“Proving Yourself” in the Canadian Medical Profession: Gender and the Experiences of Foreign-trained Doctors in Medical Practice

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By:

Vanessa N. Dolishny

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Supervisor	**Examiners**
Dr. Tracey Adams	**Dr. Jerry White**
Supervisory Committee	**Dr. Carol Agócs**
	Dr. Teresa Abada

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Vanessa Noelle Dolishny

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Abstract

In recent years the medical profession has become feminized. Additionally, there has been an increased representation of foreign-trained professionals in the Canadian medical profession; many of which are women. Thus, there is a significant number of female medical practitioners who are foreign-born and foreign-trained. This demographic faces many barriers, which are often characterized as a "double disadvantage". This paper investigates the experiences of foreign-trained medical professionals once they have gained access to the profession and whether the feminization of medicine has impacted the experiences of these individuals. Immigrant status was found to be highly significant to one's experiences in the profession. Additionally, gender, period, and country of origin were significant. It was found that the feminization of the profession did impact the experiences of the respondents to some extent. The experiences of foreign-trained medical professionals are complex and dependent on a number of different variables.

Keywords: Foreign-trained professional, gender, regulated profession, medicine, health profession, immigration, feminization, international medical graduate, skilled immigrant, professional work, reaccreditation, inequality, discrimination.

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Chapter 1: Introduction

Traditionally, the practice of high status professions such as medicine was restricted to highly esteemed males. However, current literature suggests that in recent years the medical profession has become *feminized*; that is, large numbers of women have been entering the medical profession (Williams, 1999). According to the Canadian Institution for Health Information (CIHI), female physicians made up approximately half of Canada's physician supply in 2008; 52% of new family physicians and 45% of new specialists were women. However, in addition to feminization, we have witnessed an increase in foreign-trained medical graduates practicing in Canada, many of whom are women. In 2008, 23% of new Canadian physicians were foreign-trained graduates (Canadian Institution for Health Information, 2008). Thus, a significant number of female medical practitioners are now foreign-born and foreign-trained (Canadian Institution for Health Information, 2008).

Despite this influx of women entering the medical profession, we have yet to witness the career trajectories of female medical practitioners match those of their male counterparts. Literature has suggested that a sheer increase in numbers does not necessarily result in increased equality. The medical profession is highly gendered and female practitioners experience a myriad of barriers in terms of vertical segregation, glass ceilings, and systemic discrimination (Pringle, 1998; Laurence & Weinhouse, 1994). Likewise, increased representation of foreign-trained professionals in Canada has not necessarily created an equal playing field for internationally trained medical graduates. Foreign-trained professionals face a variety of barriers upon their arrival in Canada,

resulting in their downward mobility in the Canadian labour force (Anisef, Sweet & Fempong, 2003; Boyd & Schellenberg, 2007; Galarneau & Morissette, 2008; Li, 2001). Skilled immigrants face barriers in the form of credential recognition, employment discrimination, lack of language fluency, lack of Canadian work experience, or lack of social networks that could support their job search (Boyd & Schellenberg, 2007). Moreover, similar to women, when they do gain access to the medical profession, they tend to be overrepresented in "lower status" specialties such as family medicine (Canadian Institution for Health information, 2008).

Taken together, current literature suggests that the disadvantages experienced by women in traditionally male dominated professions can combine with those faced by internationally trained professionals to create a "double disadvantage" for foreign-trained women; they are disadvantaged by both their status as women and as immigrants (Boyd, 1984; Boyd & Kaida, 2005). Both negative statuses create not just additional barriers, but an entirely unique experience of discrimination and disadvantage. However, while the disadvantages faced by women in medicine and immigrants in professions have both been documented, there appears to be a disconnect between the two bodies of literature. The literature surrounding feminization and women's experiences in the medical profession, for the most part, fails to take an intersectional approach; it usually provides a gender analysis. Similarly, the literature on immigrants' labour market integration either lacks a gender analysis or does not focus on outcomes of reaccreditation in the medical profession. Thus, the experiences of foreign-trained women in the medical profession have largely been ignored. That being said, in the present study I will investigate the impact of feminization and immigration on practitioners' experiences of medical practice.

Moreover, I will examine whether these foreign-trained women experience the "double negative effect" once they gain access to the profession; what are their experiences in the profession?

In order to identify current knowledge and gaps surrounding the literature of women in professions, the subsequent literature review (chapters 2 and 3) will examine theories of professionalization, theories of women in professions, the process of feminization, the feminization of medicine, women's experiences in health professions, and immigrants' labour market integration. Chapter 4 outlines the methodological approach undertaken and describes the study. Chapter 5 details the study findings, presenting the experiences of the foreign-trained medical doctors interviewed, and identifying the barriers and challenges they faced upon settling into medical practice in Ontario, Canada. Chapter 6 discusses the results in light of the literature review, and considers implications for research on professions, and for social policy.

Overall, this study indicates that medical doctors' experiences are shaped by a myriad of factors and that gender and immigration status intersect with many other statuses and relationships to shape their practice.

Chapter 2: The Feminization of the Medical Profession

Introduction

In this chapter I will review the literature on the feminization of the medical profession. I will outline theories of women in professions as well as theories of professionalization, specifically focusing on the medical profession. I will analyze the outcomes and implications of feminization for the medical profession and investigate women's experiences in medicine.

Professions

Professions are special occupations that carry with them a great deal of status and prestige. Professions are typically regulated occupations, and individuals who wish to practice a profession must endure rigorous training and demonstrate they have mastered the knowledge and skills required by the profession before being granted the right to practice. By regulating knowledge, education, and entry to practice, professional regulatory bodies with state support create a privileged market position and a high level of occupational control (Abbott, 1988; Freidson, 2001; Larson, 1977). The result is higher-than-average incomes, lower unemployment rates, and more workplace autonomy and authority (Adams, & Welsh, 2007). Professions achieve this level of authority through a variety of strategies, some of which are cultural and ideological (Starr, 1982; Abbott, 1988). Professions appeal to values of popular/dominant ideology to win over the public. Ideological authority, combined with legal authority, and restricted entry to practice gives successful professions the power to maintain jurisdictional control and prevent competing occupational groups from compromising their monopoly (Abbott, 1988).

Due to the restricted nature of professions, traditionally access was often only granted to high status males; thus, access to professional occupations was very much dependent on one's ascribed status (Glazer & Slater, 1986). In fact, it was not until fairly recently that women began to enter regulated professions in larger numbers, as most regulated professions were male dominated in the past. Nevertheless, more recently, professions are becoming *feminized*; that is, women are entering professional occupations at increasing rates (Williams, 1999). Despite such dramatic changes in workplace composition, women continue to face a myriad of barriers upon entering such professions, which typically have a masculine structure and culture.

Women and Professional Work

Historically, women were viewed as not belonging in male-dominated professions and careers. Rosabeth Moss Kanter (1977) was among the first to argue that this had little to do with women themselves, but had more to do with how work was organized. She argues that gender differences in organizational behaviour are a result of the organizational structure and not the gendered characteristics of men and women. Her claim is essentially that any individual, who is of minority status, will experience heightened visibility and will be highly scrutinized because of their "token" status. Accordingly, this will put them at a disadvantage. However, Kanter was later criticized for ultimately viewing organizations as gender neutral (Acker 1990). In her work, gender is disconnected from the overall structure. Subsequent theories built on her work to show that gender and organizational structure are inseparable.

Anne Witz (1992) progresses in attempting to bridge the disconnect between gender and structure by drawing on Dual Systems theory. She argues that capitalistic and

patriarchal relations interrelate to create a labour market that subordinates women. Furthermore, Witz claims that up until this point, scholars have looked at professional projects in a very androcentric way. She states that we need a theory of professionalization that acknowledges women's presence in professional projects in a way that is not gendered. Witz posits that female professional projects have been ignored because the notion of "profession" is one that is inherently gendered. Consequently, she attempts to refine Neo-Weberian closure theory in order to incorporate a gender analysis.

While Witz focused on the strategies through which women were excluded from professions and how women fought against that exclusion, Celia Davies (1996) suggests that we must look at women's inclusion in professions. She claims that examining women's participation in support roles can help us analyze the gendered nature of professions. In her work "The Sociology of Professions and the Profession of Gender", she examines the two concepts, bureaucracy and professions. Davies concludes that these two concepts are very similar and reflect a masculine organization of work. In particular, both bureaucracy and professions fail to acknowledge the presence of women within the organization (in support roles as well as outside of the organization). She states that this is highly problematic, as women's support roles are integral to the overall functioning of the organization, yet they are ignored. Furthermore, both bureaucracies and professions are embedded with masculine values and norms; everything feminine is repressed, denied, or devalued. Consequently, this trivializes the work women do in professions because the work is associated with "feminine qualities" (Davies, 1996). Ultimately, Davies believes that we may only begin to see greater equality within professions when we dissociate values of masculinity with professions.

In effect Davies argues that professions are gendered, an argument that is extended and elaborated by Joan Acker's theory of gendered organizations. Despite some minor criticisms, her two works "Hierarchies, Jobs, Bodies: A Theory of Gendered Organization" and "Inequality Regimes: Gender, Class and Race in Organizations", seem to conceptualize the gendered nature of professions in the most comprehensive way by analyzing the mechanisms that serve to disadvantage women and other minorities.

Acker (1990) examines how assumptions about gender, sexuality, and the body are used as methods of social control in work organizations and function to marginalize women. According to Acker, to say that an organization is gendered is to suggest that "advantage, disadvantage, exploitation and control, action and emotion, meaning and identity, are patterned through and in terms of a distinction between male and female, masculine and feminine" (Acker, 1990, p. 146). She claims that gender is an integral part of organizational processes; we cannot theorize about the organization without including an analysis of gender. Assumptions about masculinity underlie the structure of organizations and have real implications for individuals who occupy positions within those organizations.

According to Acker, traditional organizational theory assumes jobs and hierarchies are abstract categories that are filled by "disembodied" workers. The individuals who occupy such categories exist only for their work. Thus, Acker acknowledges that according to traditional organizational theory, the most appropriate individuals to fill such "abstract" jobs and hierarchies are men since they are perceived as more committed, and they do not have as many outside obligations. Additionally, Acker claims that sexuality, procreation and emotions are all thought to disrupt the efficiency

and functionality of an organization. This statement falls in line with her previous argument, stating that the abstract worker is actually a man. Accordingly, it is the man's body, his sexuality, minimal responsibility in procreation and conventional control of emotions, which infiltrates work and organizational processes. Thus, female bodies, their sexuality, ability to procreate, responsibility for childcare, and stereotypical emotionality, are necessarily discredited and disrespected. Acker concludes that women are relegated to lower status positions within an organization as a result of implicit assumptions associated with a gender-neutral structure, but also as a result of their sexuality, reproductive ability, and emotionality. It appears as though women and their bodies are treated as if they do not belong in work organizations. Organizational power is built upon notions of hegemonic masculinity, and a woman's body cannot be adapted to this because it would essentially require her to abolish unique characteristics that make her a woman (Acker, 1990).

Acker's (2006) work on inequality regimes contains ideas that are similar to her earlier work, however she paints a more comprehensive picture as she takes an intersectional approach. That is, she suggests that an individual may be intersectionally advantaged or disadvantaged depending on his or her unique identity. Furthermore, some individuals may experience more barriers than others if their identity is composed of multiple "negative statues" (i.e. female, racial minority, poor, etc.). Acker defines inequality regimes as "interrelated practices, processes, actions and meanings that result in and maintain class, gender, and racial inequalities within particular organizations" (Acker, 2006, p. 443). Acker claims inequality regimes are maintained through the reproduction of class hierarchies in organizations, the organization of work, recruitment

and hiring processes, wage setting and supervisory practices, informal interactions while doing the work, the visibility of inequalities for people in dominant groups, the legitimacy of inequalities within a particular organization, and organizational controls. Acker's notion of inequality regimes is particularly significant to the study of gendered organizations. Inequality regimes are especially prevalent in male dominated professions where "gender regimes" have historically prevented women from advancing in organizations.

Thus, despite women's movement into male dominated occupations, the male dominated organizational structure remains, putting women at a disadvantage. However, even though women have been making inroads in traditionally male dominated occupations for quite some time now, the past few decades have been especially significant. Traditionally male dominated occupations have been *feminizing,* as we have witnessed large numbers of women enter these professions (Le Feuvre, 2009; Reskin & Roos, 1990). There has been great debate as to how this influx of women will impact professions and female professionals.

Feminization: Issues and Implications

Many scholars question whether feminization will increase gender equality in the workplace (Le Feuvre, 2009; Reskin & Roos, 1990, Chi & Leicht, 1999). Additionally, some question whether the increased representation of women will negatively impact the status of professions. Although many scholars have documented the disadvantages women face upon entering male dominated professions, some suggest that this increased entry of women will create a more equal playing field (Chiu & Leicht, 1999).

One of the most popular explanations of feminization is provided by Reskin and Roos (1990). Using a queuing approach to explain feminization, they claim that women gained entry to previously male-dominated positions beginning in the 1970's because declining working conditions motivated men to find more attractive jobs elsewhere. They suggest that male flight, coupled with a sex specific demand for women resulting from anti-discrimination regulations and changing social attitudes, is what caused women's inroads into previously male-dominated occupations. While Reskin and Roo's theory does have some merit, most current literature on the topic challenges the notion that women's entry is caused by a decline in job status and male flight.

Using Reskin and Roo's (1990) perspective as a starting point, Wright and Jacobs (1994) initially hypothesized that women's entry into computer work would lead to increased ghettoization, sex segregation, wage gaps, and male departures. However, none of these predictions were supported in their study. Surprisingly, they found that feminization led to a narrowed wage gap and less occupational segregation. Furthermore, women's increased entry into the profession was not a result of declining working conditions and male flight (Wright & Jacobs, 1994).

Similarly, Chiu and Leicht (1999) propose that there are two types of feminization: successful feminization and unsuccessful feminization. Successful feminization occurs when women's entry into a previously male dominated occupation is accompanied by decreased workplace segregation, rising wages, and a reduced gender wage gap. Unsuccessful feminization can be characterized by the lack of the above characteristics. Chiu and Leicht suggest that successful feminization can stem from rapid employment growth, specialized degree requirements and increasing wages.

Also contrary to the findings of Reskin and Roos (1990), Boulis and Jacobs (2008) find that the influx of women into the medical profession is not a result of male flight or declining status. Rather, women's entry is a result of broader societal changes regarding women's roles. Thus, women's entry into medicine may have been spurred by a combination of the following: legal and political changes resulting from the women's movement; institutional changes occurring in the health care system; social and cultural changes in education, work, and family life. Even though women's representation has increased numerically, Boulis and Jacobs still find they are concentrated in lower status "female typed" medical specialties. Furthermore, women are underrepresented in academic research and positions of leadership, and continue to face implicit and explicit forms of discrimination and harassment. Nevertheless, we have yet to witness a decline in the status of the profession despite the lower representation of men.

Although it may seem like the more recent evidence contradicts Reskin and Roos' (1990) theory of feminization and male flight, when we do examine Reskin and Roos' theory more closely, it seems as though it has been criticized rather harshly. We must be cautious when interpreting and generalizing findings regarding feminization, as outcomes may vary significantly across professions. Most of the occupations considered in Reskin and Roos' volume are not regulated professions. One should be cautious about generalizing from occupations to professions like medicine. Since most of Reskin and Roos' case study occupations expanded as a result of economic growth, it is consistent with the logic of supply and demand that the occupation would open up to more individuals (women). As a result, this would decrease salaries and status simply because the occupation is no longer restricted as it once was. The situation for professions with

restricted entry may be different. Thus, we encounter some circularity when trying to determine if it was women who caused a decrease in status and wages, or whether larger structural processes are at work. Similarly, we must exercise caution when drawing conclusions regarding women's gains towards equality in terms of wages and position in workplace hierarchies. Just because an occupation has been feminized numerically does by no means suggest that women have achieved status equal to their male counterparts (Bolton & Muzio, 2008).

Additionally, feminization does not have to be categorized as a dichotomy that is either successful or unsuccessful. In fact, we can consider the gains women have been making in gradations. Reskin and Roos (1990) found that while women had made gains in terms of their initial entry into traditionally male dominated occupations, once there, male and female workers were concentrated in different jobs. That is, they found segregation continued to persist within desegregating occupations. Similarly, they found that the case study data suggest there was limited progress toward economic equity within the desegregating occupations. A significant economic gap was found between and within positions in individual professions. Furthermore, in occupations in which the gap between female and male co-workers did decline, it did so mostly through an erosion of men's real earnings during the 1970s (Reskin & Roos, 1990). Thus, feminization in the numerical sense does not necessarily suggest that women have achieved equal status in comparison to their male counterparts.

Nevertheless, it is important to take into consideration both the gains women have made and the disadvantages they still continue to face. For example, we must honour the women who have migrated into traditionally male dominated occupations as they have

raised their wages relative to the overall average for all women. Similarly, we must not let numerical representation fool us, as misunderstandings of women's gains may reinforce the ideology that all disadvantaged groups can advance through their own efforts without any assistance from institutional policies or structures. It is a common belief that once women have achieved a status that is similar or equal to men, they are no longer at a disadvantage. Nevertheless, research has demonstrated that it is evident even within the professions that there are still closure strategies at work. However, many of these closure strategies may not be apparent, as they are often symbolic and subjective.

Feminization and Identity: Implications for equality

Women who obtain high status positions in professional fields do not by any means have the same experiences as the men in those positions. Interestingly, even though women have obtained relative equality in the most objective sense, women continue to face a great deal of systemic discrimination. That is, "informal practices imbedded in normal organizational life which have become part of the 'the system'" (Adams & Welsh, 2008). Women are still excluded and face barriers in the form of identity presentation and homophily preferences (Dryburgh, 1999; Pierce, 1995; Roth, 2004). Moreover, It seems as though women in male dominated professions struggle to maintain aspects of their feminine identity, as masculine traits are often perceived to be valued more highly and equated with success in the field. Furthermore, men tend to exercise homophily preferences in that they often prefer to work and interact with others who share certain characteristics with themselves; they may find the presence of women in non-traditional occupations jarring. Unfortunately, this often results in female co-workers experiencing isolation and a heightened sense of visibility (Roth, 2004). Roth

(2004) finds that men possess a "status expectation". That is, they use status characteristics to assess others' competence in relation to some task. For example, since men and whites have higher status in the workplace, this leads people to believe that they are more competent than members of other demographics. Additionally, women in male dominated professions often encounter a double standard with regard to their identity management. They find that in order to succeed they must possess a number of "masculine traits"; however, the individuals around them expect them to maintain some degree of femininity (Pierce, 1995; Roth, 2004). Thus, they are faced with a dilemma where they must embody masculine traits to succeed in the profession. However, at the same time they are not accepted unless they present their femininity. For example, Cassell (1997) finds that nurses working with female surgeons tend to monitor and enforce gender appropriate roles upon these women. Women surgeons are penalized for behaving in ways that are perceived as normative for male surgeons and are often encouraged to act more feminine. Essentially, men are rewarded for the traits women are punished for. Nevertheless, in order to succeed women must necessarily possess these "masculine" traits. As such, identity management becomes a catch 22.

