Conclusions

The aim of this research was to examine how AIMGs negotiated barriers and facilitators towards their journey to Canadian medical licensure by incorporating the views and perceptions of two study groups: practicing and non-practicing AIMGs. It was revealed that each study participant had his or her unique way of resettlement and relicensure. The analysis of data using the Charmaz (2014) constructivist grounded theory generated seven factors that were key to the successful licensure of AIMGs: finances, language, family, cultural, networks, institutional rules, and intrapersonal characteristics. A theoretical framework was developed to explain how AIMGs negotiated the above seven factors to obtain a Canadian medical license. Acculturation theory was used to explain the cultural adaptation of AIMGs and institutional theory was used to explain the how existing policies and regulations act as barriers to the licensing of AIMGs. The findings of this research also brought new ideas to integrate more AIMGs to the Alberta health care system.

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APPENDICES

Appendix A

Certificate of Approval from the University of Lethbridge HSRC

CERTIFICATE OF HUMAN PARTICIPANT RESEARCH
University of Lethbridge
Human Subject Research Committee

PRINCIPAL INVESTIGATOR: Roshanee Baddegamage De Silva

ADDRESS: Faculty of Health Sciences
University of Lethbridge
4401 University Drive
Lethbridge, AB T1K 3M4

PROJECT TITLE: Theorizing the Barriers and Facilitators to Relicensing
and Resettling of Albertan International Medical
Graduates

INTERNAL FILE: 2013-049

INFORMED CONSENT: Yes

LENGTH OF APPROVAL: July 22, 2013 – March 24, 2014

The Human Subject Research Committee, having reviewed the above-named proposal on matters relating to the ethics of human research, approves the procedures proposed and certifies that the treatment of human participants will be in accordance with the Tri-Council Policy Statement, the Health Information Act, and University policy.

Susan Doty, Ethics Officer

Human Subject Research Committee

July 22, 2013

Date

Appendix B

Certificate of Approval from the University of Calgary CHREB



UNIVERSITY OF
CALGARY

Conjoint Health Research Ethics Board
Research Services Office
3rd Floor Mackinnie Library Tower (MLT 300)
2500 University Drive, NW
Calgary AB T2N 1N4
Telephone: (403) 220-7990
Fax: (403) 289-0693
chreb@ucalgary.ca

CERTIFICATION OF INSTITUTIONAL ETHICS REVIEW

This is to certify that the Conjoint Health Research Ethics Board at the University of Calgary has examined the following research proposal and found the proposed research involving human participants to be in accordance with University of Calgary Guidelines and the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans 2010* (TCPS 2). This form and accompanying letter constitute the Certification of Institutional Ethics Review.

Ethics ID: REB13-0958
Principal Investigator: Ian Mitchell,
Co-Investigator(s): There are no items to display
Student Co-Investigator(s): Roshanee De Silva
Study Title: Theorizing the barriers and facilitators to relicensing and resettling of Albertan international medical graduates
Sponsor (if applicable):

Effective: December 11, 2013

Expires: December 11, 2014

Restrictions:

This Certification is subject to the following conditions:

1. Approval is granted only for the project and purposes described in the application.
2. Any modification to the authorized study must be submitted to the Chair, Conjoint Health Research Ethics Board for approval.
3. An annual report must be submitted within 30 days prior to expiry date of this Certification, and should provide the expected completion date for the study.
4. A final report must be sent to the Board when the project is complete or terminated.

Approved By:

Christopher R. Sears, PhD, Chair , CHREB

Date:

December 11, 2013

Appendix C

Certificate of Approval from the University of Alberta REMO

Approval Form

Date: November 4, 2013
Study ID: Pro00042496
Principal Investigator: Roshanee De Silva
Study Title: Theorizing the barriers and facilitators to relicensing and resettling of Albertan international medical graduates
Approval Expiry Date: November 3, 2014

Thank you for submitting the above study to the Health Research Ethics Board - Health Panel. Your application has been reviewed and approved on behalf of the committee.

