Outpatient Precepting of International Medical Graduates in Family Medicine
Keiichiro Narumoto, MD, MPH; Kevan C. Schultz; Joel H. Merenstein, MD

BACKGROUND: The purpose of this study was to examine outpatient precepting for international medical graduates (IMGs) in family medicine residencies. The education of IMGs in residency programs has been a subject of concern. Multiple obstacles in acculturation may negatively influence IMGs’ thoughts/feelings and subsequently affect their learning in teacher-learner interaction especially during a time-constrained environment like outpatient precepting. However, there is no research on IMGs’ thoughts and feelings during outpatient precepting.

METHODS: We used qualitative research using multiple methods, primarily semi-structured individual interview during Interpersonal Process Recall (IPR). We purposefully sampled IMGs from three family medicine residency programs and videotaped their outpatient precepting. As a standard for comparison, we also videotaped US medical graduates (USMGs). We used multiple methods to explore their thoughts/feelings during precepting: brief interview, preceptor questionnaire, video review, and IPR debriefing of the precepting encounter. For analysis, we developed thematic codes from IPR transcripts and explored their consistency with data from the three other sources.

RESULTS: Seven themes emerged: cultural differences, language barriers, clinical performance, relationship, preceptor’s teaching behaviors/attitudes, internalized process, and external factors. IMGs experienced various negative thoughts and feelings related to language barriers and cultural differences. These internalized processes adversely influenced their learning attitudes, precepting behaviors, and clinical performance.

CONCLUSIONS: Precepting is more stressful for IMGs than for USMGs. IMGs need more specific orientation for outpatient precepting, and preceptors need further opportunity to reflect on their precepting skills for IMGs. Residency programs may do well to develop and test a curriculum and learning environment to meet IMGs’ special needs.

From the Shizuoka Family Medicine Residency Program, Shizuoka, Japan (Dr. Narumoto); and Qualitative Data Analysis Program (Mr. Shultz) and Emeritus Director of the Faculty Development Fellowship, Department of Family Medicine (Dr. Merenstein), University of Pittsburgh.
Methods
We conducted qualitative research with a four-part strategy: (1) brief semi-structured individual interviews (“interviews”), (2) written questionnaire for preceptors (“questionnaire”), (3) video review (“video review”), and (4) semi-structured individual interviews using Interpersonal Process Recall (“IPR”) (Figure 1). Our analysis was based on the IPR review with confirmation from the other three methods. This study was approved by the IRB of the University of Pittsburgh on June 9, 2009.

Sample
We enrolled residents in three family medicine residency programs affiliated with the University of Pittsburgh. Two of these had a high proportion of IMGs (82% and 85%) while the other had a lower proportion (13%). After acknowledging the aim of this study and providing verbal consent, participants completed a demographic survey that asked for the following: name, postgraduate year, country of origin, primary language, country of medical school, language(s) primarily used for medical education by instructors at the medical school, self-perceived English proficiency on a scale of 0%–100%, and duration of time (years) in the United States before residency. We then obtained informed consent from those who volunteered to participate in the research. The definition of IMG used in this study was family medicine residents who were born and raised and received medical school education in any foreign country whose primary language was not English.

We conducted maximum variation sampling on the IMG group and convenience sampling on the USMG group for collecting data to help identify unique themes for IMGs. We created a list of IMGs who signed the consent form with a focus on the resident’s and preceptor’s verbal/nonverbal behaviors and the overall climate, including the dynamics of precepting conversation and environment. Observation was recorded on the field note.

Within 7 days after the day of recording, KN conducted Interpersonal Process Recall (IPR) with the resident. The IPR, developed by Norman Kagan in 1962, is a tool to improve human communication by reviewing audiorecorded or videotaped human interaction. The IPR stimulates the recall process and encourages participants to explore subconscious feelings and thoughts that have surfaced during the interaction but that have not been articulated for various reasons. KN facilitated the resident’s recall and reflection on his or her internal experience at the time of precepting by watching the videotape together and pausing to reflect on questions used in IPR based on Kagan’s facilitator guide (Table 1). This interview was audiorecorded and transcribed verbatim for analysis. We revised the interview questions based on preliminary data analysis to expand data collection on important concepts and emerging themes.