Dualisms associated with masculinity and femininity can also be found in many professions. Different "feminine" and "masculine" typed skills may both be needed for success in a profession even though they may appear to be conflicting. Faulkner (2000) finds that in Engineering these dualisms are deemed to be mutually exclusive and the "masculine" traits are consistently valued more than the "feminine" traits. Furthermore, women are expected to excel in the non-masculine areas and there is a widespread consensus that one cannot excel at both. Despite the fact that both skills are needed,

engineers internalized the idea that possession of "masculine" traits was valued more highly than possession of the "feminine" traits. Additionally, even though women held the same organizational position as the men, they were thought to be incompetent in certain areas because they were perceived as unable to possess such masculine traits. Consequently, these gendered expectations led to gender segregation (Faulkner, 2000). It seems as though men in professions create restrictions or barriers for women by symbolically excluding them from positions of power by associating power and success with masculinity. Naturally, when women try to fit these masculine moulds they feel uncomfortable and out of place as if they were suppressing their natural gender identity. However, these feelings do not have to be an inevitable consequence for women in positions of power. These skills that are typecast by gender indicate evidence of closure strategies by men who could be consciously or subconsciously trying to preserve their positions of power.

Traditionally male exclusionary strategies such as those mentioned above were utilized to elevate the status of professions. This was evident in the medical profession where exclusionary strategies were implemented as part of a professional project intended to elevate the status of medicine in the nineteenth century (Glazer & Slater, 1986). Women, ethnic minorities, and working-class males were turned away and sometimes even formally banned from medical schools (Glazer & Slater, 1986). However, these practices were deemed necessary at the time in order to gain occupational control and successfully create an occupational monopoly. It wasn't until the 1970s that women began to enter regulated professions in larger numbers. Nevertheless, women continue to face barriers upon entering previously male-dominated professions despite

the democratization of entrance standards. The medical profession is one in which such barriers remain relatively pronounced.

The Professionalization of Medicine

Although we now consider medicine to be one of the most prestigious professions in society, this was not always the case. The growth of the medical profession was a lengthy process and its development into a regulated profession was arduous. The development of the medical profession in Canada began during the middle of the 19th century. The number of medical practitioners was increasing drastically and the market was largely unregulated. Regularly trained medical doctors were forced to compete not only against each other but also against the lesser trained and people practicing alternate health professions (Gidney & Millar, 1994; Howell, 1981). Uncontrolled entry into the profession was problematic for a variety of reasons. In these early stages doctors did not have a core institutional base that could protect them and control entry into the market. Furthermore, the profession was not initially held in high regard: the general public had little faith in doctors' expertise. In order to gain the trust of the public and gain professional legitimacy, the profession needed to be redefined (Howell, 1981).

Ultimately, the medical doctors needed to assert their supremacy among similar occupational groups and restrict entry to practice. This would be accomplished through demonstrating their value to society, demonstrating a commitment to, and the superiority of, medical practice, and the establishment of a medical board, which could ensure that access to practice and licensure remained restricted. Necessary to the professionalization of medicine were improvements in education and science, in addition to the

standardization of knowledge and controlled entry into educational institutions (Gidney & Millar, 1994; Howell, 1981; Shortt, 1983).

The first effective regulatory legislation in Ontario was brought to the Ontario legislature in the fall of 1868. This bill sought to establish a regulatory body, the College of Physicians and Surgeons of Ontario (CPSO). It limited entry to practice to those who had been formally trained and examined in medical science. Further, it allowed for those practicing illegally to be prosecuted. While politicians viewed the bill favourably, they inserted an amendment to bring homeopathic and eclectic medical doctors under the act. While this amendment was welcomed by laypeople and politicians alike, physicians continued to be divided on this issue. There were many who were vehemently opposed to any affiliation with those alternate medical practitioners. Some physicians believed differences were so stark that cooperation would be impossible. On the other hand, there were some medical men who supported their inclusion under the act, to ensure one route of entry and greater uniformity of training. The bill was passed in 1869. Ultimately it led to the decline of homeopathy and eclectic medicine, by making it more difficult for those doctors to gain entry to medical practice (Gidney & Millar, 1994).

This legislation, in and of itself, did not secure medicine's status. The profession's efforts to undermine its competition, and its endorsement of scientific medicine gradually contributed to its rise in status. Scientific medicine gave legitimacy to the profession and appealed to the larger society (Shortt, 1983). Professionalization was not only intended to advance the quality of medical treatment but also, solidify dominance of the elite within the profession. Regulation created a sense of prestige among medical professionals based

on the idea that one's professional identity was defined by status, regulation, educational attainment and licensure (Abbott, 1988; Gidney & Millar, 1994; Larson, 1977).

As part of the medical elite's efforts to uphold the legitimacy of the profession, they restricted the entry of women. Women wanting to enter the medical profession often faced a great deal of hostility, as they were believed to be incapable of possessing the traits necessary to succeed in medicine (Pringle, 1998). Although the number of women entering medicine increased across the 20th century, they still experienced barriers. Even today, women tend to be overrepresented in the lower status "feminized" specialties such as general practice, while men are overrepresented in the higher status specialties such as surgery (Canadian Institution for Health Information, 2008). Thus, vertical segregation in the medical profession is evident. Furthermore, the organizational structure and culture of the profession is built upon ideals of hegemonic masculinity. This masculine structure is demonstrated in the symbolism in practice, the role conflict, harassment and hostile environment women experience.

Women In Medicine

Doing Gender Doing Medicine: Symbolism in Practice

Many studies document the reinforcement of "gender appropriate" behaviours and the dichotomy of masculinity/femininity in medical practice. In general, men are rewarded for possessing characteristics of toughness, strength, action, and physicality whereas females are rewarded and encouraged to possess characteristics such as empathy, care, and passivity (Cassell, 1997; Hinze, 1999). There is a consistent valuing of male over female. Specialties that require so called "masculine traits" are considered to be more important and prestigious (Hinze, 1999).

In a similar way, much of the language that is used in the medical profession excludes women (Cassell, 1997; Hinze, 1999). For example, toughness is often equated to the size of ones “balls”. This notion is highly gendered, as it is associated with one’s competency in the field. This idea symbolically excludes women from succeeding in such high status specialties because they are physically incapable of possessing testicles (Hinze, 1999). Thus, in order to be perceived as competent and suited for the work, they must metaphorically “grow a pair” (Hinze, 1999). This is just one of the many examples illustrating how women are symbolically excluded from the medical profession. Usage of such language suggests to women that they are incapable of possessing the traits necessary to succeed in medicine. As a result, many women in surgery or other high status specialties frequently face a double bind. In order to succeed, they must be aggressive and embody “masculine” traits. However, when they do, they are often scrutinized for not acting “feminine” enough or are labelled a “bitch” (Cassell, 1997; Hinze, 1999). As mentioned earlier, women face a constant struggle to maintain a feminine identity that is consistent with their professional identity; these two are often perceived as inconsistent and opposed to one another.

Interestingly, Cassell (1997) finds that nurses working with female surgeons tend to monitor and enforce gender appropriate roles upon these women. Women surgeons are penalized for behaving in ways that are perceived as normative for male surgeons and are often encouraged to act more feminine. This same sex policing is a way to maintain gender “appropriate” boundaries (Cassell, 1997). Thus, women physicians often face a struggle to assert themselves as professional and feminine. This suggests that the medical profession is highly gendered. The “abstract” position of the physician appears to be

gender neutral on the surface. However, once we uncover the symbolism inherent in the behaviours, language, and imagery associated with the power and status of the profession, it is clear that medicine is highly gendered. Women face barriers in the sense that the personal characteristics expected of physicians are dominantly male. Furthermore, because "masculine" behaviour is expected of physicians, females are viewed as "unpredictable" or as "oddities" (Bourne & Wikler, 1978; Pringle, 1998). Femininity is seen as not belonging, or as incongruent with those characteristics traditionally valued and expected of a physician (Bourne & Wikler, 1978).

It is because of these beliefs that many women and men have traditionally perceived medicine to be largely incompatible with women's biological and social roles. The structure of the medical profession is largely based on a man's career and life course trajectories. The sequence of the training, career, and professional norms are suited to the traditional male role in the family and the male biological clock (Bourne & Wikler, 1978). Thus, a common argument as to why women do not enter high status specialties like surgery is they value having a work-life balance and need greater flexibility in order to balance work and family commitments; this explanation is often termed the "social roles perspective" (Hinze, 1999; Gjerberg, 2002).

Mothering or Medicine?

For women physicians there is a clear conflict between their multiple social roles. Moreover, medicine and especially high status specialties such as surgery involve long, arduous training and unstandardized work hours. If a woman wishes to have a child, the time frame of surgical training is not very compatible with the female biological clock. Furthermore, it is difficult for a woman to enter a high status specialty with more

demanding hours, unless she has a partner who is willing to take responsibility for much of the domestic work. Although we have witnessed the entrance of large numbers of women into professions, we have yet to witness a similar revolution on the part of men (Beagan, 2001). Until this occurs, women are naturally constrained by family considerations and their biological clocks.

Pozner (1997) finds many female physicians describe the system of medicine as being built for men; a medical career and family life just aren't compatible (See also Thompson, 1997). Moreover, male physicians still perceive the solution of balancing family and career as a woman's predicament and not something the profession can assist in. The "problem" or dilemma of how to balance a career and family becomes an individualized problem and is perceived as a woman's issue; not one for which both sexes and the larger society should be taking ownership (Bourne and Wikler, 1978). This logic drives many women into traditional "women's work", which is structured in ways that are more compatible with family and household responsibilities.

Nonetheless, despite its perceived incompatibility with family responsibilities, Gjerberg (2002) finds that vertical segregation in medicine is not necessarily a result of women's "inherent" tendencies to gravitate towards more patient-centered specialties. In fact, Gjerberg finds that female doctors begin their careers in surgery and internal medicine just as frequently as men. However, she found that only 20% of the women who started in surgery became specialists in general surgery or other surgical sub-specialties compared to 40% of their male colleagues. Thus, while there are no systematic differences between the initial preferences of women and men, Gjerberg finds the great majority of the women who enter specialties such as surgery end up dropping out or

switching specialties. However, Gjerberg notes that the incompatibility with childcare and family responsibilities does not explain this trend entirely. She hypothesizes that there must be other male closure mechanisms at work.

Interestingly, Baxter, Cohen and McLeod (1996) find that although the traditional responsibilities of women in terms of child-care and household management may be seen as contradictory to a successful surgical career, most female surgeons are married with children and have a high life satisfaction rating. Overall, it appears as though the problem is not that women are not entering high status specialties, but rather they are driven out of them (Gjerberg, 2002; Pringle, 1998; Laurence & Weinhouse, 1994).

Harassment in the Medical Profession

According to Gjerberg (2002) approximately 80% of women who start their careers in surgery end up pursuing alternative specialties. Central reasons why women may leave surgical specialties are (or include) gender discrimination, harassment, and their perceived inability to do the work (Gjerberg, 2002; Hinze, 1999; Pringle, 1998; Laurence& Weinhouse, 2006). Harassment in the workplace can be viewed as an expression of male power that functions to keep women in their "appropriate" positions (Farley, 1978 as cited in Heming, 1985). When women are numerically underrepresented they become tokens; they come to represent all women and their behaviours are highly scrutinized (Kanter, 1977; Heming, 1985). Sexual Harassment arises in male dominated workplaces as a result of unequal power relations between men and women. Sexual harassment may be used as a closure strategy, as it may confirm stereotypes regarding the unsuitability of women for high status positions in traditionally male occupations

(Hemming, 1985). Accordingly, sexual harassment can be perceived as 'doing gender' in order to construct or maintain a traditional distribution of power in the workplace.

Women physicians in male dominated specialties are particularly at risk for experiencing sexual harassment at work, as they are a numerical minority (Welsh, 1999). Although men and women resident physicians have reported experiencing harassment while practicing medicine, women physicians are significantly more likely to report being harassed (Beagan, 2001; Hinze, 2004; Laurence & Weinhouse, 1994; Witte, Stratton & Nora 2006). Moreover, women in high status specialties such as surgery and internal medicine are highly likely to experience a great deal of hostile environment harassment as well as discriminatory treatment based on gender. In a study on the prevalence and correlates of harassment among female physicians, Frank, Brogan and Schiffman (1998) find that 47.7% of women physicians report experiencing some form of gender-based harassment. Additionally, 36.9% of women reported experiencing episodes of sexual harassment. Harassment appeared to be more prevalent in medical school or during internships or residency (Frank, Brogan & Schiffman, 1998). Similarly, Manus, Hawkins and Miller (1998) find that 39% of female medical students reported experiencing some instance of harassment and 47% reported experiencing discrimination based on gender.

Women physicians experience unequal treatment and hostile environment harassment in the form of educational inequities, stereotypical comments, sexual overtures, inappropriate touching, or sexist remarks. Sometimes equipment available in clinics or operating rooms may not be designed to fit the proportions of a female body. Inequities such as this can be frustrating for women since size and bodily proportions are not something they can control (Cassell, 1996; Beagan, 2001). Even though they are

intellectually capable of carrying out such procedures, they may get the feeling that this is somewhere they do not belong. Additionally, educational experiences of female physicians may be diminished because male faculty, clinicians or fellow students may refuse to work with them, ignore them, or embarrass them during the training process (Witte, Stratton & Nora, 2006). This type of treatment influences the women's ability to learn effectively, and creates an alienating workplace environment.

Furthermore, the way men and women 'do gender' in medicine is particularly evident in the stereotypical comments and sexist behaviour that women endure. The patriarchal structure is maintained through the sexualisation of women. In doing this, the targeted woman is reduced to a sexual object contradicting her other identities. By sexualizing these women physicians, male co-workers abolish any recognition of the women's competence or professional status. Women physicians report being labelled demeaning names which question their intelligence and ability (Witte, Stratton & Nora, 2006, p. 651). Moreover, some are explicitly told by men that they don't belong in high status specialties such as surgery and should choose a "mommy career" (Witte, Stratton & Nora, 2006, p.651).

Additionally, some women face outright sexual harassment and experience unwanted, inappropriate sexual behaviours such as touching (Frank, Brogan & Schiffman, 1998; Hinze, 2004; Witte, Stratton & Nora, 2006). It is no wonder that many women find it extremely difficult to endure such behaviour. The hostile environment that women may experience in medicine not only hinders their ability to learn effectively but it also affects their performance as physicians. Likewise, the prevalence and rate at which this behaviour occurs implies to both the women and men, that this behaviour is normal

and acceptable. The harassment women face clearly demonstrates that the medical profession is neither gender neutral nor welcoming of women. While gendered closure strategies such as this may indicate a hostile sentiment toward women, the reactions and methods of resistance by the women can sometimes be even more telling.

It appears as though women physicians learn to normalize their experiences of harassment during medical training. This is largely a result of the rigid hierarchy of authority and power within the profession (Hinze, 2004; Laurence & Weinhouse, 1994). Moreover, because women are stereotyped as dependent, weak, emotional, and fragile, traits that are frowned upon in the medical profession, women physicians come to define themselves as the problem. In order to succeed in medicine, women quickly learn not to be 'over-sensitive', as any sign of sensitivity in medicine leads one to be viewed as incompetent (Hinze, 2004). Many women deliberately choose not to label the behaviour they experience as discomforting because as soon as they do, they become labelled as a "victim". Being part of a male dominated profession, these women intentionally deny the gendered nature of their work and feelings of victimization that may come with it. This perception is directly related to the culture of medicine, which embodies traits of hegemonic masculinity. Men 'do gender' or harass women in such ways to enact closure systems in order to preserve their status in a traditionally male dominated field. The harassment women physicians experience and the way they perceive these experiences evidently suggests the organizational structure of medicine is not gender neutral. The fact that these women must endure such hardships in exchange for their success and respect is highly problematic. Moreover, their acceptance and silence serves to perpetuate the

mistreatment of women within the profession while maintaining the current distribution of power, the vertical segregation of men and women.

Challenges, Change and Consequences

There is a considerable body of literature documenting that women in medicine are disadvantaged in comparison to their male counterparts; however, much of this literature is rather dated. It is possible that over the past decade or so changes have occurred to improve women's experiences and bring about greater equality. With more and more women in the medical profession, it is possible that the profession has started to change from the inside out. The organizational culture may have changed since the above studies were conducted (Cassell, 1996; Beagan, 2001; Hinze, 2004; Pringle, 1998; Laurence & Weinhouse, 1994; Witte, Stratton & Nora, 2006). In a recent report on women in medicine in the UK, Elston (2009) finds that gender may not be as significant an issue as it once was. In fact, there is evidence that professional norms have been changing. For example, part-time work is becoming more common, not just for women but also men. Thus, working arrangements may be more flexible. Additionally, in terms of career advancement, Elston found that a very high proportion of female medical graduates were achieving high leadership/management positions within the profession; these rates were higher than those in the private sector. Moreover, she finds women have early preferences for specialization in more patient-centered specialties with flexibility and standardized hours such as general practice, whereas men express early interest in more technical specialties such as surgery. Thus, her analysis cautions us not to immediately assume that these choices are constrained and a function of discrimination or "ghettoization". Women could have greater representation in these "female-typed"

specialties simply because they utilize skills and practices that women typically find intrinsically interesting.

Summary

There is an extensive body of literature documenting the special nature of professional work, and the challenges women have traditionally faced in gaining equal access to, and working in, these fields. However, much of this literature is dated. Perhaps with increased feminization there have been changes to the culture and organization of medicine as well as and women's experiences in the profession. Further, while the literature has focused on the significance of gender, other factors such as ethnicity and citizenship status have received less attention. Increasingly, more and more foreign-trained medical graduates seem to be entering the profession in Canada. The next chapter reviews the literature on immigration and the experiences of immigrant workers in the Canadian medical profession. The importance of examining the experiences of foreign-trained female medical doctors, and using an intersectional approach is highlighted.

Chapter 3: Female and Foreign-Trained: A Double Disadvantage?

Introduction

In this chapter I will highlight the barriers faced by skilled immigrants in Canada with regards to reaccreditation and credential recognition. I will outline Canada's immigration policies, reaccreditation policies of the Ontario regulatory body of medicine, the labour market trajectories of internationally educated immigrants, and provide a gender analysis of Canada's immigration policies. I will present the case of foreign-trained women in medicine and suggest that given what we know about the labour market trajectories of foreign-trained immigrants, foreign-trained women in medicine are likely to face unique disadvantages stemming from their minority status as immigrant women.

Canada's Immigration Policies

Canada depends on immigration for economic and demographic growth. In the past, Canada selected immigrants based on ethnic preference. However, in the 1960s Canada changed its immigration policy in order to compete economically on a global scale. Canada opened immigration to a wide variety of races and ethnicities and geared its policies to attract skilled immigrants (Hongxia, 2010). More recently, the Immigration and Refugee Protection Act (IRPA), which replaced the Immigration Act of 1976, holds that Canada's objective is to ensure that immigration brings great social and economic benefits to Canadian society. Currently Canada is utilizing the entry of skilled immigrants to fill gaps in the labour force, particularly in health care occupations and management positions to meet the expected demand for services from the ageing baby boomer population (Gilmore & Petit, 2008; Zietsma, 2010).

Presently, one can immigrate to Canada as a skilled worker or professional, Québec selected skilled worker, Canadian experience class (the individual has work experience in the Canadian market), investor, entrepreneur, self-employed individual, or lastly, as a provincial nominee or through family sponsorship (Citizenship and Immigration Canada, 2011). The skilled worker or professional category is most relevant to the present discussion.

