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An Exploration of Medical Residency Program Managers Resolving International Medical Graduate Acculturation Challenges

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Walden University
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Abstract

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MA, Arcadia University, 2008

BA, Indiana University of Pennsylvania, 2004

Dissertation Submitted in Partial Fulfillment

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Abstract

International medical graduates (IMGs) undergo rigorous training and certification requirements for entry into medical residency programs in the United States. Despite having professional expertise and academic training, some IMGs experience acculturation challenges that negatively impact engagement and professional relationships during medical residency. Grounded in Berry's Acculturation model and Portes and Zhou's segmented assimilation model, the purpose of this qualitative narrative inquiry was to explore the best practices medical residency program managers developed while leading IMGs. The participants consisted of 22 U.S. medical residency program managers, directors, and coordinators who had at least 3 years of experience managing IMGs. Participants responded to 10 open-ended questions in semistructured interviews, which led to six themes: communication, culture, socialization, professionalism, education, and personal challenges. Analysis consisted of gathering and coding common interview responses until data saturation was achieved. A key recommendation is that medical residency program managers implement orientation programs prior to the start of residency training while creating opportunities to build social networks among the team. The implications for positive social change include providing more robust academic and professional experiences for IMGs. This research promotes positive social change as it contributes information for medical residency program managers and Graduate Medical Education authorities seeking best practices for building and improving post-graduate training programs. This study could aid in establishing a culturally inclusive professional environment.

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Dedication

I dedicate this work to my children Gabriel and Kayla. I hope that in witnessing this journey, you too discover your passion and know that it can be attained. Both of you are smart, kind, capable, and surrounded by people who want to see you flourish in whatever your dreams may be. To my husband, Kevin, I am grateful for your constant support and encouragement. You are a blessing, and I could not have achieved this life-changing and wonderful journey without you. To my brothers, Anthony and Michael, and sisters Tyesha, Samarra, Amanda, and Katie who witnessed this expedition. You celebrated with me during my highs and lifted me during my lows. I am truly grateful for your presence and words of encouragement.

This work is also dedicated to my mom, Marnita, and godparents, J.R. Wilson II and Dawn Wilson, who showed unconditional love and helped me stay on course. You provided a foundation and helped me to accomplish my dreams. You cheered me on from the moment I expressed my interest in pursuing higher education. Thank you all for being my village. My sincere love to you all.

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Chapter 1: Introduction to the Study

An increasing number of international medical graduates (IMGs), defined as physicians working in a country other than their country of origin and training, immigrate to Western countries (Michalski et al., 2017). Highly skilled immigrants, armed with credentials and skills from their native country, make up a rapidly growing percentage of the global workforce who come to the United States with the hopes of re-establishing their professional career (Colakoglu et al., 2018). IMGs constitute approximately 25% of the total GME training pool in the United States (Ahmed et al., 2018; Chakraborty et al., 2019). IMG face challenges due to coming from different cultures and educational backgrounds, lacking U.S. mentors, and encountering language barriers and biases (Anteby, 2020). Additionally, their new patients and colleagues may have different expectations regarding professional communication compared to what they have learned and practiced in their homeland (Skjeggestad et al., 2020). These differences can lead to a troubled work environment for the medical team and negatively impact patient experiences.

Residency is a particularly difficult time for non-U.S.-born IMGs (Chakraborty et al., 2019). Assimilation and training of IMGs in non-technical skills continues to challenge medical residency program managers seeking to improve post-graduate training programs. Differences in performance in clinical practice can be attributed to differences in education and experience, both in medical school and in subsequent post-graduate practice (Henderson et al., 2017). This research may result in the identification of best practices that medical residency program managers (used interchangeably with

medical residency program manager, residency program director, and residency program coordinator) have implemented to create an inclusive environment for IMG residents challenged by acculturation. I explored types of training and support that led to medical residency program managers establishing best practices during IMG communication challenges. Some of the IMG acculturation challenges this research included are local accents and communication, local languages, rapport among staff and patients, diversity of faith, cross-gender standards, rounding in an academic medical center and physician–patient relationship, and shared medical decision-making. IMGs and medical residency program managers may benefit from narratives describing how best practices were developed and applied to resolve conflicts.

Background of the Problem

IMGs constitute approximately 25% of the total GME training pool in the United States (Ahmed et al., 2018). IMGs undergo a series of requirements to obtain acceptance to medical residency programs, such as the U.S. Medical Licensing Examinations—an evidence-based, objective assessment of an individual's progressive readiness for the unsupervised practice of medicine (Katsufrakis & Chaudhry, 2019) and medical education credential verification. The Educational Commission for Foreign Medical Graduates also assesses the readiness of IMGs to enter residency programs in the United States and tests for competence in spoken English (Zaidi et al., 2020). This process screens out individuals but does not take into account the subtleties and intricacies of language (Zaidi et al., 2020).

Despite quality assurance practices, communication problems related to cultural

differences continue to be reported. IMG residents can face acculturation challenges when interacting with patients and hospital staff. Acculturation, or the process of adjustment in a host culture, is a determinant of immigrants' overall success and well-being (Valenzuela et al., 2020). Two of the acculturation challenges are language barriers and unfamiliarity with cultural norms. Variations in accents, local dialects, and use of informal colloquialisms, idioms, and sarcasm are present in interpersonal communication across the United States and pose difficulties to IMGs (Zaidi et al., 2020). Additionally, IMGs may struggle with local vernacular, bonding through small talk, religious diversity, cross-gender norms, conducting rounds, physician–patient relationships, and shared medical decision-making (Zaidi et al., 2020). Language barriers and other acculturation stress factors could threaten the IMGs' professional identity (Skjeggestad et al., 2020). Good communication skills are essential for developing doctor–patient relationships and for teamwork (Zaidi et al., 2020). But IMGs in residency have reported both linguistic and cultural barriers in providing patient care (Fiscella et al., 1997). Many of these challenges persist beyond residency, extending throughout the careers of IMGs (Chen et al., 2010).

Historically, the role of the residency manager has been administrative and clerical; however, since the Accreditation Council for GME's (ACGME's) Next Accreditation System began in 2013 in the United States, managers' roles have expanded to include more managerial and liaison responsibilities (Ofei-Dodoo et al., 2020). Residency program managers are responsible for the administrative duties in medical residency programs within a teaching hospital or medical facility (Ofei-Dodoo et al.,

2020). They also function as managers and have greater roles in the development and implementation of program initiatives, policies, and outcomes (Stuckelman et al., 2017). Over the last decade, the knowledge and skills required to administer residency and fellowship training programs have increased in both volume and complexity (Stuckelman et al., 2017). Some medical residency program manager responsibilities consist of maintaining knowledge of accreditation compliance, overseeing and organizing educational programs, developing curriculum, providing instruction and quality improvement (QI) programming, and developing medical resident assessments to determine competence in patient care. To keep pace with continuing change, it is imperative that coordinators continue to develop these skill sets to add value to their programs, institutions, and careers (Stuckelman et al., 2017).

When they move from a less-developed country to a more developed economy, IMGs may lack advanced skills and knowledge to accomplish their tasks (Dang et al., 2020). Upon entry into medical residency, these differences may pose a challenge with adaptation to new workplace customs. Medical residency program managers lead IMGs with varied academic and professional experiences. The purpose of this study was to identify best practices medical residency program managers developed to resolve IMG acculturation challenges.

Problem Statement

Medical residency is a particularly trying time for non-U.S.-born IMGs as they can have trouble understanding non-verbal cues, exhibit challenges adjusting to workplace customs, and face difficulty navigating shared decision making and adapting

to lower hierarchies in the medical environment. Medical residency program managers expect IMG residents to master clinical knowledge and new terminology, technology, organizations, and workplace customs. But IMGs experiencing acculturation may find these expectations challenging. The practice of medicine, like that of other complex occupations, requires continued participation to maintain the mixture of explicit and tacit knowledge and to learn new knowledge (Henderson et al., 2017). However, medical residency program managers encounter cross-cultural acclimation challenges among IMG residents that negatively impact residency staff and patients. I addressed the literature gap related by exploring some of the best practice resolutions medical residency program managers have developed to address acculturation issues among IMGs.

Purpose Statement

The purpose of this qualitative narrative inquiry was to explore the knowledge, perceptions, and experiences of medical residency program managers who are leading IMGs through acculturation challenges. IMGs play a key role in health systems but face unique challenges such as language barriers and cultural differences (Hofstede, 1994), which makes effective, tailored support for IMGs essential (Osta et al., 2017). Acculturation issues such as adapting to various accents, dialects, and idiomatic terminologies can lead to communication struggles for IMGs as well as isolation, depression, stress anxiety, or alienation from team members. This study compiled stories from medical residency program managers who have successfully resolved communication challenges among IMGs. The goal of this exploration was to determine best practices developed to resolve conflicts related to communication and acclimation to

workplace customs.

Research Question

How are medical residency program managers resolving IMG acculturation challenges?

Nature of the Study

I used a qualitative narrative approach to explore professional experiences from medical residency program managers leading IMGs through acculturation challenges. A qualitative approach allows for complex human issues to be included in the research data rather than focusing on testing a priori hypotheses (Clandinin, 2016). The open-ended, exploratory nature of the qualitative method allows readers to understand the reasons behind the researched phenomenon (Taguchi, 2018). A qualitative narrative inquiry was used to explore stories, which helped determine parallels in the context of medical residency program managers' developing best practices for working with IMGs who struggle to assimilate throughout post-graduate training. I used semistructured interviews containing open-ended questions with medical residency program managers. Semistructured interviews enabled participants to share their experiences with leading IMGs through assimilation challenges and how communication barriers affected program completion. Respondents expanded on connections between cultural influences and professional performance, which helped determine best practices established during medical residency training. The qualitative narrative research design permitted flexibility for respondents to share in-depth responses and provided the option for new information.

Theoretical Foundation

Berry's (1997) acculturation model and Portes and Zhou's (1993) segmented assimilation model served as the theoretical framework in examining medical residency program managers and the IMG acculturation process. Acculturation is a process of cultural and psychological changes that immigrants or individuals new to an environment or location experience when they are in contact with the culture of their host society (Berry, 2007). Acculturation traditionally depicts assimilation as a continuous process coupled with a series of adjustments and adaptations (Berry, 1997), which acknowledges that cross-cultural adjustment is complex, active, and continuous. Portes and Zhou (1993) proposed segmented assimilation theory as a response to immigration in the United States, recognizing the diverse assimilation experiences that expatriates experience. The traditional assimilation model predicts a linear assimilation process; however, the assimilation process for IMGs is believed to be more fluid and oriented toward the immigrants' unique experiences (Chacko, 2003).

Berry's (1997) acculturation model (1997) and Portes and Zhou's (1993) segmented assimilation model were the basis for developing a research topic and framing interview questions for medical residency program managers leading IMGs undergoing post-graduate training. Segmented assimilation theory expands the current understanding of IMG acculturation experiences and the cultural adaptation strategies applied throughout medical residency training. Using this framework, I explored experiences of medical residency program managers leading IMGs through acculturation challenges during post-graduate training. The purpose was to identify best practices to mitigate

potential challenges.

Definitions

Accreditation: A recognition given to a school or health care institution by a professional association or non-governmental agency for meeting established criteria and standards (Mosby's Medical Dictionary, 2009).

Acculturation: The process by which immigrants learn and adopt the culture, behaviors, and attitudes of their host country because of their environmental influences (Lacey et al., 2015).

Cultural adaptation: Adjusting and integrating into a new culture by learning the language, understanding customs, and feeling a sense of belonging (Neuliep, 2017).

Employee assimilation: A process of relying on social interactions for knowledge and support to create change in organizations (Miller, 2018).

Graduate medical education (GME): The ACGME (2012b) defined GME as "the period of didactic and clinical education in a medical specialty which follows the completion of a recognized undergraduate medical education and which prepares physicians for the independent practice of medicine in that specialty, also referred to as residency education" (p. 5).

Integration practices: This term refers to practices that include socioeconomic support, psychological well-being, career path development, and the establishment of support mechanisms through personal relationships and belief systems for a new recruit in an organization (Runnymede, 2018).

International medical graduate (IMG): Physicians working in a country other

than their country of origin and training (Michalski et al., 2017)

Organization: Smalarz (2006) defined an organization as a "social entity that is goal-directed and has deliberately structured activity systems with a permeable boundary in place" (p. 179).

Organizational culture: A structured system in which individuals come together as a group to achieve a common goal (Buller, 2015, p. 11).

Quality improvement (QI) initiative: The QI initiative is the series of efforts by health care employees to make changes focused on better patient outcomes, waste reduction, improved performance, and employee development (Gauld et al., 2014; Pendharkar et al., 2016).

Resident: Any physician enrolled in an ACGME-accredited program sponsored by the University of Texas Health Science Center at San Antonio (ACGME, 2012b).

Assumptions, Limitations, and Delimitations

Assumptions

Assumptions define the attributes of the research that require justification to ensure relevancy (Landers, 2019). One assumption was that all IMGs would experience similar adjustment challenges during medical residency training. However, U.S. IMGs consist of individuals who were born in the United States but attended medical school abroad. This group may face different experiences because they would not be limited by language and may have access to professional connections and opportunities that an individual born outside of the United States would lack. U.S. IMGs would have an advantage in understanding workplace norms and customs. They would also not be

challenged by immigration requirements, familial separation, and duties associated with providing support for continuing obligations in their home countries. In this study, I focus on the challenges faced by IMGs born outside of United States because they experience cross-cultural adjustment challenges that U.S. IMGs would not encounter.

The second assumption was that program managers would be candid and transparent in their interview responses. It was anticipated that during residency training, program managers drew a connection between acculturation and progress during the program. It was also assumed that program managers have identified the connection between workplace conflicts and cultural differences. The final assumption was that the open-ended qualitative inquiry would yield effective responses.

Limitations

Limitations are factors that a researcher could not control that reveal a weakness in a research project (Simon & Goes, 2013). One limitation was the potential of falsifying or enhancing stories that may mischaracterize people or events. To address this, I urged participants to provide responses that were honest and based on firsthand knowledge and prompt as necessary to obtain detailed and factual information based on their experiences.

Delimitations

Delimitations are boundaries researchers impose to focus on the scope of a study (Yin, 2014). The focus of this study consisted of daily professional experiences of medical residency program managers, which I gathered through semistructured interviews. The inclusion criteria for this study was medical residency program directors

in the United States. This group had experience managing IMGs, overseeing residency programs, developing curriculum, maintaining compliance, and selecting candidates for residency.

Significance of the Study

This study can benefit medical residency program managers who oversee IMGs. Through an exploration of IMG residency managers' best practices, this study highlights ways that residency managers resolved acculturation challenges that arose during post-graduate training. IMGs play an important role in U.S. family medicine workforce (Duvivier et al., 2019), and they bring diversity to the teaching environment and their training in the United States can make them emissaries of U.S. values back home (Anteby, 2020). However, residency is a particularly difficult time for non-U.S.-born IMGs (Ahmed et al., 2018). Non-U.S. IMGs face specific challenges such as coming from different cultures and educational backgrounds, lacking U.S. mentors, and encountering language barriers and biases (Anteby, 2020). They must master clinical knowledge and skills but also adapt to new terminology, technology, and systems (Ahmed et al., 2018). The U.S. health care model is also individualistic and different from the countries where IMGs' medical schools are located (Zaidi et al., 2020). This study provides conflict resolution strategies that impact the one-quarter of U.S. health care workforce.

Significance to Theory and Practice

I aimed to contribute to improved business management productivity and healthy communication practices in post-graduate IMG training programs throughout the United

States. The focus of this study consisted of two groups within the field of medical residency: program managers and IMGs. Program managers were significant to the study because they lead IMGs during residency training and are a driving force for QI and team building. Program directors view patient safety and QI as an important part of resident education (Spraker et al., 2018). IMGs were central to the study as they play a significant role in health care and provide rich knowledge and experience that stem from cross-cultural education and training.