Data Analysis
We analyzed the transcripts of IPR for thematic code development following grounded theory. KN and KCS independently reviewed the transcripts and developed an initial set of thematic codes, reaching consensus through discussion.

Themes identified were further corroborated by JHM, and no further thematic categories or discrepancy were identified. USMG transcripts analyzed were only used to help identify unique themes for IMGs.
Field notes of “interviews” and “video review,” and typescripts of “questionnaire” were used primarily to examine if they were consistent with our interpretation of the IPR transcripts.

**Results**

We interviewed a total of 11 IMGs and six USMGs. Among IMGs, seven were male and four were female, and they consisted of four first-year, five second-year, and two third-year residents. The duration of stay in the United States prior to their residency ranged between a few months and 4 years. Their perceived English proficiency level varied from 30% to 95%. The countries of origin of the IMGs included Egypt, Nigeria, Kenya, India, Pakistan, Korea, Japan, and Philippine. USMGs consisted of four first-year and two second-year residents, and half were female.

Seven major themes emerged: cultural differences, language barriers, clinical performance, relationship, preceptor’s teaching behaviors/attitudes, internalized process, and external factors (Table 3), of which cultural differences and language barriers were unique to the IMG group. In this article, we review these two themes. Some of the residents’ quotations could represent more than one theme but are introduced under only one of them.

**Cultural Differences**

The majority of the IMGs shared their experiences related to cultural differences in the following contexts: patient care, medical education, and human interaction.

**Patient Care**

One of the IMGs was facing an “uncomfortable” dilemma between medically appropriate care in the United States and what was possibly medically inappropriate but culturally acceptable care in her country. She needed to intervene on behalf of a patient who was a bus driver with chronic alcohol dependence. However, she felt “uncomfortable” with the intervention because it could cause him to lose his job, and in her culture his alcohol issues were acceptable given he had never had previous alcohol-related driving problems. Even though she was thinking of her cultural dissonances during precepting, she did not bring up this subject to discuss with the preceptor because she was concerned about his negative reaction to it.

I don’t try to mention about it... I am from a different country and if you have cultural difference, they [preceptors] are not going to (laughing)... like you... They don’t have to deal with cultural difference if I am American.

At the same time, this IMG experienced a sense of forced acculturation.

I try to act like a native. If I’m American, I don’t need to have this kind of difficult feeling... Here is America, patient is American, and

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**Table 1: Examples of the Questions for Interviews and Questionnaire**

<table>
<thead>
<tr>
<th>Interviews</th>
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<tbody>
<tr>
<td>1. How did your precepting go today?</td>
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<tr>
<td>2. What made you feel / think that way?</td>
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<tr>
<td>3. Is there anything that you wanted the preceptor to do to make you feel differently?</td>
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<tr>
<td>4. What positive experiences during precepting have you had?</td>
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<tr>
<td>5. What negative experiences during precepting have you had?</td>
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<tr>
<td>6. Have you experienced any intense emotions for any reasons during precepting?</td>
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</tbody>
</table>

**Questionnaire**

1. What do you think the resident was thinking and feeling during the precepting?
2. What were the differences between the way that you precepted the resident compared to when you precept U.S. medical graduates?

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**Table 2: Examples of the Questions for Interpersonal Process Recall**

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<table>
<thead>
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<tbody>
<tr>
<td>1. What were you thinking/feeling at that time?</td>
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<tr>
<td>2. What was going on there?</td>
</tr>
<tr>
<td>3. What did you think the preceptor was thinking about you?</td>
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<tr>
<td>4. How did the preceptor’s body language affect you?</td>
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<tr>
<td>5. Did the camera affect you in any way?</td>
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<tr>
<td>6. Was there anything you wanted the preceptor to tell you/do to you??</td>
</tr>
<tr>
<td>7. Was there anything that you wanted to tell the preceptor but that you could not?</td>
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</table>
Table 3: Themes in Residents’ Feelings and Thoughts During Precepting