The current Immigration and Refugee Protection Act maintains that skilled workers will be chosen based on their transferable skills. Skilled workers and professional immigrants are selected based on their ability to become economically established in Canada. In order to apply as a skilled immigrant one must have work experience in managerial occupations, professional occupations, technical occupations or skilled trades as defined by the Canadian National Occupational Classification List. An individual's work experience and minimum work must include having worked for at least one year continuously (full-time or the equivalent part-time). The government of Canada defines a skilled worker as one who is educated, can speak either English or French and who has work experience that involves transferable skills rather than experience in a specific occupation (Citizenship and Immigration Canada, 2011; Human Resources and Skills Development Canada, 2005). High criteria are set with regards to education, knowledge of official languages, work experience, age, arranged employment in Canada and adaptability. Lastly, one must demonstrate that he or she has adequate finances to support him/herself or any dependents after arrival in Canada (Citizenship and Immigration Canada, 2011; Houle & Yssaad, 2010; Man, 2004). Applicants are evaluated on a points system based on desirable market attributes. Higher marks are associated with

characteristics desirable for the Canadian labour market or those characteristics associated with high success in the labour market. Prospective citizens must score a minimum of 67 out of 100 points to qualify (Citizenship and Immigration Canada, 2011).

It is evident that the human capital of new skilled immigrants is linked with giving Canada a more competitive edge in the global market while at the same time attempting to fill gaps in the labour market (Human Resources and Skills Development Canada, 2005). However, while this policy appears to be benefiting Canadian society, it carries with it a highly problematic assumption: the idea that skilled immigrant workers will experience a smooth, successful transition into the Canadian labour market upon their arrival. However, this is often not the case. The reality is that there is often an education-to-job mismatch for skilled immigrants who have recently immigrated (Houle & Yssaad, 2010). In fact, Gilmore and Petit (2008) find that among recent immigrants, higher education or training did not result in a greater likelihood of being employed. Most immigrants face downward mobility in both their job status and earnings (Picot, 2008; Plante, 2010). Canada's skilled worker immigration program seems to be a contradiction; immigrants are selected based on their abilities, yet reaccreditation barriers often prohibit them from contributing to society and utilizing their skills to the fullest extent (Boyd & Schellenberg, 2007).

In response, the government has taken some action to reduce barriers associated with foreign skill recognition and reaccreditation. In 2003-2004, the government of Canada allotted 68 million dollars over 6 years to fund activities associated with improving foreign credential recognition; this has been termed the "Foreign Credential Recognition Program" (FCR) (Human Resources and Skills Development Canada, 2005).

This program is committed to investing funds on three main fronts: rejuvenating the skills of Canada's existing workforce, addressing the needs of impoverished groups such as youth or the Aboriginal population, and ensuring internationally trained workers can participate fully in the Canadian labour market (Human Resources and Skills Development Canada, 2005). In terms of assisting with the integration of immigrants, the FCR intends on speeding the process of assessment and recognition of foreign credentials, implementing enhanced language training, and providing up to date and pertinent labour market information (Human Resources and Skills Development Canada, 2005). The FCR program claims to ensure that credential assessment and recognition is fair, accessible, coherent, transparent, and rigorous.

Additionally, Canada's Immigration and Citizenship website provides evidence that the government has noticeably reduced barriers for immigrants by making skilled worker immigration requirements more transparent and easy to understand. Essentially, prospective immigrants can take a self-assessment test to calculate their eligibility to immigrate as a skilled worker. This feature takes individuals through the points system and makes it clear to them how they match up with Canada's immigration standards. Furthermore, if they miss the mark it gives them suggestions of things they may require to boost their score (Citizenship and Immigration Canada, 2011).

The government of Canada website also provides a "working in Canada" tool. This online tool allows prospective immigrants to research their current occupation in Canada. This online step-by-step activity takes the individual through the province and city that they may be potentially settling in, informing them of the education and skills required for their occupation, main duties, licence and certification required, average

wages of the occupation, current job openings in their chosen area, and information about unions and associations related to the chosen occupation. Moreover, the prospective worker can repeat this application as many times as he or she desires intermixing different occupations, provinces, and cities (Government of Canada, 2011).

Overall, the induction of the Foreign Credential Recognition program and the above online tools suggest that the Canadian government has realized the many roadblocks many skilled immigrants encounter upon arrival in Canada. It appears as though for the most part, the government is taking a proactive approach attempting to provide solutions to common problems and barriers with regards to lack of knowledge. Nevertheless, despite government efforts to reduce barriers, recent literature on the topic suggests skilled immigrants coming to Canada continue to face barriers to employment and often experience significant education-to-job mismatch.

Labour Market Trajectories of Skilled Immigrants: Barriers, Reaccreditation and Integration

Although Canada's immigration policies emphasize the significance of having highly skilled and educated workers in its labour market, oftentimes these foreign-trained professionals will experience downward mobility in their employment status upon arrival. Furthermore, they frequently have difficulty finding work in their chosen career fields (Anisef, Sweet & Fempong, 2003; Boyd & Schellenberg, 2007; Chiswick & Miller, 2010; Galarneau & Morissette, 2008; Li, 2001). Many skilled immigrants remain unemployed or underemployed, many ending up in ethnic employment niches (Light, 2007). Skilled immigrants face barriers in the form of credential recognition, employment discrimination, lack of language fluency, lack of Canadian work experience, or lack of

social networks that could support their job search (Gilmore & Petit, 2008; Zietsma, 2007). Accordingly, they enter a paradox: foreign trained professionals are selected on the basis of their potential ability to contribute to Canadian Society, however they are seldom able to exercise such skills because of the multiple barriers they face (Boyd & Schellenberg, 2007). According to 2006 census information, 450,045 very recent immigrants are internationally educated with a post secondary education (Plante, 2010). Additionally, in 2006, the proportion of recent immigrants with a university degree was twice as high as that for native-born Canadian citizens. Surprisingly, 28% of foreign-trained men and 40% of foreign-trained women were working in positions requiring a low degree of education contrasted with 10% and 12% of native-born Canadian men and women (Glarneau & Morissette, 2008). Similarly, Zietsma (2010) finds labour force participation rates were lower among very recent immigrants. In fact, the unemployment rate for very recent immigrants (11.5%) was more than double the rate for the Canadian born population (4.9%) (Zietsma, 2010). Furthermore, despite their high education levels, sales and service jobs were the most widely held occupations in Canada for immigrants in 2006 (Zietsma, 2010). It is evident that internationally educated immigrants are often some of the lowest paid workers in Canada (Glarneau & Morissette, 2008; Plante, 2012; Zietsma, 2012). Internationally educated immigrants generally earn less than their Canadian-educated counterparts and Canadian-born workers with a post secondary education. Internationally educated immigrants who worked on a full-time basis in 2005 had median earnings of $40,800; lower than the median earnings of $49,300 reported by full-time full-year Canadian-born workers (Plante, 2010). This is an inefficient use of resources for both individuals and society as a whole.

Despite the general underemployment of many skilled immigrants as demonstrated by Zietsma (2010) and Gilmore & Petit (2008), there appears to be a significant relationship between labour market outcomes and the demographic profile of immigrants. Immigrants from English speaking regions such as the US, UK, Australia and New Zealand have higher rates of foreign credential and work experience recognition (Houle & Yssaad, 2010). Thus, the source of the credential seems to have a large impact on whether it is recognized in Canada; and it appears that ethnic minorities are at a greater disadvantage (Boyd & Thomas, 2002; Houle &Yssaad, 2010; Plante, 2010). Immigrants who are members of visible minorities and from developing countries experience the most difficulty having their foreign credentials recognized. They tend to experience credential devaluation or education-occupation mismatch more often than other immigrants (Buzdugan & Halli, 2009; Chiswick & Miller, 2010). Scholars have also documented an influx of immigrants from South or East Asia. Most immigrants are also on average, older. Thus, the demographic profile of recent immigrants has changed drastically over the past several years, as in previous years foreign-trained medical professionals have predominately migrated from more "traditional" source countries such as Europe (Canadian Institution for Health Information, 2009). Immigrants with university degrees tend to be from a more diverse set of countries and are much more likely to be visible minorities (Zietsma, 2010). In fact, the proportions of immigrants from "non-traditional" sources such as those mentioned above, have increased from only 5% prior to 1960 to almost 80% in the 1990s (Reitz, 2007). Moreover, immigrants who are members of visible minorities often have lower earnings compared to European immigrants or Canadian-born workers of European origin (Boyd & Thomas, 2002; Houle

& Yssaad, 2010). Thus, it appears as though immigrants from European backgrounds have integrated more effectively than other groups. Research suggests labour market adjustment takes longer for individuals of minority status and in some cases their outcomes will never parallel those who are Canadian-born (Li 2000, 2003 as cited in Reitz, 2007). Buzdugan and Halli (2009) suggest this trend points to limitations of the human capital theory, as immigrants are recruited based on their ability to contribute to society, yet, many never have the opportunity to demonstrate skills at their full potential. Furthermore, this has implications for Canada's point system, as many immigrant labour market outcomes seem unrelated to their initial score (Buzdugan & Halli, 2009). It is clear that this change in demographic profile has had a great influence on the opportunities available to recent immigrants and their labour market outcomes.

Nevertheless, while it is evident that recent immigrants face multiple barriers finding employment that is commensurate with their educational experience, these barriers are often enhanced for those looking to practice in a regulated profession. Since professions are special occupations, employment is reserved to only those who have endured rigorous specialized training and demonstrated a skill that only a small percent of the population have. Since the knowledge required for regulated professions is so specialized, the individuals who have trained in such areas are very highly regarded. Thus, due to the status and authority associated with regulated professions, regulatory bodies must ensure that each individual awarded a licence to practice is at par with the Canadian standard; this is to ensure the safety and protection of citizens using their service. This process can be difficult for foreign-trained professionals wishing to become reaccredited. In many professional fields, the foreign-trained must meet more stringent

standards than those individuals who are Canadian trained (Boyd & Schellenber, 2007; Li, 2001). In 2006 there were 284,000 employed foreign educated immigrants from fields of study that would normally lead to work in regulated occupations. Surprisingly, of this number, only 14% were working in their chosen professions (Zietsma, 2010). In a study of male engineers, Boyd and Thomas (2002) found that men who received their training in a Canadian institution were more likely to be employed in engineering or managerial occupations. On the other hand, those who trained outside of Canada and immigrated after the age of 27 had low probability of holding engineering or managerial positions. Moreover, men from the Philippines, Poland, and other areas of Eastern Europe had particularly low chances of finding relevant work. Similarly, Houle & Yssaad (2010) find only 24% of employed foreign-educated immigrants with a university education were working in a regulated occupation that matched their field of study compared to 62% of the Canadian-born. Education-occupation mismatch such as this tends to be strongest within the first few years of arrival in Canada (Boyd & Thomas, 2001). This phenomenon is particularly problematic in the medical profession. The Canadian government has increasingly been encouraging internationally trained medical professionals to immigrate to Canada in response to the doctor shortage. However, there appears to be a disconnect between the principle behind the immigration of skilled workers and the reality many foreign-trained doctors face upon their arrival in Canada.

Reaccreditation for Foreign-Trained Medical Professionals

The appropriate regulatory body must license individuals who wish to practice medicine in Canada. In order to practice medicine in Ontario, international medical graduates must have all Canadian postgraduate qualifications for an independent practice

certificate. Candidates must have a medical degree from an accredited Canadian or US medical school or an acceptable medical school listed on the World Directory of Medical Schools. Additionally, they must have an appointment-in-training at an Ontario medical school and pass the Medical Council of Canada Evaluating Examination (MCEE). This examination assesses the candidate's knowledge in accordance with Canadian standards of practice (The College of Physicians and Surgeons of Ontario, 2011). Foreign-trained professionals are only eligible to write this examination if their medical degree is listed on the World Health Organization's website as compatible with Canadian standards. If the degree is not compatible, the individual must become recertified starting with obtaining a new medical degree in Canada. Even if a candidate is eligible to take the examination he/she must also complete at least two years residency for general practice and four to five years residency for certain specialties. Additionally, he/she must pass the appropriate certification examinations of the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons of Canada (The College of Physicians and Surgeons of Ontario, 2011; Boyd & Schellenberg, 2007).

The reaccreditation process is, without doubt, extremely time consuming and expensive. Moreover, as mentioned earlier, in many professional fields the foreign-trained must meet more stringent standards in the reaccreditation process than those who are Canadian trained (Boyd & Schellenberg, 2007; Li, 2001). This makes the reaccreditation process even more difficult for those individuals wishing to become licensed in a regulated profession such as medicine. The difficulties are exacerbated by the limited number of residencies. While Canada has welcomed the immigration of skilled medical professionals as a solution to the doctor shortage, budgetary constraints

and restructuring in the health care system have led the Ontario provincial government to freeze the number of available residency positions at teaching hospitals (Mann, 2004). Additionally, of all the available residency positions, there are usually only a few reserved for international medical graduates. Interestingly, since 1999 the Canadian government has increased the number of available positions in medical schools to compensate for the shortage of doctors. However, there has been no comparable increase in the number of residency positions (Man, 2004). This increases the competition among the many foreign-trained medical professionals who have immigrated to Canada in hopes of continuing their practice. The limited number of residency positions creates an additional barrier that international medical graduates must face. Additionally, if the credentials of foreign-trained medical professions do not transfer, completing their professional education all over again can prove to be a very expensive and time consuming process. As a result, many foreign-trained professionals are severely underemployed, working in menial occupations (Man, 2004).

Boyd and Schellenberg (2007) find that 90% of Canadian-born, Canadian-trained medical professionals are working as physicians whereas only 55% of foreign-trained medical professionals are employed as physicians in Canada. Furthermore, 33% of foreign-trained medical professionals are employed in Canada in fields completely unrelated to health or medicine. Similarly, Plante (2010) found that earnings gaps between immigrants educated abroad and those in Canada, in medicine, were among the highest across professions ($109, 000 vs. $176, 000). Notably, among immigrants who do become reaccredited, practicing foreign-trained physicians are disproportionately located in general practice (Canadian Institution for Health Information, 2008). This could be

because general practice requires the shortest residency term. Similar to the experiences of women in the profession, this trend could be interpreted as the ghettoization or marginalization of immigrants within the profession since general practice is typically the lowest status specialty within the field (Riska, 2001). As such, it seems as though many internationally trained physicians are channelled into this field to fill the open positions that Canadian trained doctors do not want to take.

Consistent with the above findings, Plante (2010) found the overall match rate for medicine and medical residency programs was 56% for internationally trained immigrants while there is a 94% match rate for those Canadian-educated immigrants. Thus, the source country or the source of the credential appears to have a great impact on the success of the foreign medical candidate. In a similar way, Boyd and Schellenberg (2007) find a physician born in Canada and assumed to have trained in a Canadian institution would have a 92% predicted probability of working as a doctor. Taking all other variables into consideration, those born and educated in Africa or South Asia would also have relatively good chances, estimated at 85% and 87% respectively. Conversely, internationally trained medical graduates born in other regions of Asia or Eastern Europe had the lowest hypothetical chance of working as a doctor, less than 66%. It is possible that gender may be of significance here as a large number of internationally trained medical graduates (especially from Eastern Europe) are women (Boyd & Schellenberg 2007).

Consistent with the above statistics, Plante (2010) finds that more than 90% of immigrants with medical training from New Zealand, Sweden, Australia, the US and the UK reported working as a physician or in an occupation requiring similar or higher skills.

Different schooling standards across various countries appear to play a large role in shaping immigrant employment outcomes in Canada. Moreover, proficiency in either English or French is certainly an issue. However, there is the possibility that there may also be some discriminatory treatment negatively impacting the career trajectories of skilled immigrants.

While it is clear that internationally trained physicians face a variety of barriers with regards to gaining access to professional certification and then finding work, the analyses rarely examine the barriers that may be faced specifically by women. Current literature on the topic is very gender neutral and does not acknowledge the unique experiences of women. However, based on other studies documenting the more general labour market trajectories of immigrant women, we can hypothesize that female foreign trained women in medicine would experience unique barriers, as they are disadvantaged by both their status as women and immigrants (Boyd, 1984; Boyd & Kaida, 2005; Chui, 2011).

Immigration Policies and Accreditation: A Gender Analysis

The disadvantage that foreign-trained female professionals face has been defined as a “double disadvantage” or a “double negative”. That is, female immigrants’ reaccreditation barriers intersect with gender related barriers (Boyd, 1984; Boyd & Kaida, 2005). Immigrant women consistently possess occupational statuses that are lower than others’. Thus, in a sense, it has been said that their two negative statuses combine to create not just an additive effect of discrimination but an entirely different experience than that of Canadian-born women. As evidenced in chapter 2, professions like medicine are highly gendered. Women may experience a hostile work environment because their

entry into previously male-dominated territory is jarring; it is seen as violating appropriate "gender norms". However, women who are foreign-trained may not be able to identify whether such hostile treatment is a result of their race, ethnicity, or gender; the variables become confounded. Additionally, gender norms can be racialized and Canadian gender norms may not match those common in a foreign-trained women's country of origin (Welsh, Carr, MacQuarrie & Huntley, 2010). Foreign-trained women also face additional barriers in the form of reaccreditation requirements. Although we have seen that immigrant men face a number of employment barriers upon arriving in Canada, they are more likely than women to become reaccredited and experience upward mobility in the labour force as they spend more time in Canada. In fact, Houle & Yssaad (2010) find that there is a significant gap between the labour market outcomes of recent men and women immigrants. They found one third of men had their credentials recognized within four years after landing, compared to only 22% of women. Men were also more successful in having their work experience recognized 51% of the time compared with 23% for women. Migration appears to have a negative effect on women's employment outcomes and tends to undermine women's returns on education more than men's. This seems to largely be a result of patriarchal household structures, unequal division of domestic labour, and relegation of women to low status positions in women's occupational niches (Light, 2007; Raghuram, 2004; Schrover, Marlou, Van Der Leun & Quispel, 2007). Upon arriving in Canada, women often do not have the same opportunities in the labour market as men, as they are often balancing domestic responsibilities with employment, as well as experiencing gender barriers that come with career advancement, such as the glass ceiling effect (Boyd, 1984; Boyd & Kaida, 2005).

Nevertheless, it is not simply the status of 'foreign-trained' and 'female' that puts these women at a disadvantage. In fact, certain aspects of Canadian immigration policies actually serve to disadvantage women. "Independent class immigrants" (i.e. skilled workers, entrepreneurs, investors, self-employed individuals) applying to immigrate to Canada, can apply as a principle or dependent applicant (Citizenship and Immigration Canada, 2011; Iredale, 2005; Mann, 2004). The difference between these two categories is that specific selection criteria are used to assess a principal applicant independent of his or her dependents. Consequently, to ensure success it is absolutely vital for the most eligible applicant in the family unit to list him/herself as the principal applicant. That being said, considering the previous literature on labour market trajectories of men and women, the most eligible individual in a family who is able to accumulate the most "points" is usually a man (Iredale, 2005; Mann, 2004). This first step in the immigration process immediately puts female skilled workers at a disadvantage. Despite their education, experience, and obtained credentials, women who apply to immigrate as a "dependent" are no longer considered to be "skilled workers" by Canadian immigration officers (Man, 2004). Since principal applicants have the highest predicted probability of receiving recognition of their credentials and work experience, the work experience of women is not as readily recognized (Chui, 2011; Houle & Yssaad, 2010). Despite the high skill level of many recent immigrant women, Chiu (2011) finds that in 2009 only 19% of all female immigrants were economic class principal applicants. Conversely, 39% of women who immigrated in 2009 were admitted as spouses or dependents in the economic class and accounted for 56% of immigrants in that category (Chui, 2011). Boyle, Cooke, Halfacree & Smith (2001) find women who migrated with their partners

were the most likely migrant/sex group to be unemployed and economically inactive. Women in families that have moved long distances face detrimental employment outcomes. This gender inequity in immigration status (principal vs. dependent) points to and reinforces the structural gender inequities in both the woman's homeland and in Canada (Mann, 2004). Mann (2004) claims that this process suggests "skill" or "human capital" is an ideologically constructed concept, as certain groups are valued over others. Gender biases inherent in the organization of work lead to the devaluing of women's status or "worth" in a society. The fact that women are immediately put at a disadvantage suggests that the work experience of a man is more valued than that of a woman (Mann, 2004).