A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Health Research Ethics Board does not encompass authorization to access the patients, staff or resources of Alberta Health Services or other local health care institutions for the purposes of the research. Enquiries regarding Alberta Health Services approvals should be directed to (780) 407-6041. Enquiries regarding Covenant Health should be directed to (780) 735-2274.

Sincerely,

Glen J. Pearson, BSc, BScPhm, PharmD, FCSHP
Associate Chair, Health Research Ethics Board - Health Panel

Note: This correspondence includes an electronic signature (validation and approval via an online system).

Appendix D

Informed Consent Form-Non Practising AIMGs

Study Title

Theorizing the Barriers and Facilitators to Relicensing and Resettling of Albertan International Medical Graduates

Purpose of the Research

I am being invited to participate voluntarily in the above-titled research project. I have been informed that the purpose of this project is to explore the impacts of barriers and facilitators on Albertan International Medical Graduates' relicensing and resettling process.

Inclusion Criteria

I have been included into this study due to followings:

- a non-practising IMG,
- being in the process of relicensing
- lived in Alberta for more than one year

Procedures

- If needed, I will be interviewed multiple times
- Each interview will not be last more than 90 minutes
- I can ask questions and clarifications and withdraw from the study at any time
- Interview will be audio taped
- During the interview I need to provide my personal experiences, barriers, and facilitating factors encountered during my resettling and relicensing process in Alberta
- A copy of the consent form is provided to me

Risks

I understand that my participation may bring physical, psychological or sociological risks to me, but risks are unlikely.

Benefits

I know that there are no known benefits to me by participating in this study but that the information I disclose may be useful for understanding the process experienced by IMGs and may benefit relevant organizations understanding this situation.

Assurance of Confidentiality

- I will be asked not to use names or identifying information during the interview.

- I will be asked to choose a pseudonym to disguise my identity during the interview. All reference to me will use the chosen pseudonym in place of my actual name.
- When audiotapes are transcribed any identifying information inadvertently included will be deleted by the transcriptionist.
- Only the researcher, Roshanee De Silva, the chair of her thesis committee, Judith Kulig, PhD and the transcriptionist will have access to the audiotapes and the transcripts.
- Audiotapes, transcripts and data generated in this study will be kept in a secure, locked cabinet in my supervisor's office at the University of Lethbridge.

Participant's signature:

Date:

Appendix E

Informed Consent Form- Practising AIMGs

Study Title

Theorizing the Barriers and Facilitators to Relicensing and Resettling of Albertan International Medical Graduates

Purpose of the Research

I am being invited to participate voluntarily in the above-titled research project. I have been informed that the purpose of this project is to explore the impacts of barriers and facilitators on Albertan International Medical Graduates' relicensing and resettling process.

Inclusion Criteria

I have been included into this study due to followings:

- a practising IMG,
- graduated from the University of Calgary or the University of Alberta
- lived in Alberta for more than two years

Procedures

- If needed, I will be interviewed multiple times
- Each interview will not be last more than 90 minutes
- I can ask questions and clarifications and withdraw from the study at any time
- Interview will be audio taped
- During the interview I need to provide my personal experiences, barriers, and facilitating factors encountered during my resettling and relicensing process in Alberta
- A copy of the consent form is provided to me

Risks

I understand that my participation may bring physical, psychological or sociological risks to me, but risks are unlikely.

Benefits

I know that there are no known benefits to me by participating in this study but that the information I disclose may be useful for understanding the process experienced by IMGs and may benefit relevant organizations understanding this situation.

Assurance of Confidentiality

- I will be asked not to use names or identifying information during the interview.
- I will be asked to choose a pseudonym to disguise, my identity during the interview. All reference to me will use the chosen pseudonym in place of my actual name.

- When audiotapes are transcribed any identifying information inadvertently included will be deleted by the transcriptionist.
- Only the researcher, Roshanee De Silva, the chair of her thesis committee, Judith Kulig, PhD, and the transcriptionist will have access to the audiotapes and the transcripts.
- Audiotapes, transcripts and data generated in this study will be kept in a secure, locked cabinet in my supervisor's office at the University of Lethbridge.