<table>
<thead>
<tr>
<th>Themes</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Cultural differences</td>
<td>Cultural differences in medical practice, humane interaction, and medical teaching</td>
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<tr>
<td>Patient care</td>
<td></td>
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<tr>
<td>Expected learner’s behaviors/attitudes</td>
<td></td>
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<tr>
<td>Medical education</td>
<td></td>
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<tr>
<td>Forced acculturation</td>
<td></td>
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<tr>
<td>Hesitancy to share</td>
<td></td>
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<tr>
<td>Humane interaction</td>
<td></td>
</tr>
<tr>
<td>Language barriers</td>
<td>Precepting process, feelings, and thoughts influenced by language barriers</td>
</tr>
<tr>
<td>Expression</td>
<td></td>
</tr>
<tr>
<td>Negative feelings</td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
<td>Feelings and thoughts in the context of human relationship</td>
</tr>
<tr>
<td>Clinical performance</td>
<td>Feelings and thoughts related to clinical performance</td>
</tr>
<tr>
<td>Presentation</td>
<td></td>
</tr>
<tr>
<td>Medical knowledge</td>
<td></td>
</tr>
<tr>
<td>Pressure to do better</td>
<td></td>
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<tr>
<td>Preceptor’s teaching behaviors/attitudes</td>
<td>Preceptor’s factors influencing precepting, including teaching behaviors, attitudes, and feedback</td>
</tr>
<tr>
<td>Positive behaviors/attitudes</td>
<td></td>
</tr>
<tr>
<td>Negative behaviors/attitudes</td>
<td></td>
</tr>
<tr>
<td>Positive feedback</td>
<td></td>
</tr>
<tr>
<td>Constructive/negative feedback</td>
<td></td>
</tr>
<tr>
<td>Teaching style</td>
<td></td>
</tr>
<tr>
<td>Internalized process</td>
<td>Attitudes, behaviors, feelings, and thoughts of residents with regard to or during precepting</td>
</tr>
<tr>
<td>Preceptor</td>
<td></td>
</tr>
<tr>
<td>Self</td>
<td></td>
</tr>
<tr>
<td>Third person</td>
<td></td>
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<tr>
<td>Expectation/needs</td>
<td></td>
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<tr>
<td>External factors</td>
<td>Any factors influencing precepting outside of resident-preceptor dyad</td>
</tr>
<tr>
<td>Time constraint</td>
<td></td>
</tr>
<tr>
<td>Interruption</td>
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</table>

the system is American. I have to be more used to American culture.

She assumed that preceptors would simply tell her to get used to American culture even before she intended to discuss it with them.

They are going to say, ‘You have to [get used to American culture]... I know the answer.

*Medical Education*

IMGs more frequently raised their concerns about their “evaluation” and tended to regard constructive feedback as “bad” evaluation. One IMG recalled that an inability to answer the teacher’s questions correctly could indicate not only academic failure but also personal deficiency.

You had to know everything, if you didn’t know, you were made to feel really, maybe useless or like really small for not knowing. The fact that you don’t know was a really big deal. ‘How couldn’t you know that?’ something like that.

Because of her fear of being negatively evaluated and judged under her previous knowledge-weighted evaluation system, her precepting behaviors were passive earlier in her residency.

I knew the answer because what they [preceptors] gave to me, that’s exactly what I was thinking. I... just... couldn’t, for a while, could not get over the fear that’s... what if I say that’s wrong answer?

Another IMG shared a “vicious cycle” of negatively internalized processes caused by a sense of pressure from her past educational system.

It’s a vicious cycle. I’m hesitating. I don’t answer. They are going to think I don’t know at all. Because I don’t express when they ask... so they made me a little sensitive [nervous] then I have to do better next time. Then if they ask me another question I’m more sensitive [nervous] and cautious to answer in a correct way. Then I am hesitating.

*Humane Interaction*

A lack of the preceptor’s verbal or non-verbal responses from the preceptor to an IMG’s oral presentation discouraged her to learn.