This process disadvantages women, especially those who are qualified to work in regulated occupations. Upon arrival in Canada, many women just cannot afford the reaccreditation process, as it is very costly and time consuming. Many women delay their own reaccreditation in favour of their husbands', since the latter statistically have a greater chance of success. This often means that if a woman's husband is unemployed as a result of becoming reaccredited, it is likely that the woman has no choice but to support the family with whatever work she can obtain. Additionally, she may have to balance her own work responsibilities with a variety of domestic responsibilities (Boyd, 1984; Mann, 2004). This lack of free time often means that many women are unable to attend various courses offered by governments to assist new immigrants in the labour market, such as English language courses. There is only a short window of time that new immigrants have to take advantage of these courses offered by the government; as a result, many women find themselves unable to liberate themselves from menial employment.

Mann (2004) argues that the deskilling of immigrant women is complicated by processes of globalization and neoliberal restructuring. Public assistance programs are being privatized and individuals in need of assistance are being deinstitutionalized. Consequently, "caring work" becomes part of the unpaid domestic work of women. In the hopes of reducing costs, the state has also eliminated living allowances and cut daycare support for new immigrants. Accordingly, the most disadvantaged groups are being put at an even greater disadvantage (Mann, 2004). Societal gender ideologies naturally assume this work to be "women's domain"; such ideas infiltrate social policies as evidenced above (Mann, 2004). These processes clearly put female immigrants at a disadvantage; thus, the most disadvantaged groups are not receiving the assistance they require.

Similarly, Hongxia (2010) argues that Canada's credential certificate regime (CCR), the process of attributing differential value to certificates or credentials produced in different areas, serves to control the new immigrant labour force and in turn, preserve the status quo and patriarchal nature of Canadian society. She claims that more and more women are seeking labour market participation in Canada, thus they are not just "dependents". In spite of this, however, no significant changes to the receptivity of immigrants' credentials have occurred in Canada. Although we know that many immigrant women are disadvantaged by their domestic responsibilities, gendered labour market reception, and lack of credential recognition, Hongxia finds that many women resort to re-training in order to enhance their labour market outcomes. However, it is notable that all the women in her study had enormous difficulty finding employment in their original field of training and many initially had to resort to menial low-wage service

occupations. That being said, many women in Hongxia's study chose to re-train themselves in hopes of experiencing some upward mobility. Interestingly, many of the women who were trained in male-dominated fields like medicine, law, and engineering have chosen not to become recertified in their respective fields, knowing that foreign-trained female professionals face a myriad of barriers. Hongxia concludes that this credential certificate regime is essentially necessary for women who do not want to become trapped in "ghettoized" occupations. Therefore, retraining and re-education is used as a mechanism of social control or a way to manage the entrance of immigrants into the Canadian labour force (Hongxia, 2010). Accordingly, this process reinforces dominant ideologies, the status quo, and current structural inequalities. It appears that Canadian employers hierarchically value certificates and training produced in certain countries over others.

In a similar way, Zietsma (2010) finds that 24% of recent female immigrants have a medical degree but are working in jobs that require low levels of education. Perhaps if we were to break this statistic down further, we might see trends similar to those described earlier. Maybe these women have no choice but to work in these occupations, as they may be the sole supporters of the family while their spouses are becoming reaccredited. Conversely, it is possible that some women may be doing this by choice. Many recent immigrants may be coming from countries where gender norms are much more conservative and patriarchal. As a result, such women may defer to male power and actively choose to assume a more subordinate position in the division of labour within the family. We must be cautious not to strip these women of their agency with regards to their decisions in the Canadian labour market. While there are a number of negative

social forces that seem to be affecting their negative outcomes in Canadian society, these forces may be coupled with or confounded by cultural norms that may influence their decisions.

That being said, it is evident that female immigrants face a greater number of barriers than their male counterparts. However, the extent of these disadvantages may vary greatly depending on a variety of factors such as country of origin, family status and education level. While female immigrants may face a "double disadvantage" based on their status as women and immigrants, I believe this conceptualization oversimplifies the experiences of immigrant women. While the conceptualization of the double disadvantage is not meant to symbolize an added effect of discrimination, I feel as though a wider scope of variables must be considered if we wish to study the experiences of immigrant women accurately. The current conceptualization of the experiences of immigrant women does not fully consider the wide scope of variables that may be affecting their experiences. The experiences of each immigrant woman may vary significantly. Some women may essentially be faced with a triple disadvantage, experiencing barriers as a woman, immigrant and racial minority. Other women may face additional barriers enhanced by their family status; perhaps they are a single parent and face multiple barriers in the form of domestic responsibilities and time management. Moreover, it is possible that one may be intersectionally advantaged. For example, a white immigrant woman from the United Kingdom is intersectionally advantaged in comparison to an immigrant woman from India who is a member of a visible minority group. The first woman from the UK is advantaged by her ethnicity, country of origin and language comprehension. Conversely, the Indian woman may be disadvantaged by

all of the above factors. Essentially the experiences of female immigrants should not be compressed into a single category of "double disadvantage" as each woman's individual identity and life situation may create entirely different barriers and experiences of disadvantage.

Generally, it is clear that there are many gaps in the literature regarding the experiences of highly educated immigrant women, as current studies tend to take a general approach to the analysis of the gendered barriers facing immigrant women. Although gender has been acknowledged in studies of migration, the current literature fails to include analyses of immigrant women in health professions. Moreover, many studies have failed to acknowledge women's experiences of professional reaccreditation and experiences once they have gained access to regulated professions (Curran, Shaffer, Donato, Garip, 2006). Conversely, the studies that do examine the labour market outcomes of immigrants trained in regulated professions do not offer an in-depth analysis of gendered outcomes. Additionally, there are few studies that take an in-depth analysis of internationally educated medical professionals and their outcomes in the profession in Canada. Despite these gaps it is clear from the literature on feminization and experiences of women in medicine, government policies surrounding the immigration process, the labour market trajectories of immigrants, and the specific barriers faced by immigrant women, that foreign-trained women would be the most disadvantaged demographic entering the medical profession. Additional research on this group is clearly warranted and promises to contribute to our understanding of women and work, professions, and the experiences of immigrants to Canada. I hypothesize that the experiences of these women

and their disadvantages are unique from other demographics as they have multiple, unique barriers affecting their labour market outcomes.

Summary

In this chapter I reviewed the literature on Canada's immigration policies, the Ontario regulatory body of medicine's reaccreditation policies, the labour market trajectories of highly skilled immigrants and specific gender barriers facing female immigrants. It is clear that there are a number of gaps in the literature regarding the experiences of foreign-trained, female, medical practitioners. I hypothesize it is likely that in depth research on this population will highlight their unique experiences of disadvantage in comparison to other demographic groups. In the next chapter I will specifically outline the research questions of the present project and methodologies used to assess them.

Chapter 4: Methodology

Introduction

In this chapter I will specifically outline my research questions and examine the methods of data collection and analysis that were used. I will discuss my decision to use qualitative methods in the form of semi-structured interviews as well as the interviews themselves, the sampling method, selection of participants, and participant characteristics. Potential limitations and benefits of this study will also be addressed.

Qualitative Methods

This study explores the intersection of two trends affecting the medical profession-- immigration and feminization-- by exploring the experiences of foreign-trained medical professionals practicing in Ontario. The goal for the present study is to investigate the experiences of foreign-trained women in medicine, and explore the significance of gender and immigrant status to their work. Do foreign-trained women believe their gender and or immigrant status provided barriers to practice? Have these foreign-trained women experienced the "double negative effect," or are their experiences shaped in complex ways by the intersection of gender, race-ethnicity, country of origin and other factors? Additionally, has the feminization of the profession impacted their experiences?

Due to the nature of this study, I chose to use qualitative methods in the form of in-depth semi-structured interviews. Qualitative research methods strive to uncover meanings, concepts, definitions, metaphors, symbols, and descriptions of social phenomena. It also allows the researcher to play an active role in investigating reality, sharing meaning and opinions with research participants (Berg, 2009).

The current research topic is exploratory at the present stage, as general themes still need to be identified. I believe the inductive nature of qualitative methods is most appropriate for the present study since little research has been conducted on the specific demographic of interest. Qualitative research allows for the collection of data that is very rich in detail, meaning, and symbolism (Berg, 2009). The semi-structured interview method was chosen to allow for an in-depth examination of the participants' opinions and experiences, and to provide data that is rich in descriptive detail. The collection of unique and detailed narratives was intended to provide insight on the individual experiences of the participants and the significance of these experiences to higher level variables such as the process of feminization, organization of the medical profession and power within the profession. Approval of the study was sought and obtained from the Research Ethics Board at the University of Western Ontario (see appendix A).

The Project: Sampling, Sample, and Interview Strategies

My initial goal for the present study was to conduct 20 in-depth interviews (15 women and 5 men) with foreign-trained medical practitioners registered to practice in Ontario. As a masters' thesis project, it was important to keep the scope of the project realistic, while at the same time ensuring that there was a sufficient number of respondents for data analysis. The number of 20 is large enough to allow for some comparison, and yet small enough that the interviews could be conducted in a relatively short time period.

Since the focus is on foreign-trained female medical practitioners, I intended on recruiting 15 women and 5 men. I chose an unbalanced sample because the primary focus of my study is on women. However, in order to truly understand their experiences, the

experiences of foreign-trained men must also be considered. Ultimately the final sample consisted of 13 individuals (10 women and 3 men). At this point I decided to halt recruitment, as I was reaching data saturation and obtaining participants was a difficult, time-consuming process. However, due to the small sample size, we must be cautious not to draw any generalizable conclusions about the wider population of foreign-trained doctors. Rather, as an exploratory study, my goal was to conduct an in depth investigation and uncover significant themes related to the experiences of foreign-trained doctors and their implications for feminization.

The study was restricted to medical practitioners registered to practice in Ontario and currently practicing in London Ontario. I restricted my sample to those doctors who have been registered to practice in Ontario for at least 2 years. It was essential that they had been practicing in Ontario for at least 2 years, as my goal was to investigate their experiences in the profession, in Canada (more specifically, Ontario). Thus, it was important that these individuals have some experience working as a regulated medical professional in Ontario. Canadian-born and Canadian-trained medical practitioners were excluded, as I was specifically interested in those individuals who have been through the reaccreditation process. For similar reasons, I also excluded medical practitioners from countries that have accreditation requirements comparable to Canada (United States, United Kingdom, Australia). Since individuals who were included in the initial sample frame had to have been practicing medicine in Canada for at least a short period of time, the lowest potential age group included in the sample frame would have been approximately 25, the highest being approximately 65.

Participants were recruited using the online directory of registered medical practitioners published by the College of Physicians and Surgeons of Ontario (CPSO) as a sampling frame. The CPSO directory lists all registered medical practitioners in the province including name, specialty, practice location, date of registration, and location of training. This list allowed me to identify who is foreign-trained and practicing medicine in London Ontario. At the time the sample was compiled there were 267 foreign-trained medical practitioners practicing in London Ontario. Separate lists of all foreign-trained male and female physicians registered to practice in Ontario (for at least 2 years), and practicing in London were compiled. A starting point on each list was selected at random, and subsequently, every Nth name on the list was selected to be part of the sample. The sampling interval for women was 5 and 15 for men. Once 20 participants were chosen, the selected individuals were contacted first by mail, and provided with a letter of information, informing them about the study. Shortly after the letters were mailed, a follow-up phone call was used to contact the potential participants and invite them to participate in an interview. Again, because physicians and surgeons are busy people, a high refusal rate was expected. After each doctor in the sample was contacted, the refusals were replaced with new potential participants in the same manner (selecting every Nth participant). This process was repeated four times before the desired number of participants was reached. However, the last group of doctors that were selected were not selected randomly but purposively. At this point in the selection process the sample was looking rather homogeneous consisting of mostly Caucasian individuals. It was important given the goals of this study to have a more diverse sample by intentionally pursuing members of visible minorities. In total the final sample included 6 members of racial

minorities and 7 Caucasian individuals. For the purposes of this paper "racial minority" will be defined according to the Employment Equity Act.[1]

Racial Minority	Women	Men
Yes	3	3
No	7	0

Description of Participants

The majority of participants practice in traditionally female dominated specialties or those specialties that have traditionally been more welcoming to women such as general practice and psychiatry. This may have been attributable to a selection effect, as many of the traditionally female dominated specialties allow for more flexibility with regards to time and availability. However, there was one exception with one of the women practicing nuclear medicine; a traditionally male dominated specialty. With regards to race and ethnicity, the sample is quite diverse given the small sample size. As mentioned earlier, in total there are 6 members of racial minorities and 7 Caucasian individuals. However, because many of the racial minorities were purposively selected there could also be a selection effect here. Perhaps members of racial minority groups are

[1] A person in a visible minority group is someone who is non-white in colour/race, regardless of place of birth. The visible minority group includes: Black, Chinese, Filipino, Japanese, Korean, South Asian-East Indian (including Indian from India; Bangladeshi; Pakistani; East Indian from Guyana, Trinidad, East Africa; etc.), Southeast Asian (including Burmese; Cambodian; Laotian; Thai; Vietnamese; etc.) non-white West Asian, North African or Arab (including Egyptian; Libyan; Lebanese; etc.), non-white Latin American (including indigenous persons from Central and South America, etc.), person of mixed origin (with one parent in one of the visible minority groups listed above), other visible minority group.

less willing to volunteer information regarding their experiences of discrimination. The total average years in practice were 22 (combined years of practice in Canada and home country). The average year of arrival in Canada was 1992.

Pseudonym	**Gender**	**Country of Origin**	**Year of Immigration**	**Specialty**	**Total Years Practicing Medicine**
Dr. Kostopoulos	Female	Greece	1983	Family Medicine	19
Dr. Zagar	Female	Croatia	1978	Paediatrics	44
Dr. Jones	Female	South Africa	1974	Psychiatry	30
Dr. Perez	Male	Mexico	2004	Internal medicine and Hematology	18
Dr. Lukanov	Female	Bulgaria	Unknown	Psychiatry	8
Dr. Dancescu	Female	Romania	1994	Psychiatry	13
Dr. Nadeer	Male	India	2004	Paediatrics	20
Dr. Vedula	Female	India	1989	Anaesthesiology	37
Dr. Kim	Female	South Korea	1992	Psychiatry	8

Dr. Ivanski	Female	Russia	2005	Nuclear Medicine	23
Dr. Khalil	Female	Egypt	2000	Anatomical Pathology	19
Dr. Janko	Female	Ukraine	1996	Anatomical Pathology	19
Dr. Zakaria	Male	Somalia	1990	Psychiatry	29

The Interviews

One-on-one interviews were set up with practitioners willing to participate. As mentioned above, I chose to conduct semi-structured in depth interviews. This allowed for an in depth examination of participants' opinions and experiences, providing data that is rich in descriptive detail. Semi-structured interviews involve the implementation of a variety of predetermined questions/topics; however, there is still freedom to probe beyond the set questions (Berg, 2009). The semi-structured nature of the interviews also allowed for some standardization across interviews, while at the same time allowing issues important to the respondents to emerge. This structure allowed for comparable results yet still captured individual experiences (Berg, 2009). The semi-structured method also allowed me to uncover new unanticipated directions and insights from the respondents and explore these insights further. Each doctor that I interviewed had a very unique story so it was essential that I had an opportunity to delve deeper into each individual's unique experiences. The semi-structured nature produced narratives that were more distinctive than had only scheduled questions been asked (Berg, 2009).

My objectives for the interviews were to create a rapport with the participants and conduct the interview in a conversational manner. Since discussion about discrimination and disadvantages in the workplace can be a relatively sensitive topic, I wanted to ensure that the participants were comfortable enough to disclose their true feelings regarding their experiences. Specifically, participants were asked about their motives for settling in Canada and decision to practice here, the immigration and reaccreditation process, their experiences of establishing and conducting medical practice in Ontario, experiences of discrimination or disadvantage, and the significance of gender to their overall experiences in medicine (See appendix B for full list of questions).

The interviews were conducted in a private location of the participant's choosing. To protect the identity of each participant, each has been given a pseudonym. Participants were asked to sign a consent form prior to starting the interview and interviews were audio recorded with their permission. Interview recordings were kept in secure location and were erased following transcription. On average, the interviews ran for approximately 30-45 minutes. It was important that the interviews were long enough to develop a rapport and get an in-depth look at the experiences of these doctors; however, doctors are very busy professionals so it was also important to ensure that the interviews were completed in a timely fashion.

Data Analysis

Data were analyzed by reviewing transcriptions, searching for common themes that emerged from the data. Additionally, I listened to the recordings after the interviews and made notes on general themes, paying attention to cues that may not be evident in the written transcriptions such as vocal tones and silences. While the focus was on the

positive and negative experiences of the foreign-trained medical practitioners and the differences between males and females, my intention was to work inductively and allow themes to emerge from the narratives. The focus of the analysis was on respondents' experiences of immigration, reaccreditation, establishing a practice, practice experiences, and relationships with other practitioners, patients, or other health care administrators or personnel. Furthermore, the central focus was on the experiences of foreign-trained female medical professionals; the experiences of men were used primarily for comparative purposes. My intention was that the small sample of foreign-trained men would help identify experiences common to foreign-trained practitioners regardless of gender, and those that may be more specific to women.

Benefits and Limitations

This study will contribute sociologically to our understanding of professions and gender while providing insight on the experiences of foreign-trained female professionals. Moreover, it will contribute to the sociological literature on feminization, moving beyond previous literature, incorporating the variable of immigration into our understanding of feminization. The present study may benefit the population of interest by shedding light on current barriers that foreign-trained practitioners face in the reaccreditation process and in professional practice. This information may be of interest to regulatory bodies and policy makers alike as it has the potential to create greater equality for foreign-trained professionals in Canada. Breaking down such barriers could potentially benefit the wider society as the knowledge and experience of foreign-trained professionals may be utilized at its full potential.

Potential limitations of the present study include those that stem from the limited sample size. Since results are only based on the experiences of 13 individuals, the results will not be generalizable to the wider population of foreign-trained professionals. Additionally, there is the possibility that some participant bias may be present as the individuals who may have agreed to take part in an interview might have stronger beliefs than others on the topic. Some participants may have had negative experiences that were more extreme than the average whereas others may have had virtually no perceived barriers. Furthermore, results may be skewed in the sense that the sample is not representative of the population of foreign-trained medical professionals in London Ontario or in Canada. The participants are disproportionately medical practitioners who practice in more of the traditionally female dominated specialties such as family practice, paediatrics and psychiatry; there were no participants from the traditionally male dominated specialties such as surgery. Accordingly, because these "female typed" specialties are typically easier to gain access to, the participants may have shared experiences that were more positive than their counterparts in other specialties, who did not participate in this study. Lastly, because I only interviewed doctors who have successfully integrated into the profession, my sample only consists of those "successful" cases. Those who have been unsuccessful in gaining access to the profession were not included but may have had more negative experiences. Thus, the successful cases may have more positive experiences overall.