The theoretical framework for this study was Berry's (1997) acculturation model and Portes and Zhou's (1993) segmented assimilation model, which focuses on acculturation in a linear context and assimilation based on expatriates' individual experiences. Berry conceptualized acculturation as an adaptation to sociocultural and psychological changes that derive from separating from an individual's culture. Acculturation could occur due to several reasons: colonization, military invasion, migration, refuge, and sojourning (Berry, 2005). In this study, best practices related to how acculturation strategies influenced the way IMGs navigate medical residency. Medical residency program managers look at all the functions of the post-graduate training program and IMGs to see how they all work together and how conflicts in one area may impact another area.

Implications for Social Change

The potential implications for positive social change stem from establishing a productive professional environment where managers provide an inclusive and healthy workplace for medical residents throughout post-graduate training. This study's results

may contribute valuable information for medical residency program managers and regulatory authorities seeking best practices for building and improving post-graduate training programs. This study imparts relevant information to inform leaders on unique IMG needs, QI initiatives related to conflict resolution, and best practices for addressing communication challenges related to acculturation. The information provided may prompt medical residency program managers to think critically about methods to streamline training while acknowledging cultural sensitivity and how to use the two to develop an inclusive professional environment.

Summary

This chapter covered a background on the study's topic as well as providing the definitions, nature of the study, limitations, and significance of the study. Chapter 2 consists of the literature review on research that identifies medical residency program managers' responsibilities and implications for leading IMGs. The chapter also highlights resources that explain the acculturation model and segmented assimilation model and how it impacts medical residency programs.

Chapter 2: Literature Review

In this qualitative narrative study, I identified the best practices medical residency program managers used to resolve IMG acculturation and communication challenges. In Chapter 2, I describe unique aspects of IMGs who are not only navigating post-graduate training but also cultural challenges and how those challenges impact work performance, communication, and patient relations. Additionally, in Chapter 2, I explore literature that describes cultural assimilation barriers for IMG medical residents and the best practices medical residency program managers have implemented to resolve challenges. Finally, I explore the demands of medical residency, the impact of stress on medical residents, and cross-cultural adjustment during post-graduate training.

Literature Search Strategy

Literature reviews play an essential role in academic research to gather existing knowledge and examine the state of a field (Linnenluecke et al., 2019). When conducting a systematic literature review, researchers usually face the challenge of designing a search strategy that appropriately balances result quality and review effort (Mourão et al., 2020). The following platforms resulted in a comprehensive literature review: Google Scholar, EBSCOhost, industry trade journals, ProQuest Central, Healthcare Administration Database, GME authority publications, ABI, and PubMed. The leading search keywords and terms were *medical residency program managers, residency program directors, residency program coordinators, medical residency leadership, international medical graduates, acculturation, medical residency, IMG communication, segmented assimilation theory, patient safety, patient-centered care, medical resident*

wellness, *cross-cultural adjustment*, and *quality improvement*. These searches yielded dissertations, peer-reviewed journal articles from management and medical journals, and research conducted by medical regulatory authorities. Discovering relevant literature for this review consisted of using key terms and phrases to determine how program managers developed best practices for resolving workplace conflicts that emerged from acculturation and communication barriers. The organization of the literature review includes an overview of the acculturation model, segmented assimilation theory, medical residency program manager responsibilities, IMG resident acculturation challenges impact professional advancement, GME requirements, management conflict resolution strategies, and post-graduate training outcomes.

Theoretical Foundation

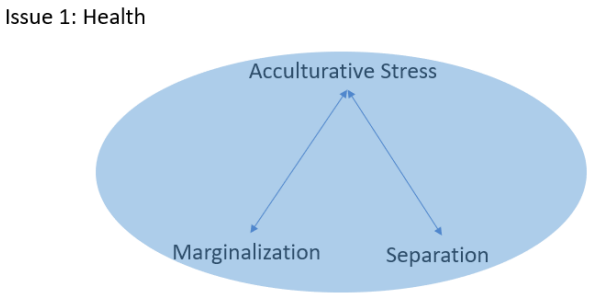
Acculturation Model

Acculturation is a dual process of cultural and psychological change that occurs when individuals from one culture come in contact with individuals from another culture (Berry, 1995). Berry (date) acknowledged four approaches of acculturation: assimilation, separation, marginalization, and integration. Adaptation directly impacts assimilation, which refers to the adjustments in behaviors that enable someone to operate in an unfamiliar atmosphere. Likewise, separation is maintaining original cultural identity while refusing to assimilate to the new culture. Assimilation involves own culture shedding (even though it may be voluntary), and separation involves rejection of the dominant culture (perhaps reciprocated by them; Berry, 1997). Increased levels of acculturative stress, due to marginalization and separation, could create an impact on

health (Duncan et al., 1986). Figure 1 is a visualization of the ongoing effects of acculturative stress due to IMGs experiencing marginalization and separation.

Figure 1

Acculturation Model



Note. Acculturation model represents the continual relationship between acculturative stress, marginalization, and separation.

Psychology

One task for psychology is to search for commonalities among people, which can allow for intercultural understanding (Berry, 2009). The key to psychological well-being may be the ability to develop and maintain competence in both cultures (Berry, 2011, p. 402). Multiculturalism involves social change to meet the needs of all the groups living together in a plural society (Berry, 2011). Attaining multiculturalism requires mutual accommodation rather than change on the part of only one of the groups (Berry, 2011). This accommodation requires that the institutions of the dominant group/larger society should evolve so that the needs of all (dominant and non-dominant) groups can be met (Berry, 2011). With data and a commitment to change, people can begin to move forward

to create a new paradigm in medical education and health care that supports rather than diminishes, and that inspires rather than disheartens (Slavin & Chibnall, 2016).

Burnout and depression throughout physicians' careers have been increasing (Talen et al., 2019). Physician well-being is essential for providing high-quality patient care and the success of the health care system (Price et al., 2020). The importance of physician well-being was formally recognized by the ACGME in 2017 when they emphasized the need for accredited residencies to develop and implement programs that prioritize resident well-being (Price et al., 2020). Mindfulness and mindful practice, which emphasizes awareness, flexibility, and reflection, have been linked to better clinical decision-making, willingness to learn, attention to the present moment, and patient-centered relationship skills (Real et al., 2017). GME must incorporate wellness training as part of a larger cultural shift (Talen et al., 2019). Well-being programs do not need to be viewed as "competing" with resident obligations and learning but rather as an opportunity to build valuable skills that can lead to longer-term resilience and success in the surgical profession (Price et al., 2020). Further research is needed to gain an understanding of the sources of distress as well as the sources of sustenance in residency to help inform interventions that could improve resident well-being (Slavin & Chibnall, 2016). Residency programs should implement well-being initiatives because these connections provide greater social support for potentially vulnerable individuals (Ziegelstein, 2018).

Culture

Culture is made up of socially shared concrete features (artifacts and institutions)

as well as abstract features (representations of these concrete aspects and symbols; Berry, 2009). That is, cultures exist as shared features of groups and do not depend on particular individuals for their existence (Berry, 2009). No single individual knows or possesses all of the culture of the group to which one belongs; the culture as a whole is carried by the collectivity (Berry, 2009).

There are variations in how people seek to relate to each other, including various alternatives to assimilation (Berry, 2011). For instance, individualistic cultures moderate the relationship between rewards and knowledge-sharing intentions in the United States (Chang et al., 2015). Individualistic cultures have shown less hierarchy in human relationships, but the majority of the people in an individualistic culture tend to move in the same direction (Beugelsdijk et al., 2017). In an individualistic society, people are the units worthy of status and could accept the existence of heroes within networks of friends, media stars, sportspeople, politicians, or deities (Hofstede, 2015). In collectivistic cultures, groups such as families, countries, or religious communities, are likely to be one inclusive reference group (Hofstede, 2015).

Additionally, there are usually individual differences across those who share cultures and societies (Berry, 2009). The compatibility (or incompatibility) in religion, values, attitudes, and/or personality between the two cultural communities in contact needs to be examined as a basis for understanding the acculturation process (Berry, 2009). Hence, intercultural relations are not viewed as unidirectional but as mutual and reciprocal (Berry, 2011). No cultural group remains unchanged following culture contact; acculturation is a two-way interaction, resulting in actions and reactions to the contact

situation (Berry, 2009).

Integration

Integration can take place in the context of relations between nation states (internationally), between groups (within culturally-diverse nation states), and between individuals (who are members of these collective entities; Berry, 2011). When there is an interest in both maintaining one's original culture, while in daily interactions with other groups, integration is the option. Integration involves the selective adoption of new behaviors from the larger society and retention of valued features of one's heritage culture (Berry, 2003). In this case, there is some degree of cultural integrity maintained while seeking to participate as an integral part of the larger society (Berry, 2011). In this context, adaptation is an outcome that may or may not be positive (Berry, 2003).

Marginalization is when there is a little possibility or interest in cultural maintenance (often for reasons of enforced cultural loss) and little interest in having relations with others (often for reasons of exclusion or discrimination; Berry, 2011). Marginalization is often associated with major heritage culture loss and the appearance of many dysfunctional and deviant behaviors (e.g., delinquency and substance and familial abuse; Berry, 2003). For acculturative stress, there is a clear picture that the pursuit of integration is the least stressful (at least when integration is accommodated by the larger society), whereas marginalization is the most stressful (Berry, 2003). In contrast, when individuals place a value on holding on to their original culture, and at the same time wish to avoid interaction with others, then the separation alternative is defined (Berry, 1997).

Acculturative stress is a reaction in response to life events that are rooted in acculturation (Berry, 1997). When acculturation experiences are judged to pose no problems for an individual, the changes are likely to be rather easy, and the behavioral changes follow smoothly (Berry, 2003). Further, when the stressors have been successfully coped with, stress will be low and the immediate effect is positive (Berry, 1997). However, if conflict occurs, it is usually resolved by the acculturating person yielding to the behavioral norms of the dominant group (Berry, 2003). In this case, individuals understand that they are facing problems resulting from intercultural contact that cannot be dealt with easily or quickly by simply adjusting or assimilating to them (Berry, 2003), which can lead to personal crises and commonly anxiety and depression (Berry, 1997).

Although integration is typically the most frequently chosen strategy, differences in how people go about their acculturation are evident (Berry, 2003). Personal factors have also been shown to affect the course of acculturation (Berry, 1997). Short-term changes during acculturation are sometimes negative and often disruptive in character (Berry, 1997). It is important to understand that acculturation is both a historical and attitudinal situation faced by migrants in the society of settlement (Berry, 1997). Intercultural relations take place over time, during which individuals explore, learn, forget, adapt and, eventually, settle into a preferred way of living (Berry, 2011). Only when there is a balance between within individuals and in society can personal integration and societal multiculturalism be achieved (Berry, 2011).

Cultural Identity

The cultural traits that characterize a group depend not only on how the group selects these traits as its identifying characteristics but also on how the larger society treats them (Zhou, 1997). If a group displays characteristics that are not comparable to the ideals of the mainstream or seem similar to characteristics identified with or projected onto native-born minorities, such as matriarchal families, these traits will be combined with the race/ethnic factor and seen as "deficient" cultural characteristics and, thus, stigmatized (Zhou, 1997). From the point of view of non-dominant groups, when individuals do not wish to maintain their cultural identity and seek daily interaction with other cultures, the Assimilation strategy is defined (Berry, 2011). If the cultural characteristics an immigrant group selects for display in America are approved by the mainstream, the group will generally be considered to have an advantageous culture, and, otherwise, a deficient culture (Zhou, 1997). In contrast, when individuals place a value on holding onto their original culture, and at the same time wish to avoid interaction with others, then the separation alternative is defined (Berry, 2009). When people have an interest in maintaining their original culture during daily interactions with other groups, they use the integration strategy (Berry, 2003). In this case, there is some degree of cultural integrity, and at the same time, they seek, as a member of an ethnocultural group, to participate as an integral part of the larger social network (Berry, 2003).

All groups in such a conception of a larger society are ethnocultural groups (rather than "minorities"), who possess cultures and who have equal cultural and other rights, regardless of their size or power (Berry, 2011). When there is an interest in both

maintaining one's original culture, while in daily interactions with other groups, integration is the strategy (Berry, 2009). In this case, there is some degree of cultural integrity maintained, while at the same time seeking, as a member of an ethnocultural group, to participate as an integral part of the larger social network (Berry, 2009). In such complex plural societies, there is no assumption that some groups should assimilate or become absorbed into another group (Berry, 2011). When individuals do not wish to maintain their cultural identity and seek daily interactions with other cultures, they are using the assimilation strategy (Berry, 2003). In contrast, when individuals place a value on holding on to their original culture and at the same time wish to avoid interacting with others, they are using the separation alternative (Berry, 2003).

Strategy

What is meant by the phrase intercultural strategies is the core idea that groups and individuals (both dominant and non-dominant) living in plural societies engage each other in several different ways (Berry, 1974). When examined among non-dominant ethnocultural groups that are in contact with a dominant group, these preferences have become known as acculturation strategies (Berry, 2011). They have been called strategies rather than attitudes because they consist of both attitudes and behaviors (that is, they include both the preferences and the actual outcomes) that are exhibited in day-to-day intercultural encounters (Berry, 2011). Figure 2 is a visualization that differentiates the two assimilation models. The figure represents the dominant cultural group and the acculturation model.

Figure 2

Assimilation Models

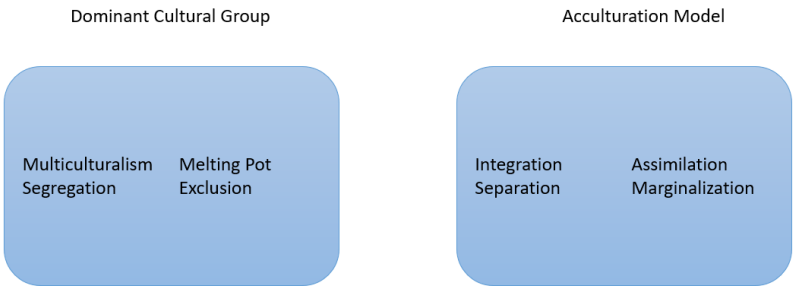


Figure: Assimilation Models

The first part is the assimilation model, in which individuals become absorbed into the dominant cultural group, losing much of their heritage culture at the same time (Berry, 2011). The second part is the acculturation model, which proposes that individuals will lose some of their heritage culture (as for assimilation) but will "always be identified as a member of the minority culture" (Berry, 2011, p. 397). In essence, bicultural competence refers to the attainment of cognitive, affective motivational qualities that permit successful functioning in both cultures in contact (Berry, 2011). Competencies are those features of individuals that develop with experience such as abilities, attitudes, and values. Performances are those individual activities that are expressed as behavior, such as carrying out projects and engaging in political action (Berry, 2011).

Medical school leaders and residency program directors should also create structured opportunities for trainees to establish meaningful connections with each other to provide greater social support and, thereby, reduce the harmful effects of stress (Ziegelstein, 2018). Acculturation strategies have been shown to have substantial

relationships with positive adaptation: integration is usually the most successful, marginalization is the least, and assimilation and separation strategies are intermediate (Berry, 1997). Another possible reason for the finding that Integration is the most adaptive strategy is that most studies of the relationship between acculturation strategies and adaptation have been carried out in multicultural societies (Berry, 1997). There could be benefits to persons matching their acculturation strategies to that generally advocated and accepted in the larger society (Berry, 1997).