I will end the interaction as quickly as possible, let me get over here. (laughing) I wouldn’t look at the preceptor... because I am uncomfortable I just want to get over and done with it. And even maybe
I want to ask something, I just like, (sigh) forget it.

This IMG thought that the preceptor might have missed non-verbal cues from her facial expression due to not looking at her. This failure to pick up on the cues made her feel reluctant to ask the preceptor further questions.

When I talk sometimes my... my uncertainty... not be spoken, it will be expressed on my face... And a good preceptor would pick up on that... but I think that's cultural thing...”

You miss it, I feel, 'Okay, so you are not paying attention to me to even... recognize that, so... I will not even bother asking you.

The “interviews” revealed that one IMG had a sense of being “discriminated” against in terms of how teachers interacted with him, although this did not emerge during IPR. In further interview, he seemed to have internalized this feeling without one clear experience making him feel this way.

**Language Barriers**

Feeling the need to speak and respond quickly made language barriers worse for several IMGs, especially those who had a lower perceived English proficiency.

I have to answer very quickly. And during the seconds, a few seconds... I was thinking ‘How can I express?’ or ‘How can I express in an organized way?’... Then time goes by. (chuckling) You know, so, I easily skip the answer and explanation.

It happens to patients and to the precepting encounter.

In the “video review,” one IMG whose self-perceived English proficiency was relatively high appeared to have linguistic challenges in precepting dialogue and then to become passive in attitude. Objectively, he could not express his thoughts clearly, and his voice eventually faded out. However, the IPR did not reveal his insight into this.

Some of the IMGs tended to feel another pressure to “do better” in general because they maybe were perceived as behind in clinical achievement due to their handicap in language proficiency and cultural familiarity.

Sometimes, in terms of the language, cultural difference, and pronunciation, they make me feel bad... compared with... colleagues... I am behind from them... because of language. So I feel like I have to do better. I have to do better than them because I feel the gap.

Similarly, one IMG shared his sense of pressure to “make up for” his disadvantage in language skills and it was “too much” challenging for him to keep himself calm during precepting.

The presence of a third person during precepting made some IMGs more self-conscious about their second language.

If... American resident [is] sitting next to me... it made me more uncomfortable... because they catch my language problem easily... maybe I become more cautious [cautious] to choose some words or sentence.

**IMGs who had lower self-perceived language proficiency more frequently shared their emotional challenges in communicating in English.**

I felt very dumb... dumb and a little stressed out... they [medical students] thought I am not good at teaching because of, not because of my language, because of my knowledge... I can feel. They consider me as IMG... not smart enough to speak English very well.

They also experienced a difficulty in maintaining their identity and confidence.

We are from different countries and not good at speaking English 100% even though I work as a doctor... so how they [medical staff] are going to think [of] us... from different countries... so, foreign doctors... Yeah, I just feel bad, really bad.

Another IMG found himself to be not the “right person to be in the residency” because he thought that the residency it was “the place to learn family medicine, not English.”

The “questionnaire” from the preceptors confirmed some of the IMGs’ challenges relating to social/cultural differences and slang but did not address many of the emotional and internalized factors nor leading environmental factors associated with their challenges.

As for presentation skills, one IMG disclosed that he was purposefully slowing down his presentation to achieve his goals.

I found it difficult, that is, because [of my own training, to say,] ‘I don’t know what to do.’ I want to come up with something... because I want to decrease the tempo so that I can have time to think of something to do, before we get to that point.

**Discussion**

In this report, we attempted to identify IMGs’ internal experiences related to cultural differences and language barriers during outpatient precepting. We also attempted to explore how these experiences influenced their attitudes and behaviors during precepting. The IPR interviews yielded several important findings for IMG outpatient education.