Conclusion

In this chapter, the methodology for the present study was discussed. Research questions and methods of data collection were clearly outlined. The reasoning behind my

decision to use qualitative methods was supported. The interviews, sampling method, selection of participants and participant characteristics were discussed. Additionally, potential limitations and benefits of the study were addressed. In the next chapter, my research findings will be presented and central themes that emerged in my interviews will be identified.

Chapter 5: Results

Introduction

This chapter will highlight the common themes that emerged from the narratives of the 13 participants. Respondents identified many challenges to entering the medical profession in Ontario and establishing a professional practice. Many participants took several years going through the reaccreditation process and gaining Canadian experience before they were able to successfully integrate themselves in the Canadian profession. More specifically, those respondents who were not from commonwealth countries tended to have greater difficulties. Moreover, these participants took more time going through the reaccreditation process. Major themes emerged around the following: race/ethnicity/immigrant status, gender, period of arrival, and country of origin. It was found that immigrant status and ethnicity were most significant to participants' experiences in the Canadian medical profession. Most respondents did not explicitly claim that they were discriminated against or treated unequally. In spite of this, most respondents did recount experiences that could be regarded as systemic discrimination. There was some variation in experience by gender, period of arrival and country of origin. These themes will be discussed in more detail below.

Race/Ethnicity/Immigrant Status

Respondents highlighted the significance of race, ethnicity, and immigrant status to their employment experiences, but very few actually conceptualized their hardships as inequality. Notably, none of the participants who are members of racial minorities felt as though they faced barriers, or were discriminated against, because of their race in particular. Nevertheless, most claimed that they had to "prove themselves" before being

accepted. Although all but one of the respondents mentioned having to prove themselves or "work twice as hard," such feelings were more prevalent among visible minority immigrants. Dr. Vedula recalls she came to this realization when she was frankly told the reality of her situation by one of her oral examiners.

> When I was taking the oral exam, one of the examiners I went to told me…. 'you have to show us that you are head and shoulders above our top Canadian graduates for you to pass the exam'. So I said okay so I set forth and prepared myself. And it worked out well because it gave me the yard stick with which I need to improve myself (Dr. Vedula).

While many respondents, like Dr. Vedula appeared sanguine about these high standards, it was clear that newcomers experienced a considerable amount of stress. Dr. Zakaria said that while he did not ever feel that he was treated unequally, he was under a great deal of pressure, as he was so highly scrutinized as a new immigrant. Furthermore, being compared to fresh, new Canadian graduates increased his stress as he was adapting to an entirely new health system, and had not studied general medicine for many years.

> Yeah you have to, you actually have to prove yourself, you have to….yeah, harder. And for example, when I did start the residency, the whole system of residency was different there. So the first day, when I…you have to do rotations in medicine, internal medicine, although I'm doing psychiatry. They do rotations in urology and also internal medicine. So they started me, they put me in internal medicine. So I'm too rotating with young people….and I'm older than them. They are fresh graduates from medical schools. And their memory is so sharp. I have to think a little slower….and then. So the first thing, and the first day I was put on

> call. I had no idea how the calls work…..so the whole system and how it works I didn't know. And I wasn't given any idea…..I was just put in and say 'go'" (Dr. Zakaria).

Thus, the uncertainty associated with a new environment coupled with the scrutiny of constant evaluation can create a great deal of stress for new immigrants.

Although there were variations in experience, all respondents stressed difficulties with adjustment and integration. White Europeans reported fewer disadvantages than other visible minority counterparts. They mostly spoke about culture shock, lack of an established professional network, lack of integration, and the competitive reaccreditation process. Dr. Perez, a male physician who is a member of a racial minority, suggested there is differential treatment within the group of IMGs (international medical graduates). That is, those who are from English speaking, Commonwealth countries are not "tainted" with the same negative perceptions as those from developing countries. He notes there is some sort of differential treatment or "quality judgements." "The bottom line is yes. I think there is a discriminatory role against IMGs in general." However, he clarifies, it is not only if you are a foreign grad and come from abroad. He believes it is "specific IMGs."

> The problem is if you are coming from developed or from an underdeveloped country, and ….and yet, it doesn't make any sense cause it's just like that or it's….there's no reason why you should be better trained in one or the other place….well there are a bunch of reasons why you could but…the difference is not so great….from what I've seen I've had, and I work with people from around

> the world and believe me, I mean….yeah there's bad people everywhere, there's fantastic people everywhere…. (Dr. Perez).

Dr Perez believes if you are coming from Commonwealth countries or countries that are more comparable to Canada, the process and transition are not as difficult. This could be related to a variety of factors such as language barriers, knowledge or quality of training, which are all related to source factors (i.e. the region of training).

Related, was the feeling that participants were more highly scrutinized because they were coming from a different or strange place. This feeling was often expressed with regards to reservations that their supervisors or peers had about their competencies and the rigor of their training in their home country. Dr. Nadeer says, as a member of a racial minority group, race definitely plays a role, however, this is only short lived. Once you prove yourself competent to others, that bias goes away.

> Preceptors or supervisors in residency programs, or elsewhere or examiners, you know, they…..definitely when they see a foreign medical graduate speaking with an accent, you know? Those red flags are there. But if you're good, if your background knowledge is good, if your training is good, within one or two days, you know, people realize (Dr. Nadeer).

He, like others in the study do not characterize this as inequality per se.

Dr. Lukanov expressed similar feelings. When asked if she felt stigmatized at all she replied:

> Yeah, definitely. Certainly among the professionals, I'm not sure patients would necessarily be aware of that but I mean it's widely accessible information. But I think….it's sort of….I remember thinking back to residency and I think

> there's…..there's a higher expectation for foreign trained physicians and so (you are highly scrutinized?) yeah. At least at entrance. Certainly I think that's the case. I think….I think you're required to have much more in order to be competitive with a graduate from the same…..from the same country (Dr. Lukanov).

Similarly, Dr. Zagar, an earlier immigrant, stated that administration and professors were "surprised" by her success in her first year at an Ontario medical school, "When you have knowledge, you have knowledge….clearly they were surprised by my knowledge base. But it doesn't matter, if you learn, you know your profession and you keep up, if you read journals, you can score" (Dr. Zagar). These feelings that knowledge is something objective and is something that cannot be taken away from an individual, was common among many participants. Many of the participants believed that if you are truly good at what you do, you can be successful in Canada; you just have to "*prove yourself*" first. This feeling of having to prove yourself was common for 11 out of the 13 participants.

Dr. Nadeer believes it all comes down to objective skills. He believes if you are a well-trained physician you have nothing to worry about.

> If you're good, reasonable communication and skills, language skills, if you are well trained, you can get into the system, you can get in, it's not that difficult…a bad doctor will be a bad doctor in Canada, or in India or in UK or elsewhere…a good doctor will be a good doctor anywhere you put him (Dr. Nadeer).

Nevertheless, Dr. Nadeer also stated that perceptions of "disadvantage" or perceived unequal treatment might vary across physicians; what he sees as short-lived biases may be perceived as inequalities by others.

While the members of visible minority groups did not feel as though they were disadvantaged by race in particular, they did express that IMGs (international medical graduates) were at a greater disadvantage. It is notable that visible minority immigrants expressed this more than the white Europeans in the sample (at least those who immigrated more recently). Moreover, it seems as though those who are members of visible minorities reported more negative experiences or hardships than did others. Those who reported disadvantage however, could not identify a source; for example Dr. Vedula, noted that she could not distinguish whether the negative treatment she experienced was a result of her status as a woman, racial minority, or immigrant. Multiple statuses intersect to shape advantage and disadvantage. Nevertheless, many foreign-trained respondents reported that they were perceived as incompetent until proven otherwise.

Another theme that emerged (especially among members of racial minorities) was the feeling of having missed out on opportunities as a result of being judged as incompetent or discriminated against based on their status as an immigrant or foreign graduate. When asked if she believed she had been treated unfairly because she was a member of a visible minority group, Dr. Vedula replied "yes":

> At the end of my residency or even during the residency, I don't know whether it's because of ethnic minority, they….I think people fail to look at the sincerity that I provided. They always looked at me with an index of suspicion.

Dr. Vedula felt she was discriminated against because she wasn't taken for a job in the department where she was doing her residency. She even offered to do a fellowship in an additional field but was still declined. She moved out of town to do the fellowship and

when she got back, someone else, who did not even have a fellowship as she did, was offered a staff position.

> They just joined the staff so I felt a little gypped at that point in time. I felt discriminated….I had my Canadian certification at that time, I had done this whole year of fellowship in regional anaesthesia six months here and six months in Boston. And he appointed me as the part-time lecturer. Which I think is a slap on the face. Because there were people who couldn't clear the local who were appointed as assistant professor at that time. So there was big variability in the way they treated you….there was discrimination, there was no question about it (Dr. Vedula).

Many respondents also reported feelings of tension or unequal treatment from colleagues or peers. Dr. Zagar recalls that her colleagues and supervisors during her residency were very sceptical about her abilities:

> So in the first year it was interesting, my first year we had to write kind of at the end of the year an exam and my score was the highest, so I was told that ….they were surprised. Well, when you have knowledge, you have knowledge (Dr. Zagar).

Dr. Zagar remembers one supervisor who was particularly skeptical of her abilities: "I got an outstanding evaluation in neonatal, he wrote 'so far'. Just tells me he still didn't believe I would do well." Although she admits there were individuals who held biases against her, she claims it is primarily due to her status as a foreign graduate rather than her status as a woman.

Dr. Zakaria similarly felt that his abilities were judged based on his status as a foreign graduate:

> So I was put on call. So one of the people, the group, one of the persons who was in my group…. paging me, I had a pager. 'Hi, Doctor Zakaria, yes, I want to sign out my patients to you, you are on call tonight.' I guess I'm on call, so apparently when someone's on call they….this other group of residents they have to bring the list of their patients they're following to me. So that I have to work with those patients overnight when I am on call. I didn't know. I said 'what do you mean signing out?' 'Don't you know signing out?' I said, 'No.' And she thought I was really dumb (Dr. Zakaria).

For Dr. Zakaria, adapting to a new medical system and environment was very difficult, especially since he was among other residents who were much younger. Being judged in an unfamiliar environment creates added stress as colleagues may interpret your mistakes as an indication of your abilities.

Dr. Vedula also experienced negative treatment from her colleagues:

> There is one nurse who really…almost physically abused me, she threw sheets at me in front of patients and things like that….So I took it to the administration….But didn't see anything was done about it. So that's what bothers me. So that means they heard me but decided this is nothing to worry about (Dr. Vedula).

When asked if she believed this was discriminatory treatment stemming from race, ethnicity, gender, or immigrant status, she replied, "yeah, I think so, its because I'm a minority. Or because I'm a woman. One of the two" (Dr. Vedula). She clarifies that

instances like this can damage your reputation as a foreign graduate. She recalls being reprimanded for mistakes she was not responsible for.

> Maybe this thing happened during my residency, with the staff trying to discipline me for a mistake that I did not do, might have made the chairman's vision jaundiced about me. That could be a possibility. For a person who has come from outside the country, eventually everything was okay for me for my residency, my program director listened to and she could call some of the others to find out if I really did that and there were people who told her 'no she did not do that'. She stayed way beyond her call of duty to help me with that case before she left at 11 o'clock in the morning post call…..but sometimes people form an opinion which they find difficult to change….so that is the component that will be difficult for a foreign graduate (Dr. Vedula).

In cases like this, Dr. Vedula has been fortunate to have others who support her and back her up. Nevertheless, she makes it clear that all it takes is one person to damage your reputation and hurt your career; this is a challenge many foreign trained graduates face.

Dr. Kim, like other participants, did not label her negative experiences as discrimination. She acknowledged that colleagues, patients and supervisors have biases or predetermined ideas about foreign graduates, or in her case, Asian people. However, she says she does not take it personally because she believes people are concerned about whether you measure up to Canadian professional standards.

> Always you meet people commenting that oh, like it's a…they asked about my previous job and then talk about cleaning ladies or taxi drivers who are of my same background…..it's all connected with that so….it's hard to

> change….especially as a student…like at the time was quite difficult because they assess you everyday, right? They give you feedback everyday, so it's quite stressful. So we did that stress whether because of the….it's….I struggles with the language, but not necessarily because I'm minority or…it's the general sense that….about the expectation of the you know professional, I think that's how I saw it. And then….yeah, already some people commented about, you know my background or those things. But not necessarily …I didn't take it as personal. They made all kinds of comments, they refused to see that Chinese doctor, whatever and so….so I didn't take it personally (Dr. Kim).

Dr. Kim claims a high tolerance for this type of treatment. She states this type of discriminatory treatment is fairly routine and common for female medical practitioners in her home country. In her home country, the profession is very male dominated so this is certainly not the first time she has experienced unequal treatment.

Dr. Khalil also had similar experiences:

> When I tried to find job, I didn't feel like there is competition between me and Canadian…But maybe you know what, later on during the work, maybe sometimes they appreciate to have a Canadian to do some tasks more than international people…..Yeah, I feel it, you know? Like sometimes they….they prefer because I'm not maybe the way of thinking, the way of talking, the way of dealing with situations, they need a Canadian to do that more than international, I don't know is a trust, or something else, other factors, I have no idea (Dr. Khalil).

Like the other respondents mentioned above, Dr. Khalil would not name her treatment as discrimination.

There was one respondent who did not claim any negative treatment or recall any experiences that might suggest she was deliberately disadvantaged. Even though she was an early immigrant, Dr. Jones does not claim she ever felt disadvantaged or unwelcome, "I think we were always welcomed and fairly treated." She admits the experience might be very different for someone who did not come from a commonwealth country as she did.

Overall, 5 respondents (4 members of racial minority groups) reported feeling particularly scrutinized due to their immigrant status, race or ethnicity. They reported having to "prove themselves" and "work twice as hard" on the job to gain respect. Many were targeted, prevented from doing certain tasks and denied opportunities. All but one, however, did not label this as 'discrimination'. All found ways to deal with it, accept it, and kept on performing their jobs at a high level. More information on how these respondents coped with such treatment will be discussed later in the chapter.

One's immigrant status and race seem to be the most significant variables in determining the root of the respondents' experiences of disadvantage. The narratives suggest that respondents who are members of racial minorities report inequalities or experiences of discrimination more frequently than the white Europeans. Although most respondents tended to attribute any difficulties they faced due to their immigrant status, the equation of disadvantage is not that simple. The narratives suggest that individuals' experiences also vary by gender, period of arrival, and country of origin. Moreover, there is evidence that these secondary variables may intersect with one's status as an immigrant and interact to create a unique experience of disadvantage.

Gender

The majority of participants did not perceive gender to produce barriers or discrimination. That is, the women did not report feeling as though they were ever treated unequally or inappropriately because they were women. Nevertheless, similar to one's immigrant status, it is clear that gender is an issue for many of these women and they tend to downplay it, adapting to the norms of the profession. Gender seems to be most significant when factors such as race, family status, and immigrant status combine to create an intersectional experience of disadvantage. Respondents did not explicitly say their specializations were constrained by gender, but certainly did acknowledge specialty choices were *influenced* by gender or lifestyle choices; oftentimes, these lifestyle choices were related to family considerations. Most participants practiced traditionally "female dominated" specialties and acknowledged these specializations were ideal, as they allowed for greater flexibility and involvement with family and time for childcare. Most women did acknowledge that females do have different experiences in medicine than men with regards to gendered constraints such as child bearing and balancing domestic responsibilities. Moreover, many of the women agreed that men and women in medicine often have different priorities, men being very career oriented and women being more family oriented, which may partly reflect the larger institutional gendered norms and division of labour in society.

Dr. Kostopoulos says that once you become a mother it changes your life. Furthermore, there are responsibilities that come with being a mother that you must acknowledge in your professional life.

> You become a mom, you become a mom for life….So you have to balance that, and it's another job….You know, it's something you have to take into consideration when you make a choice what you're going to, you know, specialize or family medicine or…..lifestyle or what works for yourself (Dr. Kostopoulos).

Thus, for Dr. Kostopoulos and many other women in the sample, child care and work-life balance played an integral role in determining their speciality choice.

Similarly, Dr. Kim recalls family considerations shaping her decision to specialize in psychiatry (in Canada) a great deal. Although the choice to become a psychiatrist in her home country was a constrained one, she discovered a passion for behavioural sciences. When it came time to choose a new specialty in Canada, she wanted to make a decision largely based on what was right for the family as a whole.

> I think it's a really important about….I…it's not necessarily about medicine per se like it's just in general and how you run the family and how you want….or it's a financial aspect and social life, everything, so …yeah, it's really….you have to work with the family (Dr. Kim).

Even though psychiatry took longer than family medicine to become reaccredited in, she and her husband collectively decided psychiatry was the right choice because she was passionate about it. Thus, the impact her decision would have on the family was a significant consideration.

Although none of the women believed gender affected or impacted one's success or career path in terms of being treated unequally, most women strongly believed gender influences one's specialty choices and career decisions, providing evidence of the effect

of larger societal gendered norms. Many women expressed that they could have chosen more traditionally "male dominated" specialties that do not offer as much flexibility. Yet, they chose not to because they truly enjoy their chosen specialities and it gives them the benefit of having a greater work life balance.

> It's always a hard interpretation. You know, do women not take on administrative roles because they aren't interested in administrative roles. Or are women less likely to be selected for administrative roles….I think its probably a bit of the former, and you know, the women don't tend….probably because there are so many other responsibilities…haven't tended to want to take on those roles and there haven't been a lot of role models (Dr. Jones).

As Dr. Jones' quote suggests, the structure of the medical profession hasn't been welcoming to women in positions of power; this tends to influence the career paths of women. On the other hand, women also tend to desire a greater work-life balance than men. However, in the case of foreign-trained females, gender norms in their home country may also shape specialty choices.

> Still I believe that women don't like to do hard stuff like surgery. Still there is a minority (of women) but it's still they don't like to do it, so….they prefer something stable, something not too hard to do, something you know, with limited hours (Dr. Khalil).

For female physicians like Dr. Khalil, cultural and professional norms in her country of origin had a strong impact on her speciality choice. Where she is from, women are restricted from entering traditionally male dominated specialties. Nevertheless, although

cultural norms may influence perceptions of professional norms, the desire to choose a specialty that provides a work-life balance was common among all female participants.

It was also commonly acknowledged that hardships associated with being a new immigrant going through the reaccreditation process might combine to create increased challenges, especially for women.

> Because we came here, I have two years old girl at that time, so we put her, since we started in the daycare. Usually, you know, until 6 o'clock every day, you know….and after she come back she had to sit quiet just because we are studying. We were not fun at all, and ….yeah, she suffered a lot this little girl. You know with such work, there's no time limit for such work, you have to go 7 o'clock and you don't know when you're going to finish and go back home, so….. yeah we suffered at the beginning like that (Dr. Khalil).