At the individual level, information about the protective benefits of cultural maintenance and social support can be disseminated through ethnocultural community interaction, thereby, reducing the stresses associated with assimilation (Berry, 1997). At the same time, the benefits of seeking to participate in the national institutions (educational, work, judicial) to the extent desired, can reduce the stresses associated with separation (Berry, 1997). The more immediate outcomes of the acculturation process (including the behavior changes and acculturative stress phenomena) are now known to be a function, at least to some extent, of what people try to do during their acculturation (i.e., their acculturation strategies; Berry, 2009).

Departments truly invested in resident well-being need to provide program directors and key faculty time to tailor the content and basic curriculum to their specific programmatic needs (Price et al., 2020). Recognition of a crisis in GME is growing (Slavin & Chibnall, 2016). Most action can be taken and most successes can be realized in the society of settlement (Berry, 1997). Increased resident and faculty engagement and buy-in by framing and orienting the well-being program can help to provide professional

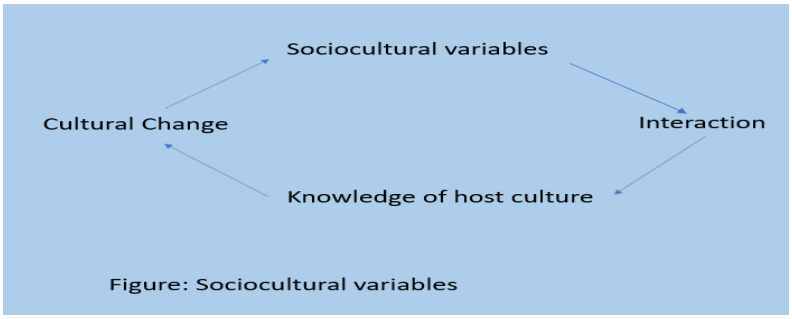
development tools. These self-reported changes included more effective interactions with healthcare team members and more successful time management, resulting in residents achieving more satisfying work-life integration (Price et al., 2020).

Segmented Assimilation Theory

Portes and Zhou's segmented assimilation model (1993) is identified in individual levels of cross-cultural adjustment and conduct and how it would appear within a new community. Increased cognizance of the host country's workplace norms and values helps expatriates to assimilate and effect positive cultural adjustment. Sociocultural variables not only enable one's ability to interact with different cultural groups and obtain new knowledge of the host culture heightens but improve one's ability to identify with the dominant group and undergo cultural change (Girmay, 2017). Figure 3 shows the ongoing relationship of expatriates navigating between cultural norms, social interactions, and the host country's cultural norms. Figure 3 shows the continuing relationship between cultural norms, person-to-person interaction, changes in culture, and knowledge of the new culture.

Figure 3

Sociocultural Variables



The use of Portes and Zhou's segmented assimilation model (1993) expanded the

current understanding of IMG acculturation experiences and the cultural adaptation strategies applied in medical residency programs. Portes and Zhou's segmented assimilation model (1993) and Berry's acculturation model (1997) helped contribute new knowledge on communication, acculturation stress, and adaptation strategies of medical residency program managers. This information is useful to inform best practice strategies for IMGs in post-graduate training programs.

Portes and Zhou's segmented assimilation model (1993) emphasized new migrants' assimilation process and that "an individual level of adaptation and behavior are necessary for the person or group to transition into a new culture or society successfully" (Xie & Greenman, 2011, p. 48). This theory distinguishes the personalized and sectored nature of the expatriate experience into the new host culture. The segmented assimilation theory (1993) acknowledged that every immigrant does not follow the same step-by-step acculturation path and process as other marginalized social groups in society (De Burgomaster, 2013). IMGs who lack resources like friends, family, and acquaintances may feel vulnerable when assimilating to a new culture. Feelings of vulnerability may lead to expatriates feeling marginalized particularly when the host country's reception is disapproving. Portes and Zhou's segmented assimilation model (1993) argued that adaptation of the marginalized population to the host culture's society will depend on access to capital, social, human, and cultural support to adapt (Lovink, 2010).

Expatriates face different challenges upon arrival to a new environment as they are adjusting to work and communication. Socialization becomes an opportunity to

connect with others who will provide information and guidance to navigate both cultures and positively mediate problems (Kim, 2014). IMGs must adapt to residents, new cultural variances, linguistic barriers, separation from familiarity, social integration, and challenges in daily professional duties. Cross-cultural adjustment challenges may differ depending on ethnicity and whether the expatriate comes from a culture that is collectivist or individualist.

Processes

Processes are those psychological features of individuals that are the fundamental ways in which people deal with their day-to-day experiences such as perception, learning, and categorization (Berry, 2011). In contrast to Berry's (1997, 2001) acculturation theory, segmented assimilation theory is based on how immigrants can adapt to an environment that is very diverse and segmented. Segmented assimilation theory emphasizes new migrants' assimilation process and that "an individual level of adaptation and behavior are necessary for the person or group to transition into a new culture or society successfully" (Xie & Greenman, 2011, p. 48). Individuals such as those with a bicultural background may choose environments and social networks that are compatible with their personality, interests, and other similar traits for support (Pedersen et al., 2011). In essence, the mode of incorporation is dependent on the challenges and obstacles faced by immigrants as they enter into a vastly different environment (Portes & Rivas, 2011). The segmented assimilation theory recognizes the fact that immigrants are today being absorbed by different segments of American society, ranging from affluent middle-class suburbs to impoverished inner-city ghettos, but that becoming American

may not always be an advantage for themselves nor their children (Zhou, 1997).

Socialization becomes an opportunity to connect with others who will provide information and guidance to navigate both cultures and positively mediate problems (Kim, 2014). Central to this perspective are the assumptions that there is a natural process by which diverse ethnic groups come to share a common culture and to gain equal access to the opportunity structure of society; that this process consists of gradually deserting old cultural and behavioral patterns in favor of new ones; and that, once set in motion, this process moves inevitably and irreversibly toward assimilation (Zhou, 1997).

Assimilation

The multicultural perspective offers an alternative way of viewing the host society, treating members of ethnic minority groups as a part of the American population rather than as foreigners or outsiders, and presenting ethnic or immigrant cultures as integral segments of the American society (Zhou, 1997). The segmented assimilation theory research recognizes the "individualized and segmented nature" of the immigrant experience into the new host culture (Rumbaut, 2005). Segmented assimilation facilitates the establishment of migrants' socioeconomic status and family structure like the host culture (Gratton et al., 2007). However, the questions of "second-generation decline" and "second-generation revolt" have been unanswered within this theoretical framework (Zhou, 1997). The segmented assimilation theory acknowledges that every immigrant does not follow the same step-by-step acculturation path and process as other marginalized social groups in society (De Burgomaster, 2013). Research has linked ethnic identity to culture, acculturation, and racial identification (Noels et al., 1996).

While how people construct or invent their ethnicity has been emphasized, how they also construct their acculturation and assimilation has been understudied (Zhou, 1997).

Segmented assimilation theory argues that adaptation of the marginalized population to the host culture's society will depend on access to capital, social, human, and cultural support to adapt (Lovink, 2010). Segmented assimilation theory has been a popular explanation for the diverse experiences of assimilation among new waves of immigrants and their children. While the theory has been interpreted in many ways, we highlight its inferences for the important role of social change: processes and consequences of assimilation should depend on the local social setting in which IMGs are surrounded.

This study investigated the interaction effects between social context and assimilation among IMG residents. IMG expatriates may assimilate with different groups and consequently, may take divergent assimilation paths. These paths include conventional upward or straight-line, assimilation, downward assimilation, and selective acculturation. Portes and Zhou (1993) noted several vulnerabilities as well as resources that may be grounded in the social contexts of acculturating groups. Vulnerabilities include larger societal prejudices that are associated with race/ethnicity, the concentration of immigrant households in poor, inner-city neighborhoods, and the absence of economic mobility ladders in such neighborhoods (Johnson & Marchi, 2009). Resources that may facilitate alternative paths of acculturation include eligibility for public benefits (as in the case of refugees), the exemption of certain foreign groups from traditional prejudices (such as white Europeans), and social capital neighborhoods (Johnson & Marchi, 2009).

Portes (1998) identified three basic types and roles of social capital including family support, benefits that are provided through extrafamilial networks, and social control. These informal networks are characterized by a strong tradition of intergenerational knowledge transfer concerning diet and stress reduction during pregnancy and the provision of material and social support by spouses, family members, and neighbors during the prenatal and postpartum periods (Johnson & Marchi, 2009).

Assimilationists focus on the changes that a new environment can bring about in cultural patterns and describe how immigrants and their succeeding generations gradually move away from the old country ways (Zhou, 1997). Thus, assimilation and upward mobility were thought to go hand in hand (Xie & Greenman, 2011). The real question is whether or not the racial/ethnic barriers to assimilation for the new immigrants are now much higher than or qualitatively distinct from earlier barriers (Xie & Greenman, 2011). The assimilationist, multicultural and structural perspectives have approached similar issues from different standpoints (Zhou, 1997).

Segmented assimilation can be viewed as a middle-range theory that concerns why different patterns of adaptation emerge among contemporary immigrants and how these patterns necessarily lead to the destinies of convergence or divergence (Zhou, 1997). Portes and Zhou outlined three potential pathways of assimilation: (a) increasing acculturation and integration into the American middle class (Path 1 or straight-line assimilation); (b) acculturation and assimilation into the urban underclass (Path 2 or downward assimilation); and (c) the deliberate preservation of the immigrant community's culture and values accompanied by economic integration (Path 3 or

selective acculturation; Portes & Zhou, 1993; Rumbaut, 1994; Zhou, 1997). Segmented assimilation theory emphasizes that there is more than one way of ‘‘becoming American,’’ and that Americanization is not necessarily beneficial (Bankston & Zhou, 1997; Zhou, 1997). This research will focus on the third pathway, individual variation among immigrants. This path makes use of differences among expatriate groups in the speed and type of assimilation. This approach also acknowledges group differences by age and/or culture. Theoretical controversies surrounding classical assimilationism are generally concerned with how immigrants adapt to American society and with the forces that promote or impede their progress (Zhou, 1997).

A closer look at these experiences indicates, however, that the expected consequences of assimilation have not entirely reversed signs, but that the process has become segmented (Portes & Zhou, 2006). Instead of a relatively uniform mainstream whose mores and prejudices dictate a common path of integration, there are several distinct forms of adaptation today (Portes & Zhou, 2006). One of them replicates the time-honored portrayal of growing acculturation and parallel integration into the white middle-class; a second leads straight in the opposite direction to permanent poverty and assimilation into the underclass; still a third associates rapid economic advancement with deliberate preservation of the immigrant community’s values and tight solidarity (Portes & Zhou, 2006). This pattern of segmented assimilation immediately raises the question of what makes some immigrant groups susceptible to the downward route and what resources allow others to avoid this course (Portes & Zhou, 2006).

Despite the vital role of IMGs within the US healthcare system, understanding of

their professional experiences is limited, though it is clear that elements of their experiences differ from those of the larger physician population (Chen et al., 2010). Immigrants who join well-established and diversified ethnic groups have access from the start to a range of moral and material resources well beyond those available through official assistance programs (Portes & Zhou, 2006). Since IMGs go through the assimilation process in line with the Portes and Zhou (1993) segmented assimilation model, this theoretical framework correlates with the research and provides a satisfactory framework to develop research questions.

This new economy is sometimes referred to in the literature as the ‘‘hourglass’’ economy, consisting of a relatively large demand for both college-educated professional workers at the top and low-paid, low-skilled service workers at the bottom, but not much in between (Xie & Greenman, 2011). Hospitals are very structured environments and working within their systems requires knowledge of specific routines and procedures, some of which, such as prescribing, require a high degree of precision (Henderson et al., 2017). Many IMGs are talented, knowledgeable, and highly motivated physicians who perform well in U.S. residency programs (Horvath et al., 2004). More importantly, over one-third of family medicine residents are IMGs (Duvivier et al., 2019). To obtain an unrestricted license to practice medicine in any U.S. jurisdiction, an IMG must complete at least 2 years, and often 3 years depending on the licensing authority of residency training (Duvivier et al., 2019).

IMGs play an important role in U.S. family medicine workforce (Duvivier et al., 2019). Many IMGs come to the United States with prior training and experience, giving

them an expertise not typical of U.S. medical school graduates (Horvath et al., 2004). A resident who performs poorly in a residency system may jeopardize patient care and create multiple problems for the residency program (Horvath et al., 2004). Equally important is that it is difficult for the IMG to get a second chance once they fail in a U.S. training program (Horvath et al., 2004). Many states are highly reliant on IMGs to fill their workforce needs (Duvivier et al., 2019). It is essential that IMGs be set up to succeed in their preliminary years so that they can move into open categorical positions and continue in GME (Horvath et al., 2004).

Figure 4

Berry's Acculturation Model and Zhou's Segmented Assimilation Model

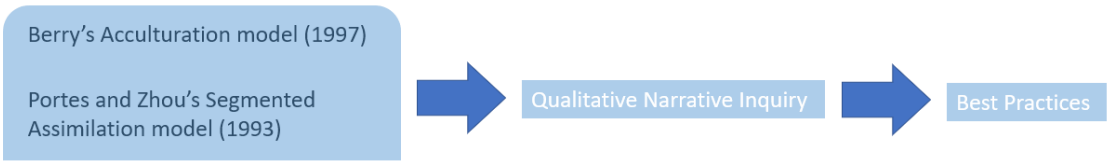


Figure: Berry's Acculturation model (1997) and Portes and Zhou's Segmented Assimilation model (1993), this study will implement qualitative narrative inquiry to explore the best practices medical residency program managers developed while leading IMGs.

Literature Review Related to Key Concepts

Medical Residency Program Managers

Managers should motivate newly acquired workers to acculturate themselves with new philosophies, policies, and organizational and national cultures from the acquiring firm (Haspeslagh & Jemison, 1991). By analyzing the differences in national cultures of the employees, leaders may be able to predict potential negative consequences related to employee stress, depression, or indifferent attitudes toward cooperation and to reduce

conflicting business values and communication styles for building new capabilities (Caiazza & Volpe, 2015). Researchers often attribute multicultural management problems to national cultures or cultural differences among employees (Hofstede, 2015). The more comfortable someone is with ambiguity, the more likely they can adapt and adjust to unstructured situations (Hofstede, 1983b).

This research observed medical residency program managers across multiple specialties. Historically, the role of a residency manager has been administrative and clerical; however, since the ACGME's Next Accreditation System began in 2013 in the United States, managers' roles have expanded to include more managerial and liaison responsibilities (Ofei-Dodoo et al., 2020). The curriculum's success could be attributed to several factors including a strong commitment of leadership and curriculum developers, the enthusiastic engagement of patient volunteers as standardized patients, and a simulation center providing space, equipment, and staff (Newcomb et al., 2017). A wide variety of job titles are used for family medicine residency managers, including program coordinator, academic coordinator, program administrator, residency manager, and program manager (Ofei-Dodoo et al., 2020). This literature review incorporates search terms using each of the titles above, including residency program directors and applying them among various residency program specialties.

Organizational Structure

Two key terms were sought during the literature search: workplace satisfaction and patient safety among residency staff. Ofei-Dodoo et al. (2020) conducted a study surrounding job satisfaction and turnover among residency program directors. Medical

residency program managers insofar are responsible for the administrative duties in medical residency programs within a teaching hospital or medical facility (Ofei-Dodoo et al., 2020).

In the business world, employee engagement has become a central element of organizational management not only because it reduces the costs of recruitment and retention but also it encourages and harnesses the development of new ideas that may produce a competitive advantage (Rabkin et al., 2019). Medical residency managers are more emotionally and cognitively engaged when their job responsibilities are clearly communicated, have the resources necessary to accomplish their work, perceive their work as meaningful, are compensated fairly and equitably, and have opportunities to be promoted (Ofei-Dodoo et al., 2020).