Participant's signature:

Date:

Appendix F

Invitation Letter

Study Title:Theorizing the Barriers and Facilitators to Relicensing and Resettling of Albertan International Medical Graduates

Dear fellow AIMGs,

My name is Roshanee De Silva; I am an International medical graduate migrated in 2007 from Sri Lanka. Presently, I am a graduate student in the Faculty of Health Sciences at the University of Lethbridge. I am conducting a research study as part of the requirements of my master degree under the supervision of my professor: Dr. Judith Kulig.

As IMGs, you all have faced many different challenges while regaining your professional identity. I believe that you can share your own resettling and relicensing experiences with me. Your participation may enhance the quality of this research. Furthermore, Alberta IMG issue is not much researched. The findings of this research may lead to open new pathways for successful absorption of AIMGs into the Alberta Health Services.

Participation for this study is completely voluntary, anonymous, and confidential. The study findings are presented in my thesis, conference presentations and journal articles, but your identity will not be revealed.

I am happy to answer any questions you may have about this study. You may contact me at 403-327-5255 and roshanee.desilva@uleth.ca. In addition, if you have specific questions about your rights as a research participant, you may contact the University of Lethbridge Research Ethics Office at 403-329-2747, Dr. Judith at 403-382-7119.

Thanks for your consideration,

Hoping to hear from you soon,

Roshanee De Silva

06th June 2013
Faculty of Health Science
University of Lethbridge
4401 University Drive W
Lethbridge, AB, T1K 3M4

Appendix G

Posting on the AIMGA Web Site


Alberta International Medical Graduates Association

contact Feedback Links register help

home about aimga news process of licensure programs & events members area

barriers and FACILITATORS TO relicensing and resettling

APPENDIXA – Invitation Letter

Study Title: Theorizing the Barriers and Facilitators to Relicensing and Resettling of Alberta International Medical Graduates (AIMGAs)

Dear Fellow AIMGAs,

My name is Roshanee De Silva; I am an international medical graduate who immigrated in 2007 from Sri Lanka. Presently, I am a graduate student in the Faculty of Health Sciences at the University of Lethbridge. I am conducting a research study as part of the requirements of my master degree under the supervision of my professor: Dr. Judith Kulig.

As AIMGAs, you all have faced many different challenges while regaining your professional identity. I believe that you can share your own resettling and relicensing experiences with me. Your participation may enhance the quality of this research. Furthermore, the Alberta IMG issue is not much researched. The findings of this research may lead to open new pathways for successful absorption of AIMGAs into the Alberta Health Services.

I am inviting you to participate in an interview that will not last more than 90 minutes to share your experiences. The interview will be conducted at a time and location that are convenient to you. With your agreement, the interview will be audiotaped. If you do not want to be audiotaped, I will take written notes. I may ask you to participate in a followup interview if it is needed.

Participation for this study is completely voluntary, anonymous, and confidential. The study findings will be presented in my thesis, conference presentations and journal articles, but your identity will not be revealed. I will send you a copy of research summary to you. Furthermore, for your participation in this study, you will not receive any remuneration, and you have the opportunity to withdraw from the interview at any stage without any penalty.

I am happy to answer any questions you may have about this study. You may contact me at 403-327-5255 and roshanee.desilva@uleth.ca. In addition, if you have specific questions about your rights as a research participant, you may contact the University of Lethbridge Research Ethics Office at 403-329-2747 or research.services@uleth.ca, or Dr. Judith Kulig at 403-322-7119 or kulig@uleth.ca.

Thanks for your consideration,

Hoping to hear from you soon,

Roshanee De Silva
06th June 2013
Faculty of Health Science, University of Lethbridge
4401 University Drive W
Lethbridge, AB, T1K 3M4

Login

username:
password:
 Remember Me
[Register](#) [Forgot Password](#)

Sign Up For Our Mailing List

email address:
first name:
last name:

if you're already an AIMGA member, you should already be on this list.