**Influences of Cultural Differences on IMG Precepting**

Some IMGs may continue to carry their cultural perspectives during their clinical encounter.20 The
“discomfort” arising from cultural dissonance could cause a breakdown in communication with the patient. Since poor understanding of cultural differences between IMGs and colleagues can negatively impact medical practice, appreciation by preceptors of the IMGs’ cultural dilemmas would be important and also help them manage their emotional and cognitive conflicts. However, IMGs might not disclose their cultural conflicts unless preceptors actively explore them. Several reasons for this can be considered. First, the most critical needs for IMGs to survive residency may be medical issues, especially for interns, on their hierarchy of perceived needs. Even if they are aware of cultural differences in patient care, their attention may be occupied with fulfilling the medical responsibility at hand. Second, “cultural deference to authority” may be the norm in their country of origin. They may perceive that the preceptor’s role is to provide them with all information they need, and their expected attitude is to receive preceptors’ advice without proactively questioning them. Third, difficulties with colloquial language may challenge IMGs in communication of cultural issues where they have to describe non-medical abstract matters in a second language. Fourth, IMGs’ cultural background and acculturation may not be sufficiently addressed within residency as part of a valuable reflective practice. This appears to be suggested by “a sense of forced acculturation,” and IMGs may perceive that this is not worth openly discussing with preceptors. This pressure to westernize may lead IMGs to shut their own culture.

The majority of existing studies have focused on identifying cultural and linguistic challenges IMGs face in patient care and medical education. Many of them have offered recommendations for IMG education in general, including orientation, feedback, and mentoring but no specific ones for outpatient precepting. Further, there is no extensive research on the impact of teachers’ behaviors on family medicine outpatient precepting of IMGs. Different cultures have different understandings about what constitutes a humane interaction. Misunderstanding these differences can adversely influence learning behaviors. Our results demonstrated that a preceptor’s ordinary behaviors, which might be culturally unacceptable for IMGs, could cause negative reactions and subsequently compromise their learning opportunity. In order for teachers to be effective with culturally diverse learners, it is essential that they first recognize their own beliefs, behaviors, and attitudes. Preceptors need to reflect on how their precepting behaviors can be perceived by IMGs in their cultural context and can influence their learning.

The informal interviews revealed that one IMG had developed a sense of being discriminated against by the faculty. He could not identify direct verbal or non-verbal discriminating behaviors, but it might have been associated with his experience of losing face or covert discrimination in the training environment without adequate support from the faculty. This can significantly undermine the teacher-learner relationship and cause distrust in teaching and feedback. This experience can exacerbate a “sense of isolation” and make the training environment insecure, which can inhibit learning. Thus, it is crucial for faculty to be aware of how IMGs are being treated within the residency.

**Approach to Linguistic Obstacles**

Poor language proficiency can act as a barrier to learning. As the existing studies acknowledged, a few IMGs who had lower self-perceived language proficiency had experienced loss of their self-esteem and identity and a sense of pressure to prove their clinical ability. Our results were consistent with previous observations that learners with higher anxiety about language were prone to have irrational thoughts, to be less able to control their impulses, to cope more poorly, and to be self-focused. As a consequence, IMGs may develop more passivity in learning attitudes and behaviors during precepting.

Foreign language anxiety in cultural context is an important concept in understanding thoughts and behaviors among IMGs. Horwitz and colleagues pointed out three processes of language anxiety: communication apprehension (anxiety about communicating with people), test anxiety (fear of failure), and fear of negative evaluation. IMGs’ “skipping” behaviors in patient communication and precepting or becoming “uncomfortable” with others being nearby during precepting can be explained by this anxiety. A sense of foolishness, embarrassment, shyness, awkwardness, and incompetence in communicating in a second language can influence communicative strategies and hamper the quality of clinical encounters with patients and learning with preceptors. However, it is noteworthy that not every learner with a low level of language proficiency is anxious. Given only a few IMGs with low self-perceived English ability shared emotional challenges related to language barriers, a propensity of IMGs for developing significant language anxiety may depend on how they perceive their language proficiency.