To be effective, support, development, and advancement opportunities must be clearly communicated to family medicine residency managers (Ofei-Dodoo et al., 2020). Currently, many organizational structures do not provide opportunities or a clear pathway for managers to undertake professional development or achieve promotion (Ofei-Dodoo et al., 2020). In industries where innovation is required, an innovation climate might signal to a company's employees that an upward voice is valuable because it would help to adapt to a changing environment (Silla et al., 2020). Given the increased volume and significance of job responsibilities and duties expected of family medicine residency managers after the adaptation of Next Accreditation System, they could be vulnerable to experiencing increased job-related stress and the negative outcomes of decreased work engagement, job satisfaction, and increased turnover (Ofei-Dodoo et al., 2020). Padgett et

al. (2017) suggested that organizational leadership reviews the current physician-staff hierarchy and renews some of the empowerment and decision-making authority of the staff that has waned over time.

Managing Quality Care

Acculturation and communication can impact the quality of care IMGs deliver. In some cases, IMGs are unfamiliar with local languages, customs, hierarchical dynamics within hospitals, or local families. The disconnect can impact a patient's understanding of medical directives, safety, and hinder a colleague's responsibilities. This study incorporated publications on quality care because it is a crucial component for IMGs in residency. Quality care is directly related to understanding how staff members work together in a cohesive and transparent work environment and inform how medical residents interact, educate, and inform patients. A thoughtful and broad consideration of stakeholders and their concerns, informed by the best evidence available, was necessary to maximize the potential for improvement and minimize the risk of unintended adverse consequences resulting from any changes to the status quo (Katsufrakis & Chaudhry, 2019). Some IMG residents struggle to create an assessment and plan and then to document that assessment and plan (Osta et al., 2017). Quality of care and quality of life are directly related to client functioning measures, which are directly related to patient and consumer satisfaction measures, and in turn, reduce the demands for services based on the needs and wants of the patients (Padgett et al., 2017). This is important to improve the performance of each individual resident but given that IMG residents often work in under-resourced areas, it is also essential in decreasing healthcare disparities throughout

the United States (Osta et al., 2017).

Spraker et al. (2018) conducted a study on patient satisfaction and QI. QI is an essential component of medical practice (Cheung, 2017). The authors provided two recommendations. Spraker et al. (2018) recommended a more formalized collaboration between medical practitioners and radiation oncology program directors or inclusion of patient safety/QI champions to close the gap of self-reported lack of expertise in these topics as a barrier to effective training. Medical students and residents must learn the skills to conduct clinical QI during their educational programs (Cheung, 2017). Strategies could include professional development training and opportunities for lateral movement to develop new skills and expand professional knowledge and collegial support networks (Ofei-Dodoo et al., 2020). Medical educators must create and implement a curriculum in QI to empower their students to develop this skill and knowledge (Cheung, 2017).

Although each medical setting has specific communication challenges, there are core issues shared across all settings, such as the ability to respond to the patient's needs and emotions and to enhance the quality of the encounter with the patient by an efficient exchange of information (Barbosa et al., 2019). Different perspectives and paths are followed in respect of approaches to patients and gaining patients' trust within different specialties, and different concepts are questioned by both the patient and the physician (Gençer et al., 2018). The biopsychosocial approaches of doctors in different specialties to their patients should be diversified without ignoring the diverse human thoughts in this changing world (Gençer et al., 2018). Designing and implementing a new curriculum is a complex enterprise, requiring the coordination of myriad resources and schedules

(Newcomb et al., 2017). This initiative is of considerable value, especially in times of funding constraints for healthcare expenditures (Rabkin et al., 2019).

Leading Medical Residents

There has been a call for medical education leaders to devote resources to bolster the next generation of providers and shift the culture of medicine to organizational initiatives that impact physician well-being (Talen et al., 2019). Sebesta et al. (2019) explained that the milestones system of evaluation is now widely used among specialties, the specific benefits and perceptions of usefulness to residency program directors and resident education, as well as barriers to implementing this system have yet to be addressed in the urology literature. The ACGME Milestones system for resident evaluation was initiated to create a uniform competency-based, specialty-specific assessment of residents (Sebesta et al., 2019). Program directors should consider integrating resident training into institutional patient safety/QI activities (Spraker et al., 2018).

Medical residents' training increasingly involves the need to demonstrate social, cognitive, attitudinal, and behavioral activities related to quality and safe patient care (Real et al., 2017). Transforming the organizational culture to improve safety emphasizes the unsettled nature of culture and raises questions about its temporal dimension (Leuridan, 2020). Noordman et al. (2019) stated that patient-centered communication and empathy are key enablers for patient-centered care. QI is an essential component of medical practice (Cheung, 2017). Several studies suggest a downward trend regarding the empathic communication skills of physicians during medical residency (Noordman et al.,

2019). Odell et al. (2019) revealed the importance of intrinsic institutional factors such as the development of a culture that promotes patient safety for improved outcomes at the patient level (Odell et al., 2019). Medical educators at the undergraduate and graduate levels are at crossroads, as medical schools and residency programs adapt to the new curricular requirements and accreditation systems (Morgan et al., 2017). Efforts to improve safety culture have demonstrated an ability to positively influence both staff perception and patient outcomes in specific areas (Odell et al., 2019).

International Medical Graduates

Educational Commission for Foreign Medical Graduates defines an IMG as a physician who receives his or her medical degree from a medical school outside of the United States or Canada (Osta et al., 2017). IMGs have become an important workforce as ‘foreign doctors’ in the health systems of most developed countries due to a shortage of health professionals in aging societies (Michalski et al., 2017). Medical students start this residency training approximately 1 month after graduation from medical school (Morgan et al., 2017). To obtain an unrestricted license to practice medicine in any U.S. jurisdiction, an IMG must complete at least 2 years, and often 3 years depending on the licensing authority of residency training (Duvivier et al., 2019).

IMGs play a key part in the U.S. healthcare system with about 26% of total physicians in the workforce (Osta et al., 2017). Najeeb et al. (2019) conducted a study on IMGs’ experiences where they observed that many IMGs enter North American residency programs every year. To obtain an unrestricted license to practice medicine in any U.S. jurisdiction, an IMG must complete at least 2 years, and often 3 years depending

on the licensing authority of residency training (Duvivier et al., 2019).

The IMG family medicine workforce indicates great diversity with respect to citizenship, country of medical school training, and various practice-based demographics (Duvivier et al., 2019). In our age, information has never been as easily accessible as it used to be throughout history, while interaction between different cultures and thoughts across the world has speeded up (Gençer et al., 2018). This situation has resulted in unprecedented diversification of sociocultural segments and faiths (Gençer et al., 2018).

Acculturation

Osta et al. (2017) defined acculturation as the cultural changes individuals who have developed in one context (e.g., non-U.S. medical contexts) go through to adapt to new contexts (e.g., U.S. medical contexts) due to migration. IMGs play a key role in host countries' health systems but face unique challenges, which makes effective, tailored support for IMGs essential (Osta et al., 2017). I-IMG and Canadian-IMG participants perceived two major challenges: discrimination because of negative labeling as IMGs and difficulties navigating their initial residency months (Najeeb et al., 2019). Participants from both groups identified two major opportunities: their desire to help other IMGs and a need for mentorship (Najeeb et al., 2019). Foreign-born physicians may be a disadvantaged group with a higher likelihood of discrimination and less prestigious jobs (Heponiemi et al., 2018).

Michalski et al. (2017) conducted a study surrounding IMGs and intercultural challenges. The main findings indicate that IMGs were unfamiliar with the concept of shared decision-making and the separation of relatives from the information and

treatment process (Michalski et al., 2017). Furthermore, IMGs described a loss of status and flat hierarchies to supervisors, other health professionals, and patients compared to their domestic countries in which they were trained (Michalski et al., 2017). Residency is a unique time of stress, especially for IMG residents who must learn not only their specialty of medicine but also how to communicate with patients and families within the context of the U.S. healthcare system (Osta et al., 2017). In addition, nonculture-related difficulties for the IMGs with the new healthcare system and with the subtleties of the foreign language were found (Michalski et al., 2017). The "safety culture" within hospital systems is increasingly recognized as important to the delivery of high-quality care (Odell et al., 2019). The concept of patient-centered care was described to be difficult to them (Michalski et al., 2017).

Previous studies of acculturation, which is a frequently investigated topic in both higher education and medical education research found that IMG residents are most likely to match into internal medicine, family medicine, pediatrics, psychiatry, and surgery-preliminary (Osta et al., 2017). Because of the critical role that primary care physicians have in our healthcare system, it is essential that residency program directors have programs in place to support IMG residents (Osta et al., 2017). Medical educators identified tension in teaching IMGs as it could be different from teaching domestic graduates in any or all aspects of a training program (Wearne et al., 2019). There is a greater tension related to intercultural coexistence favored by the cultural, language, and prejudice barrier (Urrutia-Arroyo, 2018). They felt an ethical responsibility to support IMGs to provide quality healthcare in their adopted country but faced multiple challenges

to achieve this (Wearne et al., 2019). IMGs must become acculturated to United States medical contexts (Osta et al., 2017). Good job resources, such as a good team climate and the possibility to use one's skills, may help foreign-born employees, for instance, by giving them support when needed and offering flexibility (Heponiemi et al., 2018).

Patient Safety and Quality Improvement

I included publications on patient safety and QI because they are important components of post-graduate training programs in the United States. While program managers across the United States are consistently seeking innovative ways to implement patient safety and QI into residency program curriculums, it may not be enforced in training programs outside of the country. Best practices were established to aid IMGs in applying patient safety and QI to daily work responsibilities and training sessions. Patient safety and healthcare quality have become major topics in the parlance of modern medical care (Jamal, 2017). One of the current challenges of hospitals is to explore ways to improve patient safety culture (Jafarpanah & Rezaei, 2020). Noordman et al. (2019) stated that patient-centered communication and empathy are key enablers for patient-centered care. The education of the IMGs was described as science-oriented without focusing on psychosocial aspects (Michalski et al., 2017). Patient safety requires the improvement of patient safety culture, which can be a difficult process (Jafarpanah & Rezaei, 2020). Training residents in patient-centered communication and empathy can be an opportunity to improve patient-centered care (Noordman et al., 2019). Patient safety and QI processes are vitally important to healthcare systems (Schroll et al., 2020). The quality of patient-centered care can be improved by integrating patient-centered

communication into residency programs at an academic medical health center (Noordman et al., 2019).

Preventable medical errors result in the loss of 200,000 lives per year with associated financial and operational burdens on organizations and society (Padgett et al., 2017). Real et al. (2017) found that fostering better communication and mindful practice in medical residents in critical care rotations and surgical education leads to better patient outcomes. It is known that communication training can have a positive effect on patient-centered communication, empathy, and relational skills (Noordman et al., 2019). Purnell et al. (2020) stated that accrediting bodies in medical education have recognized the importance of physician competency in quality of care, QI, and patient safety. A successful continuous QI needs to identify risks to quality healthcare and provide a solution to mitigate those risks (Ntwiga et al., 2019).

Medical residents train in complex environments characterized by uncertainty, time pressure, conflicting and ambiguous information, risk, distractions, multiple tasks, and the presence of many different professions/occupations (Real et al., 2017). These face-to-face activities are important, as many clinical interactions occur via technology (e.g., one-way text paging, phone calls, electronic order entry) with a lack of closed-loop communication (Nicholson et al., 2019). It is essential that in their training, they develop the ability to recognize their clinical and communicative capabilities as they work and interact with attending physicians, staff, and patients (Real et al., 2017). Maintaining a good team climate in cross-cultural working teams and giving foreign-born employees possibilities to use their skills may be a challenge and may require constant effort, but it

may also bring great benefits for employees and organizations (Heponiemi et al., 2018).

Nicholson et al. (2019) explained that interprofessional collaboration is vital to maintaining a successful healthcare team. Significant infrastructure is required to support residents in leading QI activities, including curricula in fundamental concepts, identification of quality targets for improvement, statistical analysis support, health systems or clinical operations staff support, and access to data on appropriate metrics, ideally along with a physician champion (Purnell et al., 2020). Ntwiga et al. (2019) explained that the application of continuous QI has a significant influence on customer satisfaction. Team-building exercises enhanced nurse and resident understanding and appreciation of their discipline-specific roles and responsibilities (Nicholson et al., 2019).

Individual residency programs are responsible for developing and implementing QI curricula in their programs both to meet the ACGME common program requirements and to support residents in achieving competency in Systems-Based Practice (SBP) and Practice-Based Learning and Improvement (PBLI; Purnell et al., 2020). Simulations permitted nurses and residents to practice escalating patient concerns and establishing a management plan, while the debriefings further reinforced the need for teamwork and communication through sharing of ideas and reflection (Nicholson et al., 2019).

Haber et al. (2020) conducted research investigating the reduction of residency programs using camaraderie and personal wellness during retreats. Besides camaraderie, residents need to see their leadership caring about them, reassuring them, and guiding them in their development as future physicians (Moresco et al., 2020). Medical school leaders and residency program directors should also realize the potential for social

connection and engagement, as well as group identification, to promote well-being and avoid burnout (Ziegelstein, 2018). The high frequency with which the residents cited camaraderie as the mechanism of how the retreat would improve their residency experience and personal wellness underscores the importance of copresident social support. Researchers reported that team-building and bonding activities served as easily implemented methods of promoting camaraderie amongst the residents (Haber et al., 2020). Heponiemi et al. (2018) noted that training increasing cross-cultural empathy and patience might be beneficial.

Mindful Medicine

Ziegelstein (2018) revealed that medical schools and residency programs implement wellness initiatives that often include meditation and other mindfulness activities, self-reflection, journaling, and lectures or workshops on resilience tools such as metacognition and cognitive restructuring. Lundh (2020) explained experimental phenomenology in research on mindfulness can take many different forms from (1) the detailed exploration and description of potentially effective mindfulness practices and their potential effects, over (2) sophisticated forms of case studies that use experimental single-case designs, possibly in combination with descriptive-phenomenological methods to test the effects of intentional variations in experiencing, to (3) controlled studies at the group level where different groups of participants are administering varying verbal instructions to induce different forms of experience and where the outcome is compared in terms of phenomenological effects in the present. Increased mindfulness leads to greater awareness, understanding of the physician’s internal thought processes and

emotions, and has implications for preventing bias and diagnostic errors (Real et al., 2017).

Moresco et al. (2020) stated, one of the challenges we faced in integrating wellness into the curriculum was the perception that there is no room or time; however, opportunities for residents to check in with each other in a residency-sponsored event may be one of the most important aspects of preventing burnout, enhancing resident camaraderie, and eliminating feelings of isolation. Developing and implementing effective QI curricula is a major challenge for residency programs in large part because physicians currently in practice did not receive QI training during their residency, resulting in a paucity of experts to teach this content (Purnell et al., 2020).

Ethics and Autonomy

When discussing patient ownership, Randle et al. (2020) indicated clinical situations that place a resident in the position to make that decision are infrequently prevalent in the modern training environment. With the capability to work one-on-one with attending physicians, there was unfiltered access to their clinical expertise and wisdom while also benefiting from numerous career opportunities and research mentorships (Moresco et al., 2020). Improving recognition of trainees' sense of responsibility might increase faulty willingness to entrust their trainees with more responsibility, but this shift in perspective is not the only way to foster a stronger sense of ownership faculty (Randle et al., 2020).

Residents who are proactive in pursuing educational goals and those who are more passively guided by their program can all be successful in residency and become

competent physicians (Moresco et al., 2020). Through direct interaction with faculty and staff, we identified individual educational needs and clinical teaching felt truly personalized (Moresco et al., 2020). A new program should provide a clearly defined set of expectations for each rotation agreed upon by all rotation faculty to guide the interns toward the learning objectives expected to be achieved by the end of the rotation (Moresco et al., 2020).