AIMGA News

Calgary office closed Jan 2
3 Jan 2013
 Calgary office will be closed today, January 3rd [read more →](#)

Holiday function Cancelled
7 Dec 2013
 Due to unforeseen circumstances, the Holiday Function has been cancelled [read more →](#)

Membership Drive – Support your Association
7 Dec 2013
 As most of you are aware, we need more members [read more →](#)

Appendix H

Poster to Recruit Study Participants

Alberta International Medical Graduates (AIMGs)

An opportunity for IMGs to share their experiences to licensure

**Research on Barriers and Facilitators to
Resettling and Relicensing of AIMGs**

**Looking for AIMGs
for Interviews**

- Participation is voluntary, anonymous, & confidential
- Approved by the University of Lethbridge, University of Calgary and University of Alberta Ethic Boards
- Completed residency training either at the University of Calgary or at the University of Alberta
- Take only 30-45 min
- Not receive any compensation
- Will receive a copy of research summary

For details please contact
Roshanee De Silva, M.Sc Candidate
Faculty of Health Sciences, University of Lethbridge,
Phone: 403-327-5255; E-mail: roshanee.desilva@uleth.ca

Further Information about the research:
Prof. Judith Kulig, Research supervisor
Faculty of Health Sciences, University of Lethbridge,
Phone: 403-382-7119; E-mail: kulig@uleth.ca

Appendix I

Interview Guide

1. Provide your home country details
(Probing questions: education qualifications, clinical experiences, social status, married life, how many kids, spouse employment, income level, added qualifications, foreign training)
2. Reasons to migrate
(Probing questions: security at home country, schools for kids, opportunities for PD, relatives or friends in Canada, Alberta selection, any helps receive to file immigration application, knew the IMG situation before migrate)
3. Your resettling experiences
(Probing questions: finding an apartment, buying a vehicle, getting driving license, getting furniture and basic house hold items, community NGO help, first winter experience, finding an employment (happy or unhappy), spouse employment (happy or unhappy), finding schools for kids, finding a family physician, receiving social benefits, health insurance, new friends, cultural impacts, language issues, religious places to visit, interaction with home country people, other barriers and facilitators for resettling)
4. Your relicensing experiences
(Probing questions: how did you receive relicensing information, experience with AIMGA, passed MCC exams, English language proficiency, expenses for exams(study loans), family support to prepare for relicensing, classes workshops help to prepare for exams, , bridging programs (observerships, MCAP, Clinical Assistants), discriminations, social exclusions, other barriers and facilitators for relicensing)
5. Your present status
(Probing questions: present job(matching your medical qualifications), living (apartment or own house), kids schooling, spouse employment, economic status, visits to home country, happy or unhappy about decision to move to Canada)
6. Your residency training experiences (If applicable)
(Probing questions: place to stay, support from co-workers and professors, communication problems with patients, support from family, hospital settings, other barriers and facilitators for residency training)
7. Describe your future plans
(Probing questions: plans to move to a different province, country, change the carrier path)

Appendix J

Demographic Information

Participant's pseudonym:

1. What is your age?

2. What is your gender?

Male

Female

3. What is your marital status?

Married

Divorced

Single

Other
(explain)

4. If married, how many children?

1

2

3

More
than 3

5. What is your country of origin?

6. When did you migrate to Canada?

7. What is your present occupation?

8. In which country did you receive your medical qualifications and clinical training?

9. What is your area of specialty and number of years of service?

My concern is with clarity about the purpose of the study and I think she should clarify things for herself as well as the reader. The title says one thing but then there is variation throughout the manuscript which suggests that the writer is not clear or not being accurate in her language.

In 5.6 page 140 and 5.8 page 143 , the GOAL and AIMS differ from the title as does the PURPOSE in the abstract page iv.

In 3.2 on page 35 it seems that the study is about reshaping professional identity and again in 3.2 on page 36 the INTENTION is reported as to "understand what it means to be an IMG"

In chapter 4 page 63 the research questions are about residency not licensing although the writer goes on to say residency is the first step to licensing.

I think more consistency indicates clear thinking and makes reading easier.

I hope this is helpful and again, Congratulations to both you and Roshanee.

Andrew