Since oftentimes women bear the bulk of the domestic work, women may face additional hardships attempting to balance a family life while struggling to integrate themselves in the profession. The challenges may be enhanced further when it is the case that both husband and wife are becoming reaccredited at the same time. This can put a great deal of strain on the family.

Similarly, Dr. Kim said she struggled dividing the household labour with her husband while she was going through the reaccreditation process. She notes while the decision for her to become reaccredited in Canada was a collective decision made by the family, struggles associated with reaccreditation, raising a family and maintaining a household seem to create extra stress for the family. She noted this was very challenging.

> Oh that one is….yeah, because, again, like, how to share the house or all the chores and raising children. And….so my husband, he always wanting to support spouse, but he didn't know, right? Because he's also…his family background is again more like a…how to say, supporting the boy and he didn't ….he didn't see, right, how the wife was working, those things. So he….he didn't know how to do it, so we had quite a struggling time because he ….he wanted to do more, his job was quite secure and the community wanted to have him more for lectures, whatever. So we had a discussion, certain time, like….not happened over night, so we had a discussion then….on and off. So actually we really divided the household chores and then the children parts, but then later my husband did it much more than I did (Dr. Kim).

While Dr. Kim's quote provides evidence that female foreign-trained medical professionals do experience challenges that are unique to women, it is also evident that power and agency is present, as she was able to work out an effective arrangement with her husband. There is also evidence of cultural norms of gender at play, as her husband came from a family where men were valued and the gendered division of labour was quite rigid. Furthermore, similar, to Dr. Khalil, Dr, Kim's husband is a professional himself. These men also had demanding jobs and little time for domestic labour. It is difficult to determine the extent to which the initial family division of labour was a result of institutionalized gender norms, or simply an instrumental decision.

It is significant to note that many of the women in the sample did acknowledge that experiences might be different for women who practice in more traditionally male dominated fields such as surgery. A few of the women noted that in these specialties

women might feel more pressured and experience greater gender inequalities. Dr. Lukanov recalls, during her rotations there were other specialties that were more male dominated with pronounced inequalities between men and women. "The more aggressive sort like surgery….there was definitely inequality and how people's abilities and….professional abilities and social abilities were perceived depending on their gender" (Dr. Lukanov). Similarly, Dr. Ivanski who practices nuclear medicine, a male dominated specialty, would not say she ever felt discriminated against as a woman. Rather, she did note that she felt some tension from men in her male dominated work environment. However, she says she never felt personally victimized because of her high degree of knowledge. "I never felt like this, sometimes, some subjects I know better than they, so….they couldn't undermine us because we're female" (Dr. Ivanski). Dr. Jones, a faculty member at a university, agrees that women in more male dominated specialties might have greater challenges, as these specialties are often not as family friendly.

> The chair of surgery….you know, has sort of talked to me about the new experience of having women in surgery who have babies, and need to go on mat leaves. You know that's a foreign experience for a surgery program (Dr. Jones).

She notes that things are changing. However, there are still struggles and we still have a long way to come in terms of equality. She notes that administration and leadership positions are still very male dominated, and gender inequality is still prevalent. Moreover, she says there are few female chairs. In a study she conducted on physicians and their specialty choices, participants were asked if there were maternity/parental benefits in the department and they all said yes. However, she says she knows there aren't any.

> It was a very glib 'yes of course' and I know that when I've raised that amongst the clinical chairs….we have that in our department. And it was a struggle and most of the opposition came from our 55 years plus males, and I….you know, I say this quite openly. So I think there are still some struggles And I think we've got some work to do still...(Dr. Jones).

Nevertheless, even though there is still work to be done with regards to gender equality, the women in the study believed we have come a very long way. Dr. Jones notes that the very fact that the chair of surgery is considering and acknowledging the idea of women having babies during their residencies is quite significant. This is very different from her personal experiences in medical school in her home country, where it was very male dominated.

> There was a belief that a female coming into a precious spot at medical school was really taking up a man's spot ….There were inequalities in terms of admission. I remember going to see the dean when I was pregnant and having a very icy response (Dr. Jones).

She recalls administration almost looked down upon you if you were pregnant in medical school. At one point she felt she needed to take a year off to care for her child and recalls she almost didn't go back because of the negative sentiment surrounding the needs of women: "There was certainly no equality at the time. It was a struggle" (Dr. Jones). Interestingly, one of the earlier immigrants, Dr. Zagar, said that when she was going through the reaccreditation process medicine was very male dominated still, especially if you wanted to get into academia. However, she did not feel as though this created any gender inequality for her; that is, at least she claims did not perceive any. Nevertheless,

she appears to express some ambivalence as to whether her hardships were more a result of her status as a female or immigrant. “It’s harder for female, you really have to prove yourself twice, as here, to ….in residency….maybe not male/female, but as a foreign grad. I definitely need to be twice as good as Canadian grad, or even UK…..So gender -- there was no inequality” (Dr. Zagar). Thus, she reported that she had to prove herself in paediatrics not because she was a female among males but more so because she was an immigrant. She believes this is attributable to her strong personality, “I …I really haven’t encountered kind of gender bias in the….ever I must say. Mind you the way you see I present myself and I’m not really….you know, submitting to anybody” (Dr. Zagar). Although Dr. Zagar suggests her resilience is a result of her strong personality, it is also possible that by adapting to the “masculine” norms of the profession, it is difficult for her to see the inequalities she may be experiencing. Moreover, it is clear that she expresses some ambivalence with regards to the influence of gender, suggesting that gender is in fact significant.

There is also evidence that each woman’s experiences may be different depending on their multiple roles and identities and how they intersect. Dr. Vedula is an example of how different statuses can intersect to create barriers that are difficult to disentangle. Dr. Vedula’s initial specialization in her home country was determined by her status as a married woman. She initially wanted to specialize in cardiology; however, she ended up having a change in thought after learning that she would have to live within the hospital quarters for most of the months during her residency; this was not possible for a married woman. A professor of anaesthesia convinced her to specialize in anaesthesia, as it was a good blend of internal medicine and cardiology and offered more flexibility allowing her

to be home more often. Accordingly, Dr. Vedula expressed that she felt as though the medical profession discourages women from having families. She says a family and medical career are very hard to balance but she was lucky: her daughter was already 7 when she moved to Canada. Nevertheless, she still found it difficult and believes her daughter lost out on a lot of things because of her rigid schedule.

> And there were so many occasions I couldn't be there, say for the birthday parties or any of those things, because of calls. Either you are doing a call or you are post call and you're absolutely just wiped out….so….yes, it is not family friendly (Dr. Vedula).

Reflecting on her experiences raising her daughter, she recalls it was very difficult.

> I hardly saw my daughter in an awake state. It was tough for me. I didn't flinch from work because I wanted to reach where I wanted to go…But it wasn't easy…its (emphasis) really (emphasis) tough. Very tough. I was with my daughter when she delivered her first baby and the second baby. And it was so vital for the mother to relate to the baby and see the baby grow up in the first year. And I think that will be missing in many of these young ladies who deliver as doctors (Dr. Vedula).

Dr. Vedula's experiences illustrate how multiple statuses can combine to create a unique experience of disadvantage. However, it is very significant to note that while most women indicated that family considerations influenced their professional decisions to some extent, the challenges and barriers seemed to be more pronounced for the women who were members of racial minorities or sometimes those from countries where gender norms differ from ours. Thus, this provides evidence to suggest multiple identities may

combine to create unique experiences of disadvantage. Moreover, if one possesses multiple "negative" statuses, there is greater potential for one to experience more challenges and barriers.

It was evident that most of the women (8/10) acknowledged that gender does strongly shape one's experiences in the profession. The men in the study however, did not believe that one's gender influences one's outcomes or experiences in the profession.

> I do not think so….I really…. don't think so. I think it's more of your….as I told you, your knowledge, knowledge of medicine. Your training, where you're trained from. And then most ….most important is communication skills. How you are able to present yourself, how you are able to sell yourself (Dr. Nadeer).

Like Dr. Nadeer, none of the men believed that gender shapes one's experiences in the medical profession. Furthermore, none of the men acknowledged any of the work-life balance or family related concerns that the women found to be significant. When recalling their hardships, all of the men described their immigrant status as the root of their barriers. In contrast to the women, men did not recall any family related concerns as sources of initial disadvantage. Thus, it is clear that gender was more of a disadvantage for the women in the study.

Although most women in the study did acknowledge that gender shapes one's experiences in the profession, all women acknowledged that gender norms in the profession have changed a great deal over time. Thus, one's experiences may also vary by time period. The narratives of the women in the sample suggest the period in which one arrived in Canada also played a significant role in shaping their experiences.

Period

Within the sample of medical professionals there is a wide range of arrival dates, the earliest being 1974 and the latest being 2005. Amongst my respondents, experience of disadvantage is correlated with the period of immigration; those who immigrated earlier reported increased disadvantage. Most disadvantaged were those who immigrated prior to the government's skilled workers initiative. At this point in time the system was not necessarily set up in such a way to encourage the migration of skilled professionals, nor streamline the immigration and integration process for them. In fact, Dr. Kostopoulos recalls that at the time she immigrated (early 1980's), the government was actually discouraging the immigration of foreign-trained medical professionals. The Premier of Ontario at the time, David Peterson, believed there was an oversupply of doctors and thus, enrolment in medical schools was cut back. Consequently, there was a lack of residency positions, which proved to be a major barrier for foreign-trained medical graduates at the time.

> IMGs (international medical graduates) were not welcomed in the country….we're considered you know, we're not as competent, we're not as good, we're not welcomed….So you almost felt inferior to say that you were a ….you know, you were not from Canada, you were not a Canadian graduate (Dr. Kostopoulos).

According to Dr. Kostopoulos, there certainly was differential treatment between International Medical Graduates and Canadian medical graduates. Moreover, one's level of competency was judged based on where one completed one's training.

Dr. Zagar recalls similar feelings noting she experienced some contention with one of the supervisors during her residency. He told her that as a foreign grad, she would not do well here, and he did not want to offer her a full-time position at the university. In another instance with the same supervisor she said, *"*I got an outstanding evaluation in rotation in neonatal, he wrote 'so far'. Just tells me he still didn't believe I would do well" (Dr. Zagar). Again, Dr Zagar's quote illustrates that there was a prevalent bias against the abilities of foreign-trained graduates.

These early immigrants each shared the belief that this was an extremely difficult time period for international medical graduates. When asked what the process was when she arrived in Canada, Dr. Kostopoulos replied, "Tough, tough, 10 times more difficult than what, you know, the IMGs are facing now. Tough…so tough" (Dr. Kostopoulos). Dr. Kostopoulos recalls having to compete against 500 other applicants for only 24 residency positions. Thus, the lack of residency positions at the time and lack of demand for medical professionals more generally, created more barriers due to increased competition. She said she failed the exams twice but was *"*determined to either be a doctor in Canada, or go back*"* (Dr. Kostopoulos).

For those immigrating during the 1970s and 1980s, there was also a lack of resources for new immigrants. Support with regards to language and information surrounding the reaccreditation process was not readily available to streamline the process as it is today. Reflecting on her experiences many years ago, it is clear that Dr. Kostopoulos struggled a great deal.

> I came here in 1983, right? And started the training in 1990, so looking back, seven years of my life….and I always believed in myself that I would practice

> medicine in Canada, I never thought that I'll waste seven years of my life here. So there were times that …..yeah I felt very down, depressed, ready to pack and leave….having a young family and financially broke….it was tough. I don't wish this on anybody (Dr. Kostopoulos).

Despite how "tough" the process was, none of these early immigrants believed they were deliberately disadvantaged because of their gender, immigrant status or ethnicity. This is consistent with previous literature on women in professions, as women in high status positions tend to downplay any inequalities or discrimination they may be facing (Demaiter & Adams, 2009). This may also be partially attributable to the fact that they are white (two of these individuals came from Europe, one from South Africa). Additionally, cultural norms in their countries of origin may have influenced these individuals' perception of what disadvantage or discrimination is. Moreover, because these individuals immigrated to Canada intentionally to find a better life, they may be thankful for their experiences here and perceive it to be something positive they have done to enhance the future and well-being of their families; not necessarily as disadvantage or discrimination.

One of the more common themes that emerged within this small group of early immigrants, was the idea that because immigrants were not necessarily welcomed at the time, they felt they had to work "twice as hard" to prove their knowledge and competency. When asked about her experiences in 1978 with regards to the reaccreditation process, Dr. Zagar replied, "I definitely needed to be twice as good as a Canadian grad, or even UK" (Dr. Zagar). Though she never felt discriminated against based on her gender or ethnicity, she believed that in order to be perceived as equally

competent as a Canadian grad, she had to work much harder. This theme of having to "prove yourself" was common for all participants.

The third of these three early immigrants, Dr. Jones, expressed the least concern when it came to how her abilities were perceived at the time. Coming from a commonwealth country, it may very well have been that the training she received in her home country was more on par with Canadian training.

> We created a panic, we were in Kingston, at Queen's. And so many of our peers wrote the exam as well. So we were all first time writing medical graduates. But we happened to be a group of commonwealth graduates…..and we all passed the exam (Dr. Jones).

It is clear that she was advantaged in terms of language and schooling in comparison to other international medical graduates. Looking back on her experiences, she did not at all feel as though she was disadvantaged as a foreign-trained graduate. She does note that unlike the other two early immigrants, when she arrived in Canada in 1974, there was still a shortage of physicians. Accordingly, she was welcomed at the time. Thus, her case reinforces the significance of period and how strongly one's date of arrival may shape experiences in the profession. However, based on her experiences it seems as though she did experience some hardships or a minor disadvantage based on her gender. These experiences included such things as balancing family life as well as a medical career during a time when families were not encouraged for female medical practitioners. Thus, in this case gender was significant. However, because she is older, this may simply be a function of a period effect and may not be generalizable to experiences female physicians may be facing today. Despite not having much trouble "fitting in" as a result of her

advantage in terms of language, perceived ability, and training, Dr. Jones did acknowledge that hers may be a unique case and the experience may be different for immigrants who are not from a Commonwealth country.

It is noteworthy that those women of European origin tended to privilege their immigrant identity over their female identity when it came to recalling their hardships and disadvantage. Conversely, Dr. Jones did not feel as though she was disadvantaged in any way by her immigrant status or ethnicity, in fact, she was advantaged in comparison to other international medical graduates. However, she did note that her multiple identities and responsibilities of being a mother, wife, and medical professional coincided to create some difficulties or hardships.

When compared to the experiences of more recent arrivals, it is evident that early immigrants identified more hardships simply due to institutionalized barriers, cultural, and gender norms in the profession. The experiences of more recent immigrants appear to be clustered into two distinct groups: members of racial minorities and white Europeans. Since the early immigrants are all white, when compared to the more recent white Europeans, it is clear that the early immigrants faced more disadvantages, suggesting a period effect. Conversely, the members of racial minorities in the study tended to report greater disadvantage (in comparison to the white Europeans); their experiences appear to be more comparable to the earlier white immigrants. Thus, it is evident that period of arrival shapes one's experiences in the profession based on structural opportunities and cultural norms. However, period seems to interact with race, ethnicity and gender to shape experiences.

Country of Origin/Region of Training

While one's gender, race, ethnicity and immigrant status do influence experiences of discrimination to some degree, country of origin or region of training is also significant. Particularly significant are the cultural norms of gender in the country of origin, the perceived status of the medical profession in the country of origin, and language.

Cultural Norms of Gender

Gender norms vary across culture and these norms may affect participants' perceptions of what constitutes discrimination or unequal treatment. For example, if a participant comes from a country where gender differences are more pronounced and bias against women in medicine is strong, they may not perceive negative treatment they experience in Canada as particularly problematic. In a similar vein, if a woman comes from a country in which medicine is highly feminized and enters a highly feminized specialty in Canada, she also may not notice or perceive there to be any cultural differences.

When asked about her experiences of gender discrimination, Dr. Kostopoulos noted that there are some significant cultural differences between her home country and Canada when it comes to defining "gender discrimination". She notes that in her home country, the medical profession was very male dominated and she did have some negative experiences with men in the profession. However, when asked to characterize whether the behaviours she experienced were harassment, she did not explicitly define it as such. In fact, she made it clear that *here* and now in Canada these behaviours would be categorized as discrimination. However, back home, in the past, this was not the case.

"Here you might….you know, somebody might consider that you crossed the line" (Dr. Kostopoulos). This seemed to be a common response for many female participants.

Dr. Jones recalls that gender norms were so rigid in her country of origin that in Canada, she did not perceive there to be nearly as many inequalities. She holds that she did not experience any gender discrimination in Canada. In contrast, in her home country in the 1960s, there was a negative sentiment toward women in medicine: "There certainly was no equality at that time. It was a struggle. There was sort of a…sort of a belief that a female coming into a precious spot at medical school was really taking up a man's spot." In fact, after taking a year off to have children, she claims that she almost didn't go back due to the negative sentiment surrounding women in the profession.

Dr. Kim, a more recent immigrant, also did not perceive herself to have had any experiences of gender discrimination in Canada. As noted earlier, she claims she has a high tolerance for such behaviour, as there were institutionalized inequalities between men and women in her home country. She says gender norms are very rigid and the medical profession is very male dominated. She recalls that only 10% of her medical class was composed of female students. Even when it comes to applying for a residency position, males were preferred. She says that this is regular practice and a general concern in her home country. Further, women are also restricted from entering popular "high status" specialties; they are neither welcome nor accepted for these positions. Thus, a woman's choices in medicine in Dr. Kim's home country were very constrained. Dr. Kim's background experiences likely had a significant impact on what she perceives to be "normal" gender relations and how she may perceive discrimination.

Similarly, Dr. Khalil states that gender discrimination is prevalent in her home country, especially in the medical profession where men and women are highly segregated between specialties. These cultural norms shape her views about appropriate roles for women and men, and she acknowledges that her views are different from some other women in medicine:

> So I don't think I feel it here like there is…. the same at home, here is different. They allow whatever you want, it's your choice. But maybe this is….it depend on the person because I saw some of the resident actually in surgery, females in surgery. I saw some in urology, and this is weird, we have a session last week and urology residents again, three of them females. So and …..even I wondered at that time, I said oh my god this all male, they got to deal with males, so how come they feel comfortable? But here in Canada it's different I think. I think gender and the specialty related to gender depend on the person more than the system. At home, this is not allowed….here in Canada, there is a choice and a chance (Dr. Khalil).

Thus Dr. Khalil, as for others what stood out was not the presence of discrimination but that bias here was less than elsewhere.

In contrast, Dr. Zakaria claims that back home there was no discrimination, so it is difficult to identify discrimination in Canada when you have no experience of it. When asked if he ever felt treated unequally or was disadvantaged due to his status as a foreign-trained racial minority he replied,

> Well (pause) when you grow up in a place where there is no discrimination, when you come here, you don't have any idea what discrimination is like. So, but if you are discriminated, you may not even notice (Dr. Zakaria).

Thus, for many immigrants the differing cultural norms in the country of origin have a strong influence on how they might perceive their experiences in Canada.

Many participants asserted that Canada is sometimes overly cautious when it comes to equality and monitoring "discriminatory" behaviours. Dr. Janko believes that sometimes here in Canada people can be overcautious about behaving in ways so that nobody is offended. Furthermore, she believes that in Canada, sometimes people tend to label actions as discriminatory when they are not such.

> Yeah, I don't think in professions there was more gender issues than somewhere on the street, it's….back home is a bit more….or less rather, civilized country than Canada here. If you go there for a day whatever is happening there in there you would call sexual harassment but it's the way things….things done (Dr. Janko).