Medical specialization is improving daily, and sociocultural shifts and the rise in the accumulation of knowledge cause new disciplines and specialties to emerge (Gençer et al., 2018). In reference to residency programs, Moresco et al. (2020) found that they should provide a framework that frequently solicits feedback from the residents and be prepared to implement changes quickly. Each specialty becomes a different discipline in itself with its sub-branches (Gençer et al., 2018). Within this context, the reality we have come across can bring different values and worries within the patient-physician relationships in various specialties. The scope of the patient-physician relationship can differ even in different disease types in the same medical discipline (Gençer et al., 2018). Residents should be flexible, creative, and not afraid to speak up with novel ideas or ways to improve the system (Moresco et al., 2020). Specialization in the field of medicine is increasing each day within the age of information and causes new specialties to emerge (Gençer et al., 2018). While physicians who are getting residency training obtain new information related to their field, they reshape their relations with the patients within the context of their field (Gençer et al., 2018). Everyone should be able to give and receive feedback regardless of the level of training (Moresco et al., 2020). Mutual

respect, as well as a unified effort for excellence, must exist between the program faculty and residents for a new program to thrive. All members of the team need to be heard and know that their contribution is valued (Moresco et al., 2020).

Randle et al. (2020) found that more faculty claimed to grant autonomy in response to ownership than to develop ownership. Modifiable aspects of residency culture that are associated with residents' sense of personal responsibility for patient outcomes include camaraderie, mentorship, and autonomy (Randle et al., 2020). Opportunities, where residents and leaders can gather for updates, questions, and concerns, are beneficial for the team at large. House staff meetings allow residents to regroup and communicate about national meetings, child advocacy opportunities, ongoing research and QI, and hospital initiatives (Moresco et al., 2020). Feedback can be accomplished with monthly resident feedback meetings, open-door policies, leaders who demonstrate empathy, and frequent updates on prior concerns or ideas brought up by residents (Moresco et al., 2020). Medical providers are at risk if strategies are not in place to address patient safety and quality (Padgett et al., 2017).

Medical ethics and ethics education have appeared as two interconnected notions from ancient times to the present that each new specialization area integrates idiosyncratic ethical priorities into the field of medicine with the advancement in information (Gençer et al., 2018). Medical schools and residency programs should create structured opportunities for trainees to establish meaningful connections with each other and with others in their learning and work environments (Ziegelstein, 2018). A partial explanation for these shortcomings is the failure to align training curricula with the

requisite skills for practice (Schumacher et al., 2020).

The path to achieving this is very loosely defined, and many programs are struggling to understand how to create such programs (Price et al., 2020). Departmental leadership must be open to supporting these efforts (Price et al., 2020). Even if ethics courses given during basic medical education list the core values, it is not all that wrong to say that the ethical approach has kind of a perpetual structure shaped by the practices within the physician-patient relationships (Gençer et al., 2018). This, in turn, leads to improved patient care quality, improved client functioning measures, and improved patient safety or satisfaction measures. Besides a patient's perceptions and reactions towards the disease, treatment setting, and crew, approaches and the attitudes of the treatment crew towards the patient have a profound effect during the treatment procedure (Gençer et al., 2018). Inability to achieve optimal assessment of trainee performance in the workplace also presents a significant barrier to adequate judgments of if, and when trainees are prepared to meet the needs of patients (Schumacher et al., 2020). When human factors, including blame culture, compassion fatigue, and poor communication are reduced, staff competency, organizational knowledge, and a positive relationship between patients and care staff increase (Padgett et al., 2017). It is significant to give ethics education like the one given throughout the basic medical education by considering different approaches for different specialties during medical residency training (Gençer et al., 2018).

When adverse events decrease, patient safety improves (Padgett et al., 2017). Besides being a different topic, which is about how to carry out that kind of a study

which will possibly be pretty extensive, it is surely beyond doubt that medical ethics form a part of the integrated and patient-centered approach (Gençer et al., 2018). Adverse events are directly related to increased costs, stemming from litigation, unnecessary care instigated by regulations, and defensive medicine in response to regulations (Padgett et al., 2017). Addressing these deficiencies is imperative because ensuring adequate preparation (through training) and ability (through assessment) to care for patients is central to safe care (Schumacher et al., 2020). With conflicting, concerning, and limited evidence of the link between educational outcomes and patient care outcomes to date, further work in this area is important (Schumacher et al., 2020). Transitioning to a reliability-seeking organization will contribute to improved reporting to regulatory entities, enhance the safety of staff and patients, contribute to staff loyalty, and reduce operational and punitive costs (Padgett et al., 2017).

Workplace Culture

Residency is a major time of stress for all physicians, but residents who are IMGs also must learn a new culture, medical system, and often communicate in a new language (Osta et al., 2017). Culture is a foundation for creating knowledge and meaning, and it is, therefore, a key element of management of the unexpected (Leuridan, 2020). Organizational mindsets might shape cultural norms and employees' trust in and commitment to their organization (Canning et al., 2020).

Brewington and Darko (2020) defined organizational culture as:

1. A group phenomenon that resides in shared behaviors, values, and assumptions.

2. Pervasive, permeating multiple organizational levels and manifest in collective behaviors, rituals, symbols, and stories; enduring, directing group thoughts and actions over the long term; and implicit, a kind of silent language.

A positive organizational culture is vital to the success of any organization (Brewington & Darko, 2020). Along with the personal point of view, from an organizational perspective, it is not sufficient for organizations to just have satisfied employees (Lopez-Martin & Topa, 2019). An organization's mindset beliefs—as expressed through the company's mission statement—shape and lay people's expectations about the specific norms that are likely to characterize the company's culture (Canning et al., 2020). Leaders play a critical role through their ability to relinquish some authority and empower employees to lead and engage in co-creating changes (Brewington & Darko, 2020). The innovation is characterized by the search for new information, creativity, openness to change, and anticipation (Lopez-Martin & Topa, 2019). Supervisors should be trained to monitor and strengthen the characteristics of organizational culture that promotes well-being and to manage and provide support to workers when coping with characteristics of the culture that can have harmful effects on their health (Lopez-Martin & Topa, 2019). To create a positive culture, leaders must authorize their employees to become self-authorized to lead, innovate, and use their creative talents (Brewington & Darko, 2020).

It is critical for residency programs to deliberately address the needs of IMG residents (Osta et al., 2017). Lopez-Martin and Topa (2019) ascertained that

organizations need people who are involved in behaviors that are useful to the organization, but that exceed the requirements of the workplace. Through collaboration, employee engagement is crucial to achieving positive change in an organization's culture. It can enhance employee productivity, engagement, and retention as well as strengthen relationships with partners and other stakeholders (Brewington & Darko, 2020). Perceiving that the organization holds growth mindset beliefs motivates employees to grow their skills, prioritize learning from others, and view failure as a learning opportunity (Canning et al., 2020). The dimensions of support and innovation appear to be related to employees' attitudes and behaviors, whereas goals and rules have an impact on health (Lopez-Martin & Topa, 2019). Leaders must step out of the way at different points in time and become followers (Brewington & Darko, 2020). Co-creating positive organizational culture should be approached from a systems perspective, beginning with an assessment of the organization's culture (Brewington & Darko, 2020). Concerning reliability and resilience, ensuring the safety of an organization cannot be achieved without a culture that conveys the right values and behaviors that emphasize safety (Leuridan, 2020).

Medical residency program managers may provide guidance and establish best practices by building relationships and sharing experiences with IMGs. This interaction may lead to methods that aid in identifying and navigating acculturation challenges that hinder training growth. Understanding the organizational structure, patient safety, ethics, and workplace culture may facilitate in establishing best practices. As medical residency program managers engage in decision-making processes, they will cultivate a sense of

reoccurring challenges among IMGs. The medical residency program manager process of evaluation and forecasting that lead to best practices can be applied through relationships with IMGs and understanding assimilation concepts.

Summary

This chapter highlighted various theories illuminating Berry's Acculturation model (1997) and Portes and Zhou's segmented assimilation model (1993) as they relate to scenarios medical residency program managers encounter while leading IMGs. Information was presented that illuminated various aspects of residency program management duties, residency program functions, IMG processes, and acculturation conflicts during post-graduate training. Organizational structure, patient safety, ethics, and workplace culture provided the groundwork for the discussion establishing a comprehensive framework on this topic.

In this chapter, the literature surrounding IMGs' cross-cultural adjustment challenges in medical residency was critically analyzed. This chapter explored how these issues connect with professional integration of expatriates within post-graduate training programs. There is a gap in the literature that identifies best practices for medical residency program managers resolving acculturation and communication challenges among IMGs. Research indicates that the lack of knowledge medical residency program managers contributes to continued integration challenges of expatriate residents. The narrative literature review exemplifies a conceptual framework on topics of knowledgeable managers of residents and assimilation needs of IMGs.

This dissertation included interview questions that acknowledge Berry's

Acculturation and Portes and Zhou's segmented assimilation concepts. Participants would have sought and established best practices related to IMG acculturation with the intent to minimize and eliminate future training errors. The centerpiece for the interview involved open-ended questions to medical residency program managers, directors, and coordinators of IMG residents. Information gathered was evaluated with documents, archival records, and medical regulatory authority reports. Each interview began with a written greeting, introduction, and information surrounding the scope of the study. A code was given to each participant to ensure anonymity. Protecting confidentiality ensured that respondents provided candid feedback without the possibility of the employer or residents subjecting participants to retaliation or retribution. Chapter 3 included the qualitative narrative research method. The following chapter included details on recruitment, participation, and data collection. The chapter expanded on the data analysis plan and integrity procedures in the study.

Chapter 3: Research Method

The purpose of this qualitative narrative study was to explore best practices developed by medical residency program managers resolving IMG acculturation challenges. The current study provides resolutions for cross-cultural adjustment strategies that IMGs experience during medical residency training, new environment, and culture. Chapter 3 describes how the research procedures were performed. In this chapter, I will expand on the methodology, data collection, population sample, sample size, and data analysis. I also highlight specific actions for resolving research limitations and ethical matters.

Research Design

The study was conducted using a qualitative narrative research design. Unlike quantitative research in which researchers use numbers and statistical analysis, qualitative researchers use words to collect and interpret data (Anyan, 2013). This method allowed participants to provide detailed accounts of residency program managers' experiences leading IMGs through acculturation challenges during medical residency training. The research question was "How are medical residency program managers resolving IMG acculturation challenges?"

A qualitative narrative inquiry allowed me to focus on reflections and experiences of medical residency program managers resolving acculturation challenges faced by IMG residents. A qualitative narrative inquiry serves the function of a story, which is the sequential telling of events, and the function of re-storying while emphasizing parts of the story that are important to the narrator (Nigar, 2020). Narrative research supports the

nature of reality as changing and becoming the way of knowing reality as constructivist (Nigar, 2020). A narrative inquiry allows a researcher to communicate the study participants' realities to a broader audience (Wang & Geale, 2015). With this design, semistructured interviews containing open-ended questions helped me to answer the research question and identify best practices. Through this research, I identified themes related to cross-cultural adjustment strategies that other medical residency program managers can implement.

Role of the Researcher

Researchers participate actively, interacting and communicating with the participants in the interview sessions (Karagiozis, 2018). As an active interviewer, I gathered data, took notes, analyzed feedback, and concluded with a report of the research study. I used semistructured, open-ended questions to gather data that would answer the overarching research question. I recorded, transcribed, coded, and analyzed all responses to identify the emergent themes. In this role, I adhered to strict guidelines. Researchers are expected to demonstrate common sense and responsibility for their study participants, their study, and themselves (Karagiozis, 2018). I maintained participants' integrity by synthesizing interview responses and ensuring that participants' identities remained anonymous. Further, interviewers' participation in the study makes them part of the interaction they attempt to investigate, and they play an influential role in those interactions (Karagiozis, 2018). I disclosed all personal expectations and biases before the interviews using journaling, including personal experiences with IMG cross-cultural adjustment. It was important to establish triangulation, which is a combination of

different theoretical perspectives, data sources, investigators, or methods in a single study (Mitchell, 1986). Triangulation of study findings aided in controlling biases and determining the legitimacy, consistency, and accuracy of the overall findings. The study included interviews, peer-reviewed journals, dissertations, and medical regulatory publications to ensure triangulation of information.

Research Methodology

To address the research question, I used qualitative narrative inquiry, which allowed participants to discuss their experiences, offering an in-depth view of medical residency program managers' perceptions of their experiences with social, professional, and cultural dynamics of IMGs in medical residency. This research method also aided in identifying best practices by compiling and recording first-hand data from the interviews. This research method offered flexibility in analysis and exploration practices for understanding IMG acculturation strategies during medical residency training.

Participant Selection Criteria

I used purposeful sampling to recruit participants with experience working directly with IMG residents. Purposeful selection helped in establishing perspectives on IMG assimilation and adaptive strategies that are useful in medical residency. This strategy ensured that participants had experience and knowledge and could provide a narrative of resolutions. Participants consisted of individuals who oversee IMG residents. I sought 20 participants who worked in a hospital or private practice medical residency programs in the United States. Interviewees could work in the capacity of coordinator, manager, or director. Respondents needed to have at least 3 years of experience working

directly with IMG residents in the following specialties: internal medicine, family medicine, pediatrics, psychiatry, oncology, radiology, neurology, and gynecology. I recruited participants using flyers, social media, and word of mouth.

Instrumentation

Data collection instruments include qualitative interviews and document analysis (Bowen, 2009). I asked participants 10 open-ended questions in semistructured interviews (Appendix). The goal of the interviews was to collect information about the acculturative experiences and cultural adaptation strategies applied by medical residency program managers who oversaw IMGs experiencing communication challenges. Triangulation was achieved by compiling various forms of information including journaling, extensive review of literature, and notation throughout each interview.

The preferred method was in-person interviews. However, due to COVID-19 precautions and time restrictions, I conducted interviews for this qualitative narrative study using web-based Zoom meetings as the data collection mechanism. Interviews of medical residency program managers served as a direct foundation of information on acculturation experiences and cross-cultural adjustment strategies applied because the participants used their own words to express their perceptions. Open-ended questions provided in-depth information on each participant's perceptions, observations, and feelings pertaining to acculturation and communication challenges during medical residency training. I interviewed the target group, coded responses, and analyzed data gathered in each interview until saturation was reached. To ensure credibility, I sought an accurate depiction of each participant's responses. After reviewing each transcript, I

allowed an opportunity for follow-up questions and clarification.

Data Sources

Data collection involved three sources: web-based Zoom meetings, audio-recorded interviews, and a journal. The primary data were collected using the narrative inquiry method through semi-structured individual interviews of contributors. The secondary source of data was a research journal kept during the process of recruitment, questioning, transcription, and analysis. I recorded, transcribed, analyzed, and coded all interviews.

I explored current research topics surrounding medical residency program managers resolving cross-cultural adjustment challenges for IMGs. Using a qualitative narrative method, I highlighted best practices that have been implemented to resolve acculturation trials and communication barriers. This research may provide useful techniques for medical residency program managers in the United States by combining literature, interviews, and documentation.

Procedure

I created flyers regarding the study and posted them on my personal Facebook, Twitter, and Instagram social media accounts. The research flyers included contact information for potential participants to communicate with the interviewer for additional details concerning the background of the study. I followed the following nine procedures:

1. Connected with medical residency program managers using my personal social media networks such as Facebook, Twitter, and Instagram to recruit respondents in GME programs.

2. Communicated with individuals who oversee IMG residents currently pursuing post-graduate training. This group of individuals would have responded to the public announcement.
3. Ensured that participants received consent form(s) via email.
4. Communicated with participants through email or telephone detailing additional information regarding the study. I used a Walden University email account for all communications regarding the study.
5. Requested participants to complete the Walden University Consent Form (Appendix B) verifying that they understand the purpose of the study and their role as a respondent. I advised participants to print the consent form and save it for their records.
6. Conducted interviews by web-based Zoom meetings.
7. Transcribed interviews into a Word document, then coded responses and analyzed transcriptions.
8. Analyzed the data on medical residency program managers resolving IMG acculturation challenges by using the NVivo software.