As found in this study, IMGs may “skip” what they are supposed to tell their patients. IMGs may not understand their patients and preceptors. Or, as Hirsch et al suggested, “They may have the words but not the meaning.” It is important to explore the extent to which IMGs comprehend conversation with patients and precepting. In this process, it is important to consider where, how to assess their level of understanding because those factors can provoke the language anxiety. Regarding how, for example, the following question can be asked of IMGs to acknowledge their language challenges: “What challenges do you face in discussing what we have talked
about with your patient?” How also includes the preceptor’s facial expression and body language; it is important not to betray judgment or impatience. Regarding where and when, dynamics of the whole precepting environment need to be carefully examined because of fear of negative impression or losing face in front of others.

Preceptors need to recognize the vulnerability of IMGs. To maintain their confidence and decrease language anxiety for better learning, preceptors should provide them with more positive feedback on their clinical performance both from medical and linguistic aspects.

Development in Orientation for Outpatient Precepting for IMGs

Our results reemphasize that residency programs should develop an introduction session that goes beyond a technical overview of the program and provides opportunities for IMGs to discuss cultural differences in norms, beliefs, values, and expectations. Although both USMGs and IMGs might avoid discussing educational and cultural differences because of USMGs’ fear of offending IMGs and IMGs’ fear of being perceived as inferior, orientation training needs to actively engage all residents, faculty, and medical staff in discussing these issues, which would help preceptors to better understand IMGs’ precepting attitudes and behaviors. This orientation can also expand an opportunity for IMGs to reflect on their internal acculturation processes and for teachers to explore the influence of their teaching behaviors on IMGs’ learning. Additionally, preceptors need to articulate their expectations for outpatient precepting to avoid IMGs’ negative reactions which stem from educational differences.

For language anxiety IMGs may have, residency programs need to explore ways to help IMGs maintain confidence. Throughout orientation activities, IMGs’ strengths, for example their culturally and medically abundant experiences in their country of origin, need to be more explicitly addressed and highly valued. Since one of the sources of the anxiety is the “culture” of the learning environment, residency programs need to foster a culturally sensitive environment and make sure that medical staff who work with IMGs appreciate different cultural attitudes and behaviors and values and beliefs.

Limitations

Several factors could affect the quality of the data. Only a few precepting sessions with various preceptors were chosen for each IPR due to limited budget and time of the videographer (KN), which led to heterogeneity on the patient and precepting encounters among the participants. The time from videotaping to IPR and the timing of IPR in an academic year also varied across the participants. The interviewer was an IMG whose primary language was not English. The participants were purposefully chosen from family medicine residencies in Pittsburgh, PA, hence the results of the study are not generalizable to other residencies.

Conclusions

Effectively educating IMGs is vital in maintaining high-quality primary care in the United States. Precepting is an important teaching strategy. However, mastering effective and practical ways to address IMGs’ needs during time-constrained outpatient precepting is challenging. IMGs’ learning attitudes, behaviors, and clinical performance can be adversely influenced by negative thoughts and feelings related to language barriers and cultural differences. IMGs need orientation to outpatient precepting for better understanding the expectations, feedback, and evaluation in Western medical education. Preceptors need to further reflect on the influences of their behaviors during precepting on residents’ learning. Precepting skills with foreign language anxiety taken into consideration may reduce IMGs’ internal barriers and promote their learning capacity. Residency programs need to develop a curriculum to meet their special needs in a culturally enriched and deeply reflective way.

ACKNOWLEDGMENTS: We would like to acknowledge Drs Laurel C. Milberg, Stephen A. Wilson, Michael Youns, William L. Miller, Goutham Rao, and Judy C. Chang, the Clinical and Translational Science Institute (CTSI) at the University of Pittsburgh, faculty development fellows, and Ms Genevra Littlejohn. We also would like to thank residents and faculty who participated in this study at St. Margaret, McKeesport, and Shadyside Family Medicine Residency Programs. Dr Milberg was a mentor for IPR and helped KN train in facilitating the IPR debriefing. The content of this manuscript was presented at the 2010 Woenca World Conference of Family Doctors in Cancun, Mexico. Dr Narumoto was a fellow in the Faculty Development Program based at St. Margaret Hospital at the time of this research project.

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