Similar to Dr. Zakaria, Dr. Janko notes that the cultural norms, especially gender norms, are very different in her country of origin. It is clear that because of this, she may not interpret certain behaviours as discriminatory.

Overall respondents demonstrated a high tolerance for 'discrimination' and suggested that it was easily ignored and overcome. It was not something that might hold someone back. Respondents felt that individuals were responsible for their own success. For instance, Dr. Zakaria argued that while the unsuccessful might claim discrimination was to blame, this was just an excuse:

> But some people who are here that are very sensitive, and they just immediately say 'no, that's not fair, I am being discriminated.' So …..in the examination there's no discrimination. Basically they don't see you. They got your name, and I don't know if they can check who you are from your name. But you're doing the exam and they checking on you either you pass or you fail so you don't blame anyone for that. If you fail you just blame yourself 'I wasn't prepared.'….You could have been discriminated, who knows (Dr. Zakaria).

Thus, the differing norms between Canada and the participants' home countries shaped their perceptions of what constitutes discrimination and helped to encourage an individual responsibility attitude. Foreign-trained medical doctors in this study did not dwell on the barriers they faced, but rather on their own hard work and commitment to succeed.

Perceived Status of Country of Origin

Variations in experience were also evident across country of origin, with respondents from nations whose medical education was regarded as inferior, experiencing more difficultly integrating into the Canadian medical profession. For example, Dr. Vedula completed her medical training at a school that was unrecognized in Canada:

> I was very aggressive with it. I wanted to find out what is the reason why my medical school wasn't recognized at par, because I realized at some point, even Harvard told me that my basic medical knowledge was phenomenal….. So I was proud about what I had in the form of training in my home country. But they don't consider as equal training here. So what makes the Canadian government

> consider a training institution as equal to the Canadian training? I think they need to have level playing field to recognize. Right now we…..I have a gut feeling, there are five countries, or six countries where the training is considered equal…..The rest of the countries, I'm sure there are medical schools that are good. I'm sure their training is equally valid…..and we don't have any mechanism to recognize the talents from those countries (Dr. Vedula).

Dr. Vedula claims she felt that because she was coming from a place where the training was not recognized, she was perceived as less competent. Because of this, she felt as though she had to work twice as hard in order to prove herself.

Similarly, Dr. Kim finds it frustrating that there are individuals from other countries that come from outside North America and have a much easier time going through the reaccreditation process.

> I have a little bit of an issue that people had the foreign training and….and didn't have to go through the…..any training here and then have the same titles right? And also didn't have to go through the tests and I have a little bit of an issue …..I know there is some prejudice about the different countries. So I know they more acceptable about the English speaking countries, they are people who came from England, Australia, or South Africa….and I don't see much difference (Dr. Kim).

Like Dr. Vedula, Dr. Kim believes that your region of training should not be an indicator of your ability. Simply put, she believes you can be just as well trained if you are not coming from an English speaking country; this is something the government must recognize.

Dr. Perez, a male physician from Mexico concurs that there is discrimination against IMGs (international medical graduates) from certain nations.

> The bottom line is yes, I think there is a discriminatory role against IMGs in general….my feeling is not only that is against IMG's is against specific IMGs. It's not only if you come from abroad…..So you have to go through the whole process, but if you're coming from….you were training in the UK, or in France (its not as bad). It's not. The problem is if you're coming from developed, or from an underdeveloped country, and …..and yet, again, it doesn't make any sense 'cause its just like that' or it's …..there's no reason why you should be better trained in one or the other place (Dr. Perez).

Additionally, the status of the profession in the country of origin seems to be significant. For instance, the status of medicine in many Eastern European countries is relatively low and the profession tends to be more female dominated. These countries are viewed as not having training programs that are as rigorous as countries, like Canada, where medicine has a higher status. Dr. Dancescu, reports that in her home country, the status of the medical profession has been quite low post World War II (and post communism). In fact, in contrast to Canadian professional norms, the status of physicians there is comparable to that of a nurse. Moreover, their salaries are often equivalent to that of a nurse or even lower, depending on the region of practice. She reports experiencing many difficulties adjusting to the Canadian standards and professional norms.

> Really, the residency training grew really tough. It will take you all day long and weekends and ….is a bit easier in my home country…..I found it tough, difficult you know I adjusted and the residency once you start, you know…. you learn how

> the system is and you know more, and then you work more in your interest area and you feel more connected, accepted by your colleagues, because they will know you become a specialist in that area (Dr. Dancescu).

Also from Eastern Europe, Dr. Zagar believed her training was viewed as "second rate" compared to other IMG's from the UK, Ireland, Australia, and South Africa. She had the feeling that many professors were biased against her. She felt that because of these stereotypes, she had to prove her knowledge and work twice as hard to prove herself.

Conversely, Dr. Janko was one of the few respondents who openly agreed that she was under qualified upon arriving in Canada:

> In some areas you do sometimes, it's not like feeling, that you feel less qualified. The truth is, you are less qualified. The thing is, if you don't know how to open door and which….which way to communicate with patients and how to behave yourself, you are under-qualified and it's something that you just need to deal with, it's…..I don't think it's an unfair thing to say that people who are coming from different countries with different level of education background, they are somewhat unfitted to go right away into Canadian system and start practicing. Just letting people go right away it's not safe for patients, for system, for everything, so…..I did not feel that something unfair going on but sometimes on several occasions I would be told or understood that that's how things are and I understand that it's fair game (Dr. Janko).

Dr. Janko does not believe that international medical graduates are unfairly treated because they are perceived as unqualified. As she suggests above, the truth is, many foreign-trained professionals are under-qualified when they arrive in Canada. She

understands Canada has high standards for medical practice to ensure the safety of patients. She believes that immigrants must understand they are not necessarily being targeted; there must be standards in place.

While most participants (approximately 10/13) felt that they had to prove their knowledge to be perceived as equally competent as Canadian graduates, these feelings were more prominent for respondents who came from countries in which the medical training was considered to be inferior to Canada's. The respondents highlighted above were more outspoken with regards to their feelings regarding the differential treatment of foreign graduates. However, while many others did acknowledge that there is a differential treatment between foreign graduates, they tended to internalize the idea that they were less qualified and did need to prove their knowledge. Moreover, many agreed that this was a fair game and continued to work through the barriers and perform their work at a high level.

Language

It is not surprising that those participants who were more skilled with the English language had a much easier time transitioning, as English language comprehension is an essential element of the reaccreditation process. Dr. Zagar acknowledges that she had a great deal of trouble with the language and oral exams. She recalls it seemed as though they were especially tough on the foreign grads. "They are downright nasty when they're trying to….you know in oral. And it's not only to foreign grads, but definitely more I think." She believes that grasp of the English language is paramount to succeeding in the Canadian system. Thus, she believes this is one area where foreign graduates could use more institutional support upon arriving in Canada. Similarly, Dr. Janko found that her

lack of competency with the English language made it much more difficult to prepare for reaccreditation exams: "It is tough, it's so…..language barrier because we came…..we did know some language but it was not enough to communicate with people, and it was not enough to prepare for exams, so it took some time." Dr. Ivanski reported no trouble adapting to Canadian medical practices, as she did not feel her education or training was inferior to Canadian standards; it was language that proved to be her biggest barrier.

> The problem, the language barrier, to begin was because I know four languages, but English only I wrote and read. So my spoken skills were just very limited and I needed to start and practice and talk to colleagues and speak with patients which was more complicated, so they needed to understand me, I needed to understand them. So it took me quite a while. And, you know my grammar is currently not perfect, but I'm working on it (Dr. Ivanski).

As one of the few respondents who did not feel her training or knowledge base was inferior to Canadian standards, it is significant to note that language proved to be a problem for her. Likewise, Dr. Kim has a very heavy accent. Consequently, it was very difficult for her in the beginning, as she felt very self-conscious being constantly evaluated during her Canadian medical training.

> To me it's more ….like it's….some people have difficultly understanding my accent. I have a very strong accent, and I understand that part. Sometimes I make it very clear from the beginning, but you know, initially I …..maybe part ways more I'm kind of very self-conscious about that and ….especially student…..like at the time was quite difficult because they assess you everyday, right? They give you feedback everyday, so it's quite stressful. So we did that stress whether

> because of the….it's…..I struggled with the language, but not necessarily because I'm a minority or……it's just a general sense that….about the expectation of the…..you know, professional, I think that's how I saw it (Dr. Kim).

Dr. Kim felt that people tended to judge her simply based on her accent and make judgements of ability based on the fact that she is from another country. However, she never perceived this as discrimination per se, as she realizes that learning the English language is a standard and necessary requirement for a Canadian medical professional.

It is evident that several respondents struggled with English language comprehension upon arriving in Canada. It proves to be a significant barrier when it comes to collecting information about the reaccreditation process, successfully completing exams, and securing employment. Furthermore, many respondents felt that their strong accents and poor grammar often led to them being stigmatized or judged as incompetent. These respondents felt that since language is an essential skill for employment, more government sponsored language training and support should be provided to new immigrants.

Summary

In sum, it was found that participants' experiences were strongly shaped by gender as well as period of arrival, and country of origin. However, most significant was one's immigrant status and ethnicity. Many participants felt that because of their immigrant status, they were more highly scrutinized and had to "work twice as hard" to "prove themselves." Although many did not explicitly report discriminatory treatment, many respondents did report experiences that could be regarded as discriminatory. In the following section I will discuss how the respondents cope with such treatment.

Methods of Coping

The participants in the study have reported facing a myriad of barriers including systemic discrimination. One of the prevailing themes was that the respondents tended to see success and failure as a result of their own efforts. Many participants internalized the belief that if you are a "good doctor," possess the objective knowledge, and work hard, you will succeed. It is evident that this individualistic attitude has been a great source of stress for many of the respondents. Despite whether respondents reported experiencing hardships or not, it became clear that many utilized similar coping methods to help them see past any negativity they may be experiencing. These coping methods included focusing on the positive, using their education and knowledge to cope with stereotypes, and building a professional network.

Focus on the positive

Each participant immigrated to Canada with a distinct purpose to improve their quality of life and increase opportunities for their families. Thus, despite barriers that they may have encountered, most participants tend to focus on the positive. They emphasize that the life they have created here is better than what they would have had in their country of origin.

Dr. Vedula claims, although she has had some tough experiences with discrimination, particularly abuse from colleagues and administration, whenever she feels stressed she tries to focus on the positive aspects of her life and career. In particular, she states that the Dalai Lama book, "How to Find Happiness at Work" helps her do this.

> I go back and read, and suddenly I'll realize what am I complaining about? I'm living in…..I call it heaven on earth with a fantastic job. I should learn to take

> things on the stride and….and maintain my focus, my focus is to provide the best quality care for my patients and make them feel better and anything else that comes my way, just let go, let go, let go…..is what I have taken….and I'm happier, I'm much happier. Much happier….and when people will verbally abuse me in front of patient, I don't have to recognize them even as fellow human beings….so I've learned to deal with conflict at work in a more….non-confrontational way (Dr. Vedula).

Thus, despite the harships Dr. Vedula has faced, she finds that focusing on the positive, particularly by reading the Dalai Lama's book, helps her cope and proceed successfully with her work. By focusing on what she is thankful for, she is able to remove herself from any negativity her colleagues may create.

Similarly, Dr. Jones claims that although her move to Canada and integration in the Canadian profession was an uphill battle, because she came here with the intention of making a better life, these challenges were never something she dwelled on, "It never occurred to me that it was a huge challenge cause it was just life. It was just….I mean you sign up for it, yeah….make your own choices" (Dr. Jones). Thus, the move to Canada was a free choice; she left her home country for politically motivated reasons. This statement illustrates that she is very grateful for what she has in Canada, as she and her family have faired better here than they would have back home. Dr. Jones did not regard her experiences here as "challenges", but simply as being a "part of life", and hence did not perceive "challenges" as negative or discriminatory.

Dr. Zagar immigrated to Canada mainly because of her husband. However, it seems as though her successes in Canada outweigh the alternatives in her home country.

She claims it was very difficult at first but once she proved her knowledge, everything worked out and her overall experience was positive. She felt successful and did not feel disadvantaged by gender or ethnicity. Although she had to work "twice as hard" and "prove herself" to get where she is today, she says the payoff is definitely there.

> I find that I'm grateful I became a Canadian citizen like as soon as you've done three years so I can travel, get a passport and travel. My children, got a….you know, my son is a professor of organic chemistry and he holds a chair at a university in organic chemistry, actually he's well ….world known now. My daughter is a lawyer and has a beautiful family here, you know, so I think we succeeded. We would be poster family for Canada (Dr. Zagar).

Since Dr. Zagar focuses on her successes in Canada, she does not characterize her experiences of reaccreditation and integration into the profession as negative, despite the hardships she may have faced.

Also in search of better opportunities, Dr. Nadeer decided to move to Canada because he wanted to move to a place where his children would get a good education. If he had stayed in his home country, in order to keep his job, he would have had to move away from his family to continue his practice. Wanting to keep his family together, he decided to move to Canada.

> Because I had three young children when I came to Canada, you know, then it's a new place, a new culture, everything is new. So we had difficulties, you know. But then, as I told you, the whole process is such an uphill task, so that all becomes part of that right? (Dr. Nadeer)

Like Dr. Jones, Dr. Nadeer believed that difficulties were expected and part of the process, so he did not necessarily perceive the barriers or challenges as negative experiences or unequal treatment. In the same way, Dr. Zakaria came to Canada as a refugee. Although he experienced a myriad of difficulties over 10 years before he became a physician in Canada, he was determined to become a physician or leave.

> Yeah, we came with nothing, just….me, my wife, and my son. Nothing else. We lost everything in the war. We were doing good, we had a big house. We were newly married when the fighting started, she…my wife was four months pregnant. I had my big clinic. Then all of a sudden we had to flee on foot to another country. Phew. And my son was born in the refugee camp…..then we had to come here….oh we got to start over. But I'm not complaining. It's very hard….it was tough….that's what I say, it was really tough (Dr. Zakaria).

Dr. Zakaria struggled a great deal with the examination and interview process, however, as mentioned earlier, he does not attribute any of his failure to discrimination. He felt there was a better future for his family in Canada, despite all the hardships he went through.

Thus, study participants deliberately moved to Canada in search of opportunities for themselves and their families. Despite the challenges they may have faced, these foreign trained graduates tend to see the uphill integration process as something that is expected and simply part of the process. Furthermore, the opportunities available in Canada outweigh those in the home country. Accordingly, these individuals are very appreciative and primarily focus on positive experiences.

Use of Education and Knowledge to Cope with Stereotypes

Another common coping method participants used to help them get past the label or stigmatization of being foreign-trained (and perceivably less competent), was focusing on their objective knowledge and education.

Dr. Nadeer believes, yes, people may be hesitant towards your abilities at the beginning, however, if you are well trained and have the objective skills, you will succeed.

> If you are well trained, you can get into the system, you can get in, it's not that difficult. So you can be a doctor, but you can be a good doctor and …..or you can be a bad doctor. So a bad doctor will be a bad doctor in Canada, or in India or in UK or elsewhere….a good doctor will be a good doctor anywhere you put him right (Dr. Nadeer).

Although it was an uphill battle at the beginning, Dr. Nadeer believes knowledge is power. He believes if you are a well-trained foreign doctor, you can get through the system.

Dr. Ivanski, a female who specializes in nuclear medicine, feels as though her high level of education and unique specialization played a large part in her success here. Moreover, despite her mostly male team at the hospital, she has never felt undermined or inferior because of her high level of education and experience, as well as confidence in her own abilities. "I never felt like this, sometimes, some subjects I know better than they, so….they couldn't undermine us because we're female." Similar to Dr. Nadeer, she believes her objective knowledge is primarily responsible for one's success in Canada. Dr. Khalil argues that because foreign grads are more likely to be stereotyped, they often

have to work harder to prove that they are capable and do have the knowledge to be successful in Canada. However, she suggests foreign-trained graduates actually work harder than their Canadian counterparts because they want to succeed here in Canada.

> But, you know, fortunately actually, all the international people, once they started a career like that they excel. You know? They do the best, you know? They are so prominent, you know? And they are so active, they want to do a lot of things, you know? Everything at the same time. So I don't think you know, they did….if they choose one international they did wrong thing, you know, this is a mistake- no it's not a mistake because they know this guy is going to do a hard work. Going to be active you know, three times or three times….two to three times more than a Canadian person because Canadians actually also rely on you know, they are from this country, they are their students, they are, you know, in medical school and ….their medical school, whatever. So, you know, relax later on. But for internationals, they want to show that they are ok, and they are perfect and it's not a mistake to take us (Dr. Khalil).

Dr. Khalil claims that although foreign graduates may be perceived negatively as being less competent, they can demonstrate their worth through their hard work and eventually it will be recognized. Similarly, Dr. Zakaria states that immigrant grads put in more effort and work extra hard. "So we have that disadvantage but we work hard hard hard hard…..double the work, double the effort than the people here" (Dr. Zakaria).

Thus, focusing on objective skills and hard work seems to be an effective coping mechanism when dealing with negative stereotypes or discrimination. Similar, to the "focus on the positive" mechanism, focusing on objective skills provides some

psychological reassurance and confidence that helps one persevere through the uphill battle of reaccreditation and integration, alongside any discrimination or unequal treatment.

Professional Networking

Professional networking was another strategic mechanism participants used to help integrate themselves in the profession. Many participants noted that the Canadian medical system is much different than that of their home countries. That being said, finding someone who can show you how the system works and establish a professional network is an effective strategy for success. Oftentimes, foreign-trained graduates not only need help adjusting to the professional norms but also to everyday cultural norms. Most participants said that establishing a professional network, not only assists with finding a job, but also helps counteract negative stereotypes against foreign-trained graduates.

At the time Dr. Kostopoulos immigrated, getting into the profession was very much dependent upon who you knew, "You know you had to pass one exam and then you had to apply for a position and it depended on whom you knew" (Dr. Kostopoulos). At the time, she did not feel as though her disadvantage and struggle getting an internship was due to her immigrant status/ethnicity, it was more due to the fact that she did not have an established network in the profession. Once she made a contact, she had an easier time.

> I had a friend and he's a gynacologist, and helped me a lot in terms of, you know, guiding me a little bit, he would take me in his clinics in the gynaecology, and he helped me a little bit in terms of opening up, you know my mind or my eyes and

> see how the professionals would behave here, how the teamwork works…..and you know it was quite an eye opener, you know, for the system. Looking back it was the best thing that this friend of mine did. You know, he didn't put me through the system. I passed my exams and got my position. But when I started my internship, oh my goodness, I knew exactly how the system worked (Dr. Kostopoulos).

Dr. Kostopoulos mentioned that there were vast cultural differences in terms of the way medicine was practiced back home and this was a very beneficial opportunity which allowed her to learn all the ins and outs of medicine in Canada; this was essential to her success. Similarly, Dr. Zagar recalls that her experiences were positive in Canada once she built a professional network and figured out the system. At first she felt stigmatized, but she found that having a network in the profession is a great help when it comes to "proving yourself", increasing your legitimacy and assisting with gaining access to the system.

Some participants also reported utilizing other networking strategies such as doing a Masters degree first to get a foot in the door or securing a position as a lab assistant.