Data Collection and Analysis

I refrained from including pre-conceived notions and was open to receiving new information from participants. I adhered to Walden University's procedures. I assigned all participants numerical codes to ensure anonymity. All interviews were recorded and expected to last under 1 hour, depending on participant responses. At the start of each interview, I allotted 20 minutes to review procedures and answer participant questions.

Semi-structured questions guided the interviews.

I coded interview responses and analyzed data upon completion of the interview. Codes were established as patterns were identified. Themes consisted of patterns related to best practices established by medical residency program managers. I reviewed each participant's data individually to ensure responses related to the research questions. The five processes conducted were:

1. Reviewed data and highlighted all meaningful information using Microsoft Excel.
2. Used highlighted information to identify themes and establish codes.
3. Omitted data that is not highlighted.
4. Used the same procedure for each participant and created clusters as patterns emerged.
5. Synthesized data once all information was compiled, coded, and clustered.

Issues of Trustworthiness

This qualitative study used integrity and reliability as well as ethical procedures to establish trustworthiness. Trustworthiness ensures that the research is accurate and dependable. To establish credibility, I ensured that the research question and purpose of the study were consistent with the interview questions and analysis. An accurate account of each participant's experience was captured through recorded narrative inquiry. The focus was on medical residency program managers resolving IMG assimilation challenges. Consistency is imperative while interacting with participants, applying observation skills, documenting research notes in a journal, and using data triangulation.

Data saturation was determined when repetition in responses was more frequent than new data. Each of these steps aided aid in establishing credibility within the research. To ensure anonymity and integrity, I informed participants that interview recordings and data would be maintained in a locked file cabinet for safekeeping throughout the study.

Validity and Reliability

The validity of the study results comprised each participant's awareness that they were taking part in the study. Participants were briefed before starting the interviews to ensure that their honesty and the integrity of the data was important to the conclusion and value of the study. Honesty was an integral foundation of the study.

Internal Validity

Factors that may influence the research were subject to the size of the target group and device sensitivity. There can be internal validity issues if results are influenced by factors other than those thought to have caused the findings or unclearly defined data interpretations (Leedy & Ormrod, 2005). I removed any issues that may compromise the internal validity of the study. To accomplish this goal, a pilot test of the interview guide and a field test for the recorder was conducted. In performing the test, I recruited a team of experts on the subject matter to participate in the study. Their participation in the pilot test automatically disqualified them from partaking in the actual interview. I asked pilot study participants to review the interview questions and discuss their recommendations concerning clarity. I consolidated the recommendation and implemented them in the design of the interview.

To confirm reliability, I conducted a test of the audio recorder that was used in the

interviews. The recorder was used to test the participant on two different occasions. The first occasion was to test the Zoom feature and the second was to test the sound quality of the interview. This ensured accuracy and reliability in the recording device.

External Validity

Factors that may attribute to external validity include participant selection, contributor characteristics, and data collection methods. Findings can have external invalidity if they cannot extend or apply to contexts outside of the study's scope (Leedy & Ormrod, 2005). Research surrounding IMG acculturation challenges are applicable to individuals working in U.S. medical residency programs and may not apply to other fields. This research contributed to the larger body of GME knowledge.

Reliability

To establish reliability, I analyzed data to regulate the frequency with which a particular code may appear in participant transcripts. Reliability in qualitative research designs refers to how consistent the data obtained are for a given study (Hesse-Biber & Leavy, 2006). The reliability of a qualitative study research design consists of two different components: internal consistency and external consistency (Neuman, 2003).

I created a journal to use as a reference for qualitative data, dependent and independent variables. Internal consistency refers to how consistent the data collected are, as well as whether there is consistency in the observations obtained from each of the participants in the study (Hesse-Biber & Leavy, 2006). Data were examined and compared to information in other studies surrounding expatriate medical residents. External consistency was verified using literature surrounding the topic of cross-cultural

adjustment in the workplace. I reviewed current publications to determine whether the discoveries of this study reflect current information.

Ethical Procedures

This study was conducted in accordance with Walden University's ethical and professional considerations. I safeguarded participant confidentiality, obtained consent, and protected contributors from maltreatment. Each participant received an electronic informed consent form via email before participating in the study. Participants were required to provide acknowledgment, consent, and confirmation of a willingness-to-participate-in-the study release. Pseudonyms aided in protecting participants' privacy in cases where precise responses were used to support the analysis.

I remained impartial and cognizant not to impose personal opinions that would create biases in the study. I informed participants that all information gathered from the interviews will be secured and that their contributions to the study were voluntary. To ensure confidentiality, participants were requested to select a private interview location. I conducted interviews in a closed office excluding other listeners. Participants did not share their names or other identifiable characteristics during the interview.

Ethics are a matter of understanding and mitigating conflicts from moral imperatives (Avasthi et al., 2013). In an effort to follow Walden University's ethical guidelines for interviewing respondents and gathering data, I provided an outline containing a thorough description of the research objectives, questions, and admission to acquire participants' consent. I also maintained all notes, transcriptions, and recordings. I also stored interviews in a locked cabinet in my office and encoded electronic files with

an alias. I will destroy all research materials after 5 years of completing the study.

Summary

I used a qualitative narrative inquiry to address the problem statement and research question. The information gathered helped to gain insight into best practices used to resolve IMG acculturation and communication challenges during medical residency training. I recruited participants by posting a flyer on my personal social media pages.

I gathered information using semi-structured, open-ended interviews through Zoom. Participants confirmed that they identified with the interview standards by signing and returning consent forms, and I adhered to the ethical standards outlined by Walden's IRB. Using a qualitative narrative research, I collected, transcribed, coded, and analyzed interview data using a computer-based research software. I collected interview responses until saturation was obtained and there were no further themes in responses.

Chapter 4 of this narrative qualitative inquiry addresses the gap in the literature by exploring best practices medical residency program managers have developed to resolve IMG acculturation and communication challenges. Current literature does not describe resolutions for cross-cultural adjustment challenges for expatriates pursuing post-graduate training programs. Chapter 5 describes a pathway for positive social change, resources, and improved awareness of cross-cultural assimilation barriers for IMG residents.

Chapter 4: Results

I interviewed 22 participants who work in hospitals and private practice medical residency programs in the United States. Results include insights obtained from direct quotes of the contributor interviews and triangulation. Exploring participants' perceptions of acculturation challenges during medical residency yielded diverse findings related to the overarching research question: How are medical residency program managers resolving IMG acculturation challenges? The results are consistent with qualitative studies as presented in the literature review and the theoretical framework of Berry's (1997) acculturation model and Portes and Zhou's (1993) segmented assimilation model.

This chapter contains data collected, analysis of findings, discoveries about the research question, the theoretical framework, and information that corresponds to the literature review and results from the analysis of the data. I also discuss the research setting, population, instrumentation, sampling strategy, data collection, and data analysis. The chapter ends with a summary.

Research Setting

Due to COVID-19 restrictions, I conducted interviews at various times that were convenient to each participant and hosted using Zoom. I made efforts to ensure privacy, sound, and technology were conducive to capturing the full discussion. The strength of a qualitative design is that the research must occur in the participants' natural setting, where the natural setting is described as an organization's facility, private office, or the home of the individual (Klassen et al., 2012). In all the situations, the interview process and outcomes were similar in nature as all participants were sincerely engaged. In all the

scenarios, participants seemed comfortable during the entire period of each session of the interview and responded candidly.

Data Collection

Evidence for a qualitative narrative study may arise from several sources such as interviews, documents, archival records, direct observation, participant observation, and physical artifacts (Yin, 2014). The primary data source for this study included 22 interviews with participants who were medical residency program directors, coordinators, or managers. I recruited participants using Facebook, Instagram, and LinkedIn social media pages. Data collection consisted of open-ended questions in a semistructured, face-to-face interview hosted on Zoom as designed originally. Participants responded based on their experience with leading IMGs through acculturation challenges.

To ensure anonymity, no additional details specific to individual demographic information were collected. I ensured that each participant was comfortable and addressed any questions or concerns before they participated in the interview. Following all initial discussions about the purpose of the study, potential risks, and benefits, I recorded the sessions using Zoom and an Olympus digital voice recorder WS-853. After receiving permission from participants, I took notes for the journal as part of the data collection process to be used for cross-checking. As participants were enrolled, everyone was assigned a unique code for identification (ex. KT, LS, MW, etc.). This identifier was referenced on a master list that was maintained by only me. Each interview session lasted between 11 and 28 minutes. I recorded the interviews using Zoom and an Olympus digital voice recorder WS-853. I transcribed the audio recording of each session using the

REV transcription service and transferred to a Word document. I also reviewed the data transcripts for any omissions and errors. Following the completion of the reviews to confirm accuracy, I input data and significant responses into Excel. Each interview was labeled with "Candice Love Research Interview" along with the number in which they were recorded (e.g., Candice Love Research Interview #1).

Data Analysis

Transcription

I transcribed interviews to capture all recorded verbal interview responses. To complete the analysis, I conducted several playbacks and careful listening of the digital audio recorder and Zoom recordings. I saved the recorded responses and transcripts using unique identifiers to identify each participant file. I transcribed each file into a Microsoft Word document with the responses tagged with participant codes and corresponding questions. I also reviewed the transcriptions several times using the audio file and cross-checked with my notes to ensure accuracy and to obtain insight on experiences.

Coding of Data

I coded participants' transcribed responses along with the journals notes. Patterns and trends provided insight and understanding of the responses captured and helped in the analysis and discoveries of the study. Transcripts were substantiated by comparing the Zoom voice recordings with the transcribed interviews and subsequently transferred to a draft spreadsheet. I condensed interview questions and participant responses into a word document for accuracy. I verified the responses several times with the Zoom recordings to ensure the accurateness of transcripts and the information stored in files. I

uploaded all files into Microsoft Word and coded them in Excel for analysis. Excel contains documentation of relevant and noteworthy information based on participant responses to the interview questions. I drafted notes of recurring responses that were relevant to the study.

I applied coding methods to identify additional themes that emerged from responses from each interview to obtain similar categories. Each code was created to uncover the identical classifications that permitted widespread coding of responses for analysis. I examined participant responses following the identification of pertinent patterns and themes for recurring participant experiences. I analyzed the responses based on the suggested structured open-ended question approach designed for a qualitative narrative inquiry as follows:

- Grouping participant experiences.
- Listening to recordings, note-taking, and creating a structure for coding transcripts.
- Examining and validating interview transcripts.
- Describing the importance of participant experiences.
- Categorizing the critical declarations into various components.
- Procuring a group of themes and conducting the examination.

The analysis consisted of groupings of like terms specified by the responses, categories, and labels based on participants' experiences. I compared the information gathered with previous studies to either confirm repetition or identify new themes. No recognized conflicting responses were observed in the analysis. The absence of bias, saturation, and

the avoidance of any conflict of interest was ensured during the study. I diminished the possibility of obtaining contradictory interview feedback by following Walden University's procedures and providing concise interview instructions.

Evidence of Trustworthiness

Credibility

A qualitative approach allows for complex human issues to be included in the research data rather than focusing on testing a priori hypotheses (Clandinin, 2016; Merriam & Grenier, 2019). The ability of participants to share their unique experiences to explain pertinent issues surrounding best practices for managing IMGs who faced acculturation challenges using Zoom meetings assured the credibility of the study. Due to COVID restrictions, interviews could not be conducted in person.

Providing a brief overview of the interview procedures and expectations of participants during the interviews, coupled with the distribution of the Consent Form, and drafting journal notes was significant in ensuring success during the interviews. Occasionally, I paused to take notes on details that stood out or were unique compared to other interviews. I informed each participant that I would take notes occasionally and did not sense that any contributors appear distracted during the process.

Transferability

I gathered a panel of experts who vetted, revised, and validated the interview process, flyer, Consent Form, and interview questions. The IRB ensured the appropriateness of the research topic and the relevance of the subject matter for the accuracy of information specific to the intended population. Berry's Acculturation model

(1997) and Portes and Zhou's segmented assimilation model (1993) segmented assimilation model provided an invaluable foundation for the study. Experiences of medical residency program managers resolving IMG acculturation challenges led to uncovering best practices to mitigate potential challenges. The theoretical frameworks utilized for the study helped establish validity to adequately support the study. To ensure transferability, research findings from medical residency program managers' responses may be applied to post-graduate training programs throughout the United States.

Dependability

I accomplished dependability using a combination of transcribed digital audio recordings and journal notes taken during each interview. The purpose of reviewing notes and transcriptions was to compare responses about experiences and feelings for each participant. I imported transcripts into Microsoft Word for analysis.

Confirmability

Coding, examination, and interpretation of responses helped to establish confirmability throughout the interview process. One core value of qualitative research is to maintain neutrality by reframing from possible biases. This process ensured participant responses were consistent and applicable to the study. To maintain impartiality during interviews, I remained engrossed in participants' responses to avoid reactions based on my experience or personal views.

I uncovered and eliminated biases by simultaneously reviewing audio recordings and journal notes. This helped to minimize personal responses during the review, transcription, coding, analysis, and interpretation of responses. These measures assured

nonjudgmental and careful procedures to sustain neutrality and the circumvention of biases.

Results

The overarching research question this study sought to address was: How are medical residency program managers resolving IMG acculturation challenges? A qualitative narrative study comprising of 22 participants helped to answer the research question. I utilized face-to-face interviews via Zoom to gather interview responses. This study explored the perceptions of medical residency program managers leading IMG through acculturation challenges. Discussions centered around participants' experience leading IMGs through cross-cultural adjustment strategies, the impact on medical residency, IMG strengths, work outside of their home country, advice to program managers, potential best practices developed, and the impact of best practices. I created a Word document to illustrate the configuration of participant responses. I gave each participant an individual code such as Participant 1-LS (P1), Participant 2-MW (P2), Participant 3-TS (P3), etc. to protect each participant's identity and for presenting interview responses in support of the following themes. The following themes related to acculturation challenges began to develop (a) communication, (b) socialization, (c) culture, (d) professionalism, (e) education, and (f) personal challenges.

Theme 1: Communication

Theme 1 outlined reoccurring statements about IMG acculturation challenges that relate to communication. Residency is a unique time of stress, especially for IMG residents who must learn not only their specialty of medicine but also how to

communicate with patients and families within the context of the U.S. healthcare system (Osta et al., 2017). PT 5 “Sometimes there is a communication barrier here because of the language differences, probably one of the biggest challenges there.” Many of the difficulties IMGs experience are due to misunderstanding and language barriers such as accents. PT 3 “It’s not just the language difference. It’s almost you know, what’s okay and what’s not okay to say to people.” Communication challenges sometimes interfere with the interactions with staff and patients. PT 6 “Some words maybe a little more difficult to understand.” Medical residency program managers who seek opportunities to resolve communication challenges improve interactions among the residency staff.

Theme 2: Socialization

Theme 2 highlighted reoccurring statements describing ways that socialization impacts IMG progress throughout residency training. IMGs play a key role in host countries’ health systems but face unique challenges, which makes effective, tailored support for IMGs essential (Osta et al., 2017). Participants explained that IMGs who lack a social network struggle to adapt to their surroundings. PT 3 “If there’s some way to connect them to others who are in a similar situation. They don’t necessarily have to be from the same country.” Having peers and team members who are welcoming and seek new methods of inclusiveness foster a cohesive professional and academic environment. PT 3 “A sort of a group even before they arrive. They can get together and socialize and just freely and openly talk about their problems.”

Theme 3: Culture

Theme 3 frames ways unfamiliar cultures can either hinder or enhance the

experiences of IMGs and the residency team. Migrants bring cultural and psychological qualities with them to the new society; and the new society also has a variety of such qualities (Berry, 2009). PT 6 “When they aren’t able to adjust, they end up being removed from their medical residencies or they give up. They get discouraged. They may end up finding a new career or just going back home.” IMGs faced with prejudice can experience feelings of loneliness and depression. Medical residency program managers who seek opportunities to embrace culture create a healthier workplace. Providing occasions for staff members to learn about their unique differences and the differences in the patients can enhance the learning environment. PT 7,

> Just bringing their own culture and cultural norms to medicine here in the United States. You know, there are lots of people from all over the world, so not just having that U. S perspective. Having their own cultural perspective to bring to medicine.

IMGs may feel valued for their unique education and professional experience.

Theme 4: Professionalism

Theme 4 outlined ways IMGs’ professional backgrounds impact medical residency. Medical residents’ training increasingly involves the need to demonstrate social, cognitive, attitudinal, and behavioral activities related to quality and safe patient care (Real et al., 2017). Participants discussed that some IMGs enter the United States with experience working as physicians in their country of origin. PT 3,

> They often had a short period of practice where they’re coming from, so they have some experience already in the field. Those folks right out of medical school

won't have had and so they also have some solutions to problems that we may not have thought of. They're going to be a little bit more innovative because they've seen things through a different lens.

This experience is often helpful because it creates opportunities for IMGs to be inventive, share knowledge, and implement new methods for treating patients. Some challenges occur when medical terms differ or the names of equipment vary. Strategies could include professional development training and opportunities for lateral movement to develop new skills and expand professional knowledge and collegial support networks (Ofei-Dodoo et al., 2020). PT 5 "best practice creates a very positive atmosphere because you put everybody on an even playing field. It creates a better learning environment for everyone; US residents as well as to IMG residents." To mitigate this challenge, IMGs can either have electronic tutorials or written materials to offer preparation before the start of residency.

Theme 5: Education

Theme 5 highlighted recurring responses about IMG education. Success of the curriculum could be attributed to several factors including a strong commitment of leadership and curriculum developers, the enthusiastic engagement of patient volunteers as standardized patients, and a simulation center providing space, equipment, and staff (Newcomb et al., 2017). Some residency staff and patients have a misconception that IMGs are less educated or have less experience. The U.S. licensing examination results and workplace performance often dispel this misconception. Residency staff often find that IMGs are knowledgeable and experienced. PT 3 "Having some idea of what they've

experienced before they arrived and where that fits in with what your academic goals are for them. That would be the best way to approach it."

One way to resolve this conflict is for managers to educate staff on the value of IMG contributions to U.S. healthcare. PT 3 "There are some programs that are more intense in terms of orientation and that they come have folks coming for six weeks before residency starts." Participants also suggest providing orientation to support academic needs that help IMGs prepare for workplace norms and expectations. Designing and implementing a new curriculum is a complex enterprise, requiring the coordination of myriad resources and schedules (Newcomb et al., 2017).

Theme 6: Personal Challenges

Theme 6 outlined reoccurring statements regarding personal challenges that impact cross-cultural adjustment for IMG residents. Personal factors have also been shown to affect the course of acculturation (Berry, 1997). Participants explained that IMGs are typically motivated, hardworking, and dedicated to learning. PT 6 "They are extremely motivated to make it work, to live in America and have a better life."

These statements are proven considering IMG residents have overcome obstacles like licensing exams, credentialing, immigrant visa regulations, and matching to a program. Despite overcoming these obstacles, IMGs may feel discouraged when they lack a support system, engaging environment, and have limited resources. PT 3 "Get people who were struggling, who recognized they were struggling to a place where they perform better, and that's not easy to do." Medical residency program managers who establish opportunities to voice concerns and implement strategies to support unique

needs may help IMGs feel valued.

Summary

The qualitative narrative inquiry used was pertinent to this study because the method allowed findings that helped supplement the knowledge and experiences of medical residency program managers adopting best practices to resolve IMG acculturation challenges. This methodology supported the need to gather perceptions, opinions, and personal accounts in resolving cross-cultural adjustment challenges. The research methodology and design facilitated the participants responding to questions while contributing to existing knowledge. Chapter 5 includes research findings, interpretations, limitations, implications for positive social change, and recommendations for future research.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative narrative study was to explore best practices developed by medical residency program managers to resolve IMG acculturation challenges. In this study, I incorporated the views and experiences of medical residency program managers within the framework and constructs of Berry's (1997) acculturation model and Portes and Zhou's (1993) segmented assimilation model. In this chapter, I draw a connection between the literature review and theoretical framework and the results. Chapter 5 also includes recommendations for future research, limitations of the study, and implications for positive social change.

Interpretation of Findings

The findings of the study indicated that medical residency program managers' experiences are a vital factor of post-graduate training programs. The responses included the desire to resolve acculturation challenges through the implementation of best practices. In Chapter 4, I discussed themes based on the reoccurring concepts and research questions. The interpretations of the findings are further explained in this chapter and are organized based on the themes that emerged as a direct result of participants' responses and recommendations.

Theme 1: Communication

Residency is a unique time of stress, especially for IMG residents who must learn not only their specialty of medicine but also how to communicate with patients and families within the context of the U.S. health care system (Osta et al., 2017). Interview participants provided an expansive list of acculturation challenges that impacted medical

residents, which included communication and language barriers. Researchers have shown that IMGs often experience language barriers and find that their new patients and colleagues have different expectations regarding professional communication compared to what they have learned and practiced in their homeland (Skjeggestad et al., 2020). Although IMG medical residents speak English, for many, it is their second language. Some of the equipment and medical terms used in other countries have different names or meanings in the United States. Additionally, when working with patients and staff members, IMGs would encounter difficulty understanding various dialects or accents. Some IMGs also had difficulty understanding sarcasm and slang. Further, one participant recollected when she needed a translator for the IMG even though they were speaking in English because of their strong accent. One participant explained that when residents have strong accents, masks can create further difficulty for staff and patients to understand some IMGs.

In some cases, IMGs would experience prejudice during residency. In one instance, a participant discussed patients asking for an American doctor after meeting the IMG during training. Some residents are thought to be inferior because they have an accent or attended medical schools outside of the United States. Patients would question the resident's knowledge and ability. However, one participant explained the benefits of being bilingual because this knowledge gives IMGs the option to communicate with non-English speakers. Coming from a different culture means IMGs may have a new and possibly more efficient way of working and engaging others. Bringing in new cultures exposes staff and patients to new heritages, traditions, unique perspectives, and possible

new methods in medicine.

Participants also shared ways that IMGs managed challenges. To mitigate communication challenges, IMGs would draft notes or collect written materials because reading comprehension is sometimes easier to navigate than verbal comprehension. Some IMGs would confirm understanding several times to ensure the information is accurate. Respondents shared that residents would occasionally recap their understanding of the discussion or confirm with colleagues. Additionally, IMGs would manage cultural challenges by seeking other IMGs who have gone through residency training or cross-cultural adjustment to request advice or ask questions. Being observant and seeing others undergo adaptation difficulties aids others in adjusting to unfamiliar cultural practices.

Participants shared advice for medical residency program managers who were leading a new cohort of IMGs. When supporting communication challenges, managers, directors, and coordinators should ask probing questions to identify the needs of residents. Since IMGs may not initiate the discussion, asking in-depth questions about their background and needs may aid leaders in preparing necessary details and instructions to support IMGs who are new to the program. Another recommendation to support communication challenges among new IMGs is to gather assistants to work directly with IMGs and explain policies and procedures. Participants also suggested that managers explain expectations in detail and be open to conversation. The program managers in this study would take additional time to review information to ensure IMGs grasped the materials. They would also change wording when IMGs misunderstood instructions. One participant also recommended providing written materials in addition to

verbal discussions on program expectations. The last recommendation about communication is that leaders should encourage IMGs to ask questions of staff and peers when they are unsure about expectations. Contributors in this study reminded IMGs residents that it was a safe environment to ask questions if they did not understand details. These methods ensured all residents could work together and have all the appropriate information to advance in their efforts to communicate.

Theme 2: Socialization

Participants acknowledged that socialization directly influenced IMG acculturation challenges. Medical school leaders and residency program directors should create structured opportunities for trainees to establish meaningful connections with each other to provide greater social support and thereby reduce the harmful effects of stress (Ziegelstein, 2018). Lacking resources, no connection to peers, loss of family, and being new to the community lead to feelings of loneliness. IMGs who feel isolated may be negatively impacted by cross-cultural adjustment. In many cases, IMGs do not have an established social network. To navigate social settings, IMGs may seek a peer system with residents of the same culture. Some teammates may invite IMGs to partake in holidays. Participants felt that it creates personal connections, shows they care, and establishes a support system. Engaging IMGs in social settings helps to build bonds with other residents, which creates a social network. Socialization becomes an opportunity to connect with others who can provide information and guidance to navigate both cultures and positively mediate problems (Kim, 2014).

Best practices to support social challenges consisted of creating opportunities

where IMGs could connect with peers. IMGs could share meals and engage in local events. Occasions for residents to socialize with one another serve to build a bridge and establish friendships. Team-building and bonding activities served as methods of promoting camaraderie among the residents (Haber et al., 2020). The participant who developed best practices to support social needs witnessed comradery. IMGs connected with residents and established friendships with peers who were taking steps toward the same academic endeavor. Residents can get to know each other and may experience diminished feelings of loneliness and isolation. Another recommendation was to let IMGs know the staff is there for them in times of need; having an open-door policy at the beginning may help IMGs feel supported.

Theme 3: Cultural

Participants indicated cultural differences impacting IMG cross-cultural adjustment. Segmented assimilation theory emphasizes that adaptation is necessary to transition to a new culture (Xie & Greenman, 2011, p. 48). Participants discussed that some IMGs have a “reality shock” when practices differ greatly between the United States and other countries. Some IMGs were unfamiliar with religious differences and dietary restrictions. This may impact the doctor–patient relationship if the resident is unaware that the patient may be fasting for religious purposes and may not eat food with their prescribed medicine. Additionally, in some cultures, the male is seen as the head of the household and all instructions should be posed to the male spouse, brother, father, or even child. One participant explained that in some cultures, males may disregard or even be patronizing to people whose ethnicity differs. The participant recalled her experience

with female IMGs and expressed that they were “more flexible.” The respondent expressed that leadership roles could present a challenge to some IMG women because they are seen as second-class citizens in their home country. Respondents acknowledged gender inequality where men looked down on women and struggled to take direction from female counterparts. Thus, female IMGs may have trouble taking leadership roles, while others thrive because the new opportunity may be stimulating.

Medical residency program managers shared other challenges related to culture like having sensitivity when interacting with others in difficult circumstances, knowing what is appropriate to say in times of crisis, being able to relate to staff and patients, and interacting with secondary roles. Acculturative stress is a stress reaction in response to life events that are rooted in the experience of acculturation (Berry, 1997). Some IMGs struggle with being able to relate to others and make quick decisions based on restrictions as it relates to different cultures. Participants discussed IMGs having a difficult time interacting with unfamiliar medical roles that are not in their home countries.

Interview participants suggested that managers establish opportunities for further training on cross-cultural challenges. IMGs may work in community centers to obtain hands-on experience and introduce them to local traditions and customs. IMGs gain experience interacting with the public through community work. Medical residency program managers should seek ways to educate IMGs and staff on linguistics, food, and traditional practices. One participant recommended managers create opportunities to have one-on-one lessons on culture and provide history and cultural norms to inform IMGs on common practices and workplace customs in the United States. IMGs who understand

local customs, local languages, and traditional practices may have fewer adaptation challenges. Additionally, to support social interactions, managers may connect residents with established IMG doctors. This individual may act as a mentor or advisor for common challenges that develop when living in another country, providing information in situations where their culture differed from standard U.S. practices. With these best practices, IMG residents may be prepared to navigate local customs and workplace practices. They will have a better understanding of their needs and can take advantage of program offerings that support their professional and academic development.

Theme 4: Professionalism

Another factor that impacted acculturation challenges is professionalism. Participants reported that some IMGs had trouble adjusting to work duties in which they traditionally excelled because of new processes, policies, and expectations. One participant reported that IMGs felt defeated because they were licensed physicians in their home country and in the United States, they had to undergo the same licensing exams, credentialing, and residency training as if they were a recent medical graduate. Participants reported IMGs experiencing stress because they were conducting menial tasks in which they were overqualified. One participant also responded that pay structure is sometimes unusual to IMGs. They may be acclimated to receiving payments daily, whereas in the United States, income may be issued weekly, bi-weekly, or even monthly.

Another professional practice respondents discussed was expectations for bedside manner. The concept of patient-centered care was described to be difficult to them (Michalski et al., 2017). The United States emphasizes bedside manner, but this practice

varies in other countries. The level of importance in bedside manner is not standard worldwide. Some IMGs were also challenged by restrictions in U.S. hospitals that were different from IMGs' countries of origin. IMGs were thus impacted due to unfamiliar professional experience.

Despite these challenges, many participants felt that IMGs were open to nontraditional practices which helped them to think outside the box during residency training. Many IMGs come to the United States with prior training and experience, giving them an expertise not typical of U.S. medical school graduates (Horvath et al., 2004). Since some of the IMG residents had previous experience in the field, which led to innovation. One contributor stated, "diversity breeds innovation." Some were experienced with new technology that was not commonly used in the United States and offered creative ways to improve the quality of care. In some cases, IMGs were able to adapt to unfamiliar practices because they lacked resources in their home countries.

Contributors advised on professional practices for new IMG residents. One recommendation is to have regular check-ins. Feedback can be accomplished with monthly resident feedback meetings, open-door policies, leaders who demonstrate empathy, and frequent updates on prior concerns or ideas brought up by residents (Moresco et al., 2020). Managers who provide consistent support may be able to address needs early in the residency. Support groups may also help IMGs advance in their careers and give them the necessary resources needed to provide better care. Participants also suggested that program managers ask IMGs what their needs are directly. To support professional challenges, medical residency program managers should get to know

residents. Learning unique IMGs' needs may help leaders adapt the program to suit areas where residents struggle. Medical residency programs must also be willing to alter the program even though it may take considerable work to modify the curriculum. Further, maintaining a good team climate in cross-cultural working teams and giving foreign-born employees possibilities to use their skills may be a challenge and may require constant effort, but it may also bring great benefits for employees and organizations (Heponiemi et al., 2018). Improving the educational impact may help IMGs advance professionally and experience fewer conflicts during performance evaluations. IMGs can be more successful, advance through the residency training, and experience better team relations. Incorporating best practices creates a healthy work environment and improves the academic and professional experiences of the team.

Theme 5: Education

Another strength in training IMGs is that some were more accepting of taking on residencies in underserved, rural, and suburban areas that paid less. Since IMGs often face difficulty with gaining acceptance into medical residency programs, some are willing to take on post-graduate training programs in areas that USMGs would typically overlook. One participant explained that although IMGs would take on residencies in underserved areas, they would often face prejudice among the staff and patients because they had accents and were trained internationally. Participants shared that results from the licensing exams were proof that IMGs were well educated and knowledgeable. Several respondents commented that IMGs were bright and committed to learning despite the misconceptions of staff and patients in underserved areas.

Contributors shared experiences on ways IMGs minimized educational challenges. Residents asked questions when they were uncertain. They take opportunities to learn. IMGs remain observant to identify steps other residents are taking to progress throughout the program. One participant shared that some IMGs would seek additional ways to gather more equipment and skills outside of the residency program to ensure they are prepared to adequately perform duties.

Interview participants suggested several methods to support the educational impact of IMGs. Departments truly invested in residents' well-being by providing program directors and key faculty time to tailor the content and basic curriculum to their specific programmatic needs (Price et al., 2020). Managers may offer a curriculum in residents' primary language. Leaders may virtually meet with IMGs to get an understanding of their level of preparedness and understanding. This serves as a guide for medical residency program managers who are outlining resident needs and abilities. Participants suggested identifying learning gaps, informing IMGs on available support services, and determining an efficient way for informing IMGs on cross-training options. One participant explained that IMGs may not be in the country before residency. In such instances, medical residency program managers can offer Zoom training before the official start of residency. Upon arrival, IMGs can work with team leaders to help them prepare, gain clarification, review online modules, and build study groups. The final suggestion was to ensure IMGs received proper technology training. The computer software, platforms, and educational program may differ from their country of origin.

Best practices to support academic challenges included offering documents that

corresponded to instruction and providing examples to help IMGs connect the information to previous experiences. There has been a call for medical education leaders to devote resources to bolster the next generation of providers and shift the culture of medicine to organizational initiatives that impact physician well-being (Talen et al., 2019). Another method to support educational needs is to offer early entry to conduct an intense orientation. Having written materials about academic requirements, professional expectations, and safety measures before residency ensured IMGs were prepared with pertinent details ahead of time.

Best practices to resolve academic challenges may create a smoother process. IMGs who may have struggled with cross-cultural challenges may feel supported. In situations where IMGs feel overwhelmed by academic rigor, they may be encouraged to remain dedicated.

Participants shared experiences on academic improvements after implementing best practices. Medical residents train in complex environments characterized by uncertainty, time pressure, conflicting and ambiguous information, risk, distractions, multiple tasks, and the presence of many different professions/occupations (Real et al., 2017). The peer program allowed residents to learn cooperatively. USMGs and IMGs worked closely together to help each other advance. IMGs who previously struggled began to perform better.

Theme 6: Personal Challenges

Participants noted personal challenges that impacted medical residents. Personal factors have also been shown to affect the course of acculturation (Berry, 1997). Some

IMGs struggle more than others. The challenges may be related to the level of confidence. IMGs may feel stressed by internal and external hindrances to performance. These struggles can lead the IMG to feel withdrawn and overwhelmed. Some examples of external hindrances are USMGs looking down on IMGs. USMGs may have the misconception that international medical schools are not up to U.S. standards.

Respondents listed several personal attributes they discovered while training IMGs. Participants reported that IMGs were smart, driven, worldly, and impactful with other residents. Due to the rigorous process to enter medical residency, participants noted IMGs being dedicated to the profession, accommodating, and helpful to others. Despite some of the stigmas, IMGs are equipped with invaluable education and experiences.

Participants explained that IMGs are usually open to learning new processes. One contributor noted that since many have families in other countries, personal obligations did not cause a distraction and they can contribute more hours. IMGs are often driven to succeed. Although many of them have experience working as physicians abroad, they still persevere in starting from the beginning to obtain U.S. medical licensing. This perseverance leads IMGs to be flexible, grateful, and motivated. Participants reported that IMGs often have a great work ethic and will do all that is possible to make their dream of being a physician come true. Respondents reported that IMGs are hardworking, considerate, humble, accomplished, and kind.

Respondents highlighted personal challenges that related to working outside of the country of origin. Some IMGs lacked social networks while others struggled with uprooting family members. In many countries, there is a cohesive familial environment

that poses a professional challenge since they lack family support. IMGs have reported to managers that they feel lost and alone being separated from family. One participant explained that some IMGs never experienced hiring a caregiver for their children when they work because a close family member would look after their children. Being separated from family meant that they had to get comfortable with the idea of seeking babysitters or daycares.

Participants shared several methods IMGs use to navigate personal challenges. Some IMGs are vigilant about following rules. IMGs must be prepared for change because U.S. local and workplace customs may differ from their home countries. Other key actions for residents are to consistently try their best and be persistent. While IMGs have expressed feelings of discouragement, they do not let those moments hinder their goal of becoming licensed physicians in the United States.

Participants offered suggestions to support new IMG residents on personal challenges. Besides camaraderie, residents need to see their leadership caring about them, reassuring them, and guiding them in their development as future physicians (Moresco et al., 2020). Managers recommended showing empathy, giving grace, and having patience. Having conversations with IMGs may help medical residency program managers to learn about interests and their individual needs. Contributors suggested being a good listener. IMGs may feel supported if they are given respect, understanding, receive kindness, and positive feedback.

Interview participants offered two pieces of advice to support personal challenges. As contributors thought about the educational impact, the first recommendation is for

medical residency program managers to be open-minded. The second is to be flexible. Each IMG and residency team will have a unique set of needs, challenges, and expectations. Program managers who have an open mind and are willing to be flexible may provide opportunities to ensure academic and professional improvement for residents.

Contributors provided best practices implemented to support personal acculturation challenges. Some participants sought methods of inclusion. Program managers invited residents out for holiday festivities and sought opportunities to teach each other about IMG holidays and traditions. Participants created an atmosphere that respected individual religious beliefs and practices and encouraged others to learn. One implemented social occasion to introduce IMG traditional meals that supported dietary restrictions.

The last best practice discussed that was highlighted during interviews was being positive. Having a positive, uplifting environment may set the tone for having a healthy workplace that is culturally sensitive and inclusive. Participants who developed best practices to suit personal challenges reported a positive impact on the program and residents. They aspired to be helpful and were hopeful that IMGs were happier, comfortable, and more confident in their abilities.

Some contributors felt that IMGs were appreciative and more confident. One respondent explained integrating IMGs created enthusiasm. They felt welcomed and that they had a network of people who wanted to see them succeed. Respondents who used best practices to resolve personal challenges noted that IMGs were more comfortable.

Residents who received encouragement and support early in the program were more open to voicing their concerns. IMGs who received positivity and were encouraged to share their unique perspective were more confident in establishing relationships and adjusted to unfamiliar surroundings.

Limitations of the Study

Research studies have limitations regardless of methodology or design (Yin, 2014). This study was limited by the distribution of outreach. I distributed the fliers solely using my social media accounts which caused delays in retrieving potential participant responses. Despite delays, the appropriate number of contributors who met the requirements participated in the interview. The sample size of 20 was deliberate in gathering rich and exhaustive responses.

The results of the sample population denote the perceptions of medical residency program managers in the United States and may not apply to workers in other countries. The limited depiction could vary due to differing circumstances in medical residency programs in other geographic locations. Medical practices, cultural norms, or workplace customs may differ significantly. Participant biases may contribute to an additional limitation of the study. Contributors may have opinions and experiences with the immigrant population outside of medical residency that could impact responses. I was not aware of those experiences during the recruitment process.

The final limitation of the study was that I relied solely on the participants' candor as they responded to the research questions. The semi-structured interviews provided an open forum for participants to share as much or as little as they felt comfortable, and the

expectation was that they would be honest about their experiences. Concerns about how the participant would be viewed when sharing information about other cultures may have produced fear of being regarded as prejudiced. This fear could lead to participant dishonesty, incomplete, or dishonest responses. The participant could even opt to give no response to questions during the interviews, which may serve as a limitation to the study. This concern combined with self-reporting could skew honesty in participant responses.

Recommendations for Future Research

This study has provided information on the experiences of medical residency program managers resolving IMG acculturation challenges in the United States. Since there is limited research on best practices, it is recommended for future researchers to conduct further studies that incorporate residency staff members in ancillary roles. These studies could generate practical information that may aid managers who are seeking to improve medical residency training programs and foster an inclusive work environment for IMGs.

I recommend that additional research explore acculturation challenges using different approaches to research and include specific residency programs throughout the United States to provide an all-inclusive view based on perspectives of local customs and unique workplace cultures. Each residency program has different expectations; every state varies in IMG resident acceptance and these differences may impact the responses and may produce different challenges. Research should be conducted to investigate whether residency staff relationships and communication can influence IMG completion outcomes and how this can be used to improve educational impact, program

improvement, and decision making.

Another recommendation is that researchers use a quantitative study to offer detailed statistical findings on medical residency manager experiences related to communication barriers, written understanding compared to verbal understanding for IMGs navigating post-graduate training. Perceptions of ways IMGs retain information may impact performance and may provide insight to program managers as they are modifying curricula for newly matched IMGs. Exploring various residency programs throughout the country adds value to the study because it increases the range of best practices among different types of programs throughout rural, suburban, and urban settings.

There may be varying types of residency program expectations and duties based on specialty, location, the volume of IMGs, and country of origin. These variables should be pursued because the types of challenges program managers address may differ. Further research on equality perceptions of hospital staff and patients is needed. Residency program managers could benefit from knowing about external challenges that may negatively impact IMG performance during training and ways to mitigate those challenges to improve the program. Further evidence is required to potentially inform policies and procedures for decision-making to improve program structure and educational impact for IMG residents.

Implications for Social Change

Positive social change related to the experiences of residency program managers leading IMGs through acculturation challenges has the potential for contributing to

creating healthier work environments for medical residents. The findings of this study suggest that the implications for positive social change should continue to remain relevant for current trends among post-graduate training programs. The results imply that there is a need for change to improve the perceptions of staff and patients as it relates to cultural sensitivity, inclusion, and cross-cultural adjustment for IMG residents. In the findings, I was able to recognize that medical residency program managers expressed concern about the treatment and biases that IMGs residents face that lead to acculturation challenges.

Recognizing the perceptions of medical residency program managers provokes the need for evocative best practices, social interactions, and innovative resources to provide an efficient support system. Study findings have helped identify three implications for possible social change. There is a need to create awareness and responsiveness among medical residency program managers about the perceptions of staff members on IMGs. Understanding the perceptions of staff members' satisfaction provides an avenue to improve workplace interactions and establish healthy communication dynamics among team members. Managers providing support systems for IMGs help contribute profound visions and understanding of acculturation challenges among residents. Medical residency program managers with heightened cross-cultural awareness may contribute to staff motivation, patient understanding, cultural sensitivity, and retention among IMGs. Provided all interview responses are honest, feedback may be used to develop further best practices to be used in other residency programs throughout the United States.

Significance to Practice

This study includes information on the experiences of medical residency program managers resolving acculturation challenges among IMGs. The research discusses an in-depth qualitative analysis and results that revealed best practices created to address cross-cultural adjustment challenges during residency training. The overall research question and interview questions aided in providing themes surrounding the perceptions of medical residency program managers.

Practical implications include understanding unique challenges that stem from working in unfamiliar territory and providing a support system that enhances education, professional development, and communication among team members. Medical residency program managers creating awareness among team members about diversity inclusion promote a healthy work environment. Continued support efforts may include staff involved in the planning cultural awareness program, mentoring/peer programs, providing written materials that correspond to verbal instruction, design, and implementation of IMG communication of feedback, and training before the start of medical residency.

Medical residency program managers could use the information presented in this study to improve cross-cultural adjustment challenges and improve perceptions of staff and patients about IMG residents. Residency programs may apply the findings derived from the research as an invaluable resource to improve the educational impact of post-graduate training for IMGs and create bonds among residents. This study has contributed to the experiences of medical residency program managers, directors, and coordinators.

Although there are existing literature acculturation challenges, this study focuses on the experiences of medical residency program managers and how those challenges have been resolved.

Significance to Theory

Medical residency program managers must help establish a supportive workplace atmosphere for IMGs, identify missed opportunities, and address the disconnect that may exist among the residency team and patients. Perceptions of medical residency program managers are essential, considering the workflow nature of post-graduate training programs, and should be connected to the theories used for the study. An increased understanding of the experiences related to acculturation challenges among IMGs would render the theories more applicable and appropriate during residency as program managers enforce theories. Though theory development was not the driver of this research, the theoretical framework applied helped diminish hindrances surrounding the experiences of the medical residency program. The theoretical framework will contribute to current knowledge about improving residency program functions and communication efforts among medical residents. Exploring best practices may promote positive social change by helping program managers gain more insight and understanding about cross-cultural adjustment challenges.

Significance to Positive Social Change

The experiences of medical residency program managers are a crucial component that could contribute to the positive image of post-graduate training programs in the United States as a significant change agent to convey positive social change. IMG

residents who lack trust in program managers and staff due to prejudices or cultural insensitivity may feel unmotivated to perform and may be uninformed of standard workplace customs needed to advance in medical residency training. Facilitating cohesive professional relationships among IMGs and staff through education and social interactions may result in a positive social change by inspiring the residency team to influence positive decision-making. Inclusion among IMG in social situations, supportive opportunities, and enhanced resources may contribute to residents being aware of personal biases and IMG acculturation challenges. Their involvement in communication efforts and peer support opportunities, integrating resources about work customs, communication techniques, publications on U.S. medical terms, and creating a thoughtful professional environment may improve the experiences of managers, patients, and staff within the residency program. Improvements may enhance the positive image of the program, enhance work output, and improve staff relations. Cultural sensitivity and awareness should be maintained while medical residency program managers incorporate best practices that promote enthusiasm, improved communication efforts, frequent options to deliver feedback, consistent transparency, and opportunities for IMGs to express concerns.

Researchers have conducted exhaustive studies surrounding immigrant acculturation challenges and noted the need for professional and community support. My goal for this study was to add new information on best practices to the existing body of literature. The results of the study could lead to a positive social change in medical residency programs throughout the United States. The current study was intended to

explore a defined group of managers with extensive experience working with the IMG population. Challenges may persist if medical residency program managers are unwilling to take necessary steps to learn about the unique challenges faced by their IMG residents and apply best practice methods specific to their program. I recommend that further research be conducted.

Conclusion

A complete understanding of the experiences of medical residency program managers resolving IMG acculturation challenges is vital to U.S. post-graduate training. This research has provided a rudimentary understanding of larger incidents across the country that could be adopted and used expansively to impact IMG cross-cultural challenges. Material gathered from the study may add to the understanding of medical residency program managers, directors, and coordinators. The distribution of the research findings may enable medical residency program managers to implement resources and opportunities to develop best practices, improve resident and staff motivation, promote sensitivity, and engage in healthy communication practices. Participant experiences shared advocate unceasing communication and feedback to ensure that IMG residents have countless opportunities to respond to challenges and make the necessary changes that improve the educational and professional impact for the entire team.

Research discoveries suggest that inclusiveness is at the core of a healthy workplace to promote understanding, acceptance, and respect, which may assure team members will learn and appreciate each other’s differences. Findings highlight the value of IMG contributions to U.S. healthcare system and the benefit to their unique personal

and professional experiences that U.S. patients benefit from regularly. Research results may call for a need to gather more theories to ensure best practices that improve acculturation challenges, staff and patient perceptions, and opportunities to improve communication and relations. Best practices may need to be tailored based on the individual program, local customs, and present IMG needs. Medical residency program managers need to ensure IMGs and USMGs incorporate appropriate assessment methods and procedures that suit the environment because each program will have a different residency population, workplace expectations, and patient experiences. This is compulsory because medical residency program managers encounter different acculturation challenges and rely extensively on the team's ability to express concerns, gauge the severity of the challenge, and implement conflict resolution strategies that align with program requirements and staff needs.

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Appendix: Interview Questions

(1) What are some of the acculturation challenges you have witnessed among IMG during residency training?

(2) How have acculturation challenges impacted medical residents?

(3) What do you think has been the greatest strength of training IMG and how has that impacted your residency program?

(4) What do you think has been the greatest challenge IMGs have faced as a direct result of being an expatriate?

(5) How did you cope with or manage the challenges you described in question #4?

(6) What advice would you give to program managers who are leading a new cohort of IMG?

(7) What advice would you give to those leading a new residency program for ways to support IMGs through acculturation challenges and maximize the educational impact?

(8) Describe best practices that have been implemented to resolve IMG acculturation challenges.

(9) How have best practices impacted IMG residents?

(10) How have best practices impacted the residency program?