> The challenge is the difficulty to find the job of course at the beginning, so I decided to start with a master degree first just to see….to go to, to involve in the system to find a way to apply for residency later on because, you know, if you have something like a degree from here, or, you know, involved in the system in Canada, it's better than you stay home and study and do nothing, you know? And also observership and this kind of stuff. Very helpful to many people, but I …..I

> think I decided to do the research part because it's a …..you know, I like research very much so I did basic research actually and this degree also, I knew the master degree later on was very helpful for me just to be accepted here back at the university (Dr. Khalil).

However, for some immigrants, building a professional network can prove to be just as difficult as getting into the profession. This may be due to cultural differences, language barriers or simply a lack of knowledge. Dr. Vedula felt she was treated unfairly when it came to consideration for jobs due to her lack of established network.

> Sometimes people get….form an opinion which they find difficult to change. So that is the component which will be difficult for a foreign graduate. For a local graduate it might be much easier because they have grown up in the system, they have got evaluations coming from this kindergarten onwards that they could find out if there was any problems with this candidate (Dr. Vedula).

Dr. Vedula, a female who is a member of a visible minority group, experienced many difficulties early in her career, and she felt that her lack of a network worked against her. It is evident that if a foreign professional has an established network in the Canadian profession, it is much easier for employers to confirm their abilities and character. Foreign professionals who do not have such a network may face stigmatization and discrimination, making it difficult to gain entry into the profession. In the same way, Dr. Zakaria felt that his lack of network also created more barriers for himself. He recalls that the individuals who did have an established professional network had a much easier time gaining access to the system.

> There are some people who do not meet all those. But they….and they have references and they allowed, they skip certain parts 'cause they have some people helping them….that's what I thought, was there are people who get an …..reference from some professor that's well known, academics….they work for and then they get reference and they get accepted. Yet, you don't have anyone, just go go go, cover everything…..I have reference from my professors in my home country, they don't know them. And they don't even trust, probably…..you could have forged those stuff (Dr. Zakaria).

Like Dr. Zakaria, foreign trained professions coming from countries where training is less rigorous or unrecognized by Canadian standards may feel distrust or suspicion from those evaluating their competencies. It is evident that with more time in Canada, one has an opportunity to build a professional network, which can help dispel negative perceptions. It is clear that an established professional network is central to one's success in the Canadian system. It is evident that those participants who reported successful integration, their network or prior professional experience in the Canadian system helped them a great deal. Conversely, it is clear that those who did not have an established network experienced increased barriers gaining access to the system.

Conclusion

It is clear that foreign-trained medical doctors face many barriers. Although many respondents did not label their experiences as discriminatory, many of their experiences could qualify as such. It was found that respondents' immigrant status and ethnicity were most significant in shaping their experiences in the profession. Furthermore, participants' experiences may vary by gender, period of arrival, and country of origin. Respondents

tended to take on an individualistic attitude internalizing the idea that success or failure is solely a result of their work ethic or knowledge base. Respondents tended to cope with negativity by focusing on the positive, utilizing their knowledge base, and building a professional network.

Summary

In the following chapter I will provide a discussion of the above results incorporating support for my findings from previous literature. Additionally, I will outline shortcomings or limitations of my research, discuss implications for policy and provide policy suggestions, and lastly, discuss areas for future research.

Chapter 6: Discussion

Introduction

In this chapter, I will discuss the significance and implications of my study findings. I will answer my research questions and highlight how my results support and differ from previous literature. Furthermore, I will contribute to the literature by proposing a new way of conceptualizing the experiences of foreign-trained women. Lastly, I will provide policy suggestions, discuss the shortcomings of this study and suggest areas for future research.

What are the Experiences of Foreign-trained Women in Medicine?

In reference to my first research question investigating the experiences of foreign-trained women, it is evident that there are many variables affecting the experiences of this demographic. Women's experiences are shaped by their country of origin, timing of their immigration, gender, visible minority status, their specialty, their family circumstances and other variables; thus, theories of intersectionality and the "double disadvantage" were strongly supported (Boyd, 1984; Boyd & Kaida, 2005; Weldon, 2008; Acker, 2006). Participants identified immigrant status as the most significant factor shaping their experiences in the profession. A common theme of having to "prove yourself" emerged. While most respondents did not label their experiences as discriminatory, what they described could be considered systemic discrimination. That is, informal discriminatory practices that have become part of 'the system' (Adams & Welsh, 2008). Many reported they were targeted, highly scrutinized, denied opportunities, had skills discounted, and faced institutional barriers. It is possible that the cultural and gender norms in the participants' home country could have influenced their perceptions of discrimination

(Welsh et al. 2006). On the other hand, similar to women in male dominated professions, it is possible that immigrants in general downplay structural inequality and simply see systemic discrimination as a challenge that can be overcome through hard work (Hinze, 2004; Lawrence & Weinhouse, 1994).

Respondents did not report gender to be particularly significant to their experiences; however, participants suggested that men and women do have different experiences in the medical profession. It appears as though women tend to privilege a work-life balance and choose specialties based on lifestyle choices and family considerations (Gjerberg, 2002; Bourne & Wickler, 1978; Pozner, 1997). Moreover, many women reported that women do tend to have different experiences in the medical profession than men. Although men did not report gender to be significant to their experiences in the Canadian medical profession, this does not necessarily mean gender is insignificant for them. Instead, because men tend to be advantaged by their gender, and do not have the same gendered experiences as women, they may not be as conscious of how it has influenced their experiences.

With regards to experiencing gender inequalities, women seemed to report hardships that were compounded by their other statuses and roles. For example, many women faced difficulties balancing family time and child care with their responsibilities of adapting to a new profession and advancing their career. Moreover, added to these stresses are those associated with immigrant status, such as the systemic discrimination that was reported (Boyd, 1984; Boyd & Kaida, 2005). Thus, for the respondents, gender seemed to be most significant when it intersected with race, family status, and immigrant status to create a unique intersectional experience of disadvantage. Nevertheless, there is

also a selection bias at play, as the participant recruitment was done by voluntary response and women in traditionally female dominated specialties typically have more flexible schedules than those in the traditionally male dominated specialties such as surgery. Perhaps if more women in specialties such as surgery and internal medicine were included in the sample the views of the women would have been different and perhaps less positive.

Women's responses were consistent with previous literature in that women did not overtly identify gender as a problem, even though they mentioned times when it clearly was an issue (Hinze, 2004; Lawrence & Weinhouse, 1994). However, it is notable that some participants expressed ambivalence with regards to whether their disadvantages were a result of gender or immigrant status; providing support for theories of intersectionality (Acker, 2006; Weldon, 2008; Boyd, 1984). Previous literature has shown that women in male dominated professions do not characterize their disadvantages as a 'gender' problem; but simply challenges to "put up with" to advance their career (Demaiter & Adams, 2009). Women in traditionally male dominated professions tend to take on traditional "masculine" characteristics or exhibit personalities that are more authoritative and assertive in nature (Hinze, 1999; Cassell, 1997; Pierce, 1995; Roth, 2004). Thus, it can be difficult for these women to see inequalities, as they have adapted to the norms and culture of the profession; normalizing actions that could be considered discriminatory.

It was also found that region of training influences one's perception of discrimination based on cultural norms of the home country (Welsh et al., 2006). Some participants found the barriers to women in Canada to be significantly less than in their

country of origin. Furthermore, the status of the medical profession in the country of origin, as well as one's comprehension of the English language, influences the extent to which one might experience disadvantage. Not surprisingly those immigrants who came from countries with medical training comparable to Canada's standards had a smoother transition upon arrival in Canada (Houle & Yssaad, 2010; Plante, 2010). Visible minority status also influenced respondent's experiences. Medical doctors who were members of a visible minority tended to report more experiences of disadvantage or discrimination in comparison to others. Although they too downplayed the significance of race, they did express that IMGs (international medical graduates) from certain countries perceived as less developed, were at a greater disadvantage than others from Commonwealth or more highly developed nations.

Despite recalling experiences that could be considered systemic discrimination, most respondents did not suggest what they experienced could be categorized as discriminatory. Instead psychological and personal characteristics of the individual such as resilience, perseverance and work ethic were emphasized. Thus, an individualistic attitude toward success emerged.

Coping Strategies and an Individualistic Attitude Toward Success

Participants reported coping in a number of ways to overcome barriers: focusing on the positive, utilizing education and knowledge, and professional networking. These coping strategies helped but did not overcome barriers. In fact, coping strategies reinforced the individual attitude of attributing any experiences of disadvantage to themselves and not the structure or the individuals within the structure. Thus, although these coping strategies helped respondents overcome hardships in the short term, in the

long run, these coping strategies will continue to perpetuate existing inequalities. By normalizing these experiences of disadvantage and perceiving themselves as the problem (i.e. "I need to work twice as hard", "I need to prove myself"), the real problem surrounding structural inequalities is never addressed. Similar to studies on women in medicine, such as Bourne and Wikler (1978) and Hinze (2004), immigrants define themselves as the problem; not the structure. This individualistic attitude toward success and individualistic work ethic seems to be common among immigrant groups (Shih, 2002). Furthermore, a greater understanding of such attitudes is needed to inform future policies in the medical profession. Since the prevalence of immigrants in the medical profession continues to increase, it is important to gain a better understanding of this individualistic attitude that may be preventing structural changes from occurring. It is clear that this individualistic attitude is not the only dimension of inequality negatively influencing the experiences of these immigrants. However, this finding is significant, as change cannot occur if the voices of foreign-trained professionals are not heard.

What is the Impact of Feminization on the Experiences of Foreign-trained Female Medical Professionals?

In reference to the second research question, does feminization have an impact on the experiences of foreign-trained female medical professionals, the results of this study suggest that the feminization of the Canadian medical profession has impacted the experiences of these foreign-trained women. As Elston (2009) suggests, it is possible that the medical profession may be starting to change from the inside out. With the influx of foreign-trained professionals and more individuals with multiple intersecting identities, it is possible that norms in the profession have changed. This idea also coincides with

Boulis and Jacobs (2008) theory that feminization of the medical profession is a result of broad societal changes such as institutional changes in the health care system as well as social and cultural changes in work, education, and family life. Accordingly, it appears as though the feminization of the profession has led to the greater acceptance of women. With regards to gender, all of the early immigrants in the study noted that great structural changes have occurred over the last few decades and norms regarding women in the profession have changed a great deal. At least for the respondents in this study, the experiences of gender discrimination and harassment as reported in previous studies were nonexistent, although women may still face challenges in combining their medical work with family life. Thus, according to Chiu & Leicht (1999), the feminization of the medical profession appears to be "successful". The main problems for respondents surround their immigration status. Women felt targeted and more highly scrutinized not because of their gender but because they were immigrants. The entry of foreign-trained women into the profession is quite prevalent and it is clear that we cannot examine their experiences with only a gender lens. Immigrant status, race and ethnicity are highly significant to their experiences. Moreover, it is quite likely that the changing demographics in the profession will have an impact on the structure of medicine and the way medicine is practiced; this is an area that requires further investigation. I believe it is possible that eventually the entry of foreign-trained medical professionals (primarily women) will mirror the trend of feminization and the profession will become more accepting to foreign-trained graduates. Furthermore, as more foreign-trained practitioners enter the profession, it is likely that similar to feminization, the norms, structure and policies of the profession will change accordingly.

A New Conceptualization of the Disadvantages Faced by Foreign-trained Women?

It is clear that the experiences of foreign-trained women in the study are consistent with the experiences of professional women and foreign-trained professionals in terms of their experiences of disadvantage. There is strong evidence supporting the "double negative" theory and theories of intersectionality. However, I believe the term "double negative" or "double disadvantage" tends to homogenize the experiences of foreign-trained women. Although this term is not meant to be additive, it implies that one may only experience 2 "layers" (woman, immigrant) of disadvantage when in most cases, the situation is much more complex. Intersectional experiences may not only cause one to experience disadvantage; one may also be intersectionally advantaged. Experiences of disadvantage and advantage can be simultaneous and advantage can shape experiences just as profoundly as disadvantage. Furthermore, there are many other variables that have not been considered in traditional analyses of intersectionality and foreign-trained women such as time period, culture, norms, region, family status etc. Additionally, it is not only significant to consider how these individuals experience inequalities but also why they experience them and what influences their perceptions of discrimination.

In order to improve our conceptualization of foreign-trained women's experiences, I believe we must begin to consider a wider scope of variables. When studying the experiences of immigrant women we must go beyond the traditional conceptualization of "double disadvantage" and intersectionality. That is, we must consider more variables than have been traditionally considered. As the results of this study suggest, multiple variables including gender, family status, race, ethnicity, country of origin, and period of arrival may influence women's experiences in the Canadian

medical profession. Moreover, it can be difficult to tell which variable is the cause of such negative experiences or whether they might be interacting. Each woman's unique situation may cause her to experience challenges that are unique to her identity and incomparable to the experiences of other women. While it is more likely for women who have several "negative" overlapping statuses (i.e. racial minority, immigrant, woman), it may be just as likely that a woman who is traditionally thought to be more advantaged (i.e. a white European woman) to experience similar degrees of disadvantage depending on her situation.

Thus, we cannot take a template approach to conceptualizing the disadvantages of foreign-trained women. Although the exact variables that are causing the disadvantage may be difficult to disentangle, it is important to analyze such experiences with a theoretical approach that takes all possibilities into consideration. When the experiences of foreign-trained females are defined by a "double-negative", we cognitively limit ourselves to only consider the variables "immigrant" and "female". Consequently, since the experiences of each woman truly are unique, considering a wider scope of variables will allow us to study the experiences of immigrant women more effectively than the current notion of "double disadvantage".

Implications for Policy

With regards to immigration policy, it is imperative that the needs of foreign-trained, skilled professionals must be evaluated from an intersectional perspective. By using a new conceptualization of disadvantage that includes a wider scope of variables, the needs of foreign-trained immigrants can be more accurately assessed. Furthermore, improvements to the reaccreditation process can be made.

More specifically, the results of the study suggest immediate improvements could be made with regards to communication process with immigrants and the home country, language comprehension support, as well as support in building professional networks. Respondents suggest more effective communication between Canada and their home countries could have been made with regards to information surrounding the reaccreditation process and what it entails. Moreover, more preparatory programs and support with regards to the development of skills necessary for the Canadian workforce, such as language comprehension, would be helpful. This is one element of the reaccreditation process that proved to be a significant barrier for most participants. Likewise, many respondents had trouble developing a professional network, which can prove to be very helpful when it comes to securing a job or residency position. It would be of great assistance if the government (or the profession) could provide resources to new skilled immigrants with information regarding how they might gain access to the profession before they are fully reaccredited (i.e. observerships, lab assistants, graduate school, etc.). Nevertheless, due to the lack of generalizability of this study, it is difficult to say for sure if this is a common problem for all immigrants, especially since it has been several years since many of the study participants went through the reaccreditation process. In recent years, some changes have been implemented to some extent. For instance, in 2003-2004, the Canadian Government implemented the Foreign Credential Recognition Program to fund and improve various activities regarding the improvement of foreign credential recognition. Additionally, the new tools and information available on the Government of Canada website makes finding skilled worker immigration information more transparent, accessible and easy to understand. Moreover, by providing

more information about the process and job market in different areas of Canada, tools such as this help manage the expectations of skilled immigrants upon their arrival in Canada. The CPSO (College of Physicians and Surgeons of Ontario) has also put forth a number of recommendations fairly recently by way of its Physician Resource Task Force. These recommendations were put forth to address the doctor shortage as well as address barriers to practice for foreign-trained graduates to help ease the transition into the Canadian medical profession (CPSO, 2004). Of the CPSO's 15 recommendations, the Ontario government has supported several which include: creation of a clearing house to assist international medical graduates through the registration/credentialing process; increasing the number of post-graduate training programs; increasing funding for educational infrastructure to support the increase in number of training positions; the establishment of a quality assurance program to province accelerated registration for physicians who are currently in practice in other jurisdictions; establishing a policy to recognize non-family medicine specialists who, while meeting educational and practical criteria, have not received the royal college of physicians and surgeons specialist designation (CPSO, 2004). Despite the significant improvements that such recommendations may have made and will continue to make over the next several years, the experiences of foreign-trained medical professionals gaining access to practice continues to be an area that requires more research in the future.

With regards to policies in the medical profession, it is highly significant that most women in the study reported their immigrant status to be more significant then their gender when it came to classifying their experiences of disadvantage. As mentioned above, this trend might indicate that the medical profession is starting to, or has changed

from the inside out. This finding is significant to professional policies, as more attention must now be devoted to helping the influx of foreign-trained women integrate into the profession. Since norms with regards to gender have appeared to change in medicine, we must now focus on the needs of immigrant women. Again, when doing this it will be important to examine their needs with an intersectional lens to fully understand their issues. Nevertheless, this does not mean to suggest that gender issues should be dispelled as nonexistent. Women in the study tended to privilege family and work-life balance. Furthermore, many decided against initial specialty choices opting for others that were more "family friendly". This suggests the structure of medicine has not completely transformed. It is evident that the structure of the medical profession is still inherently male, as it does not accommodate the unique needs of women. Thus, while great gains in medicine have been made for women, there are still many hurdles that need to be overcome. As a result, this is an area of the profession that could still be improved to accommodate the needs of women. However, more research with a representative sample of women is needed before policy decisions can be made.

Study Limitations

There are several shortcomings of this study that limit the generalizability of the findings to the wider population of foreign-trained female medical professionals. While the qualitative nature of the study allowed for rich, detailed descriptions of the participants' experiences, it must be kept in mind that the main purpose of this research is exploratory. Only 13 individuals practicing in London Ontario are included in the sample; this is not by any means representative of the larger population of foreign-trained medical professionals. Moreover, while participants were randomly chosen and invited to

participate, there is a selection bias as participation was voluntary. The self-selection process could have influenced the results in a few ways. The participants could be outliers; that is, these individuals may have more extreme views or different experiences than the average foreign-trained medical professional. In this case "extreme" might mean some participants may have experienced more hardships than the average foreign-trained professional and may have had the desire to vocalize their opinions. On the other hand, there could have been others that had fewer disadvantages and might want to express their views for the same reasons. It could also be the case that individuals who have experienced explicit discriminatory behaviour may not have wanted to share their stories. Accordingly, it is important to be aware that participants may have had their own motivations for participating. Furthermore, we must consider that their views may not represent the "average" of their population. Those who participated may be particularly passionate about their experiences and related issues of immigration. Thus, these individuals may differ from the wider population of foreign-trained medical professionals in some way.

Another issue regarding the selection bias is that the majority of participants were clustered in traditionally "low status" or "female dominated" specialties. This could be a function of time in the sense that these specialties typically offer more flexibility. Women in traditionally "high status", "male dominated" specialties were contacted but tended not to participate. As mentioned earlier, perhaps if such women were equally represented in the study, different opinions may have been expressed. It is possible that if more women who practiced traditionally male dominated specialties were included, results may have been more consistent with previous studies of women in male dominated professions.

That is, they may have reported more harassment, gender inequalities and exclusionary treatment. Nevertheless, it is clear that despite this, significant results consistent with previous literature did emerge. Moreover, as mentioned earlier, it is possible that the medical profession has changed from the inside out.

In a similar vein, related to immigrant status, we must also consider the fact that many foreign-trained medical professionals enter family medicine because it is the most underserved specialty in Canada. It is also interesting to note that even a couple of the men in the sample practiced family medicine and psychiatry (traditionally female dominated fields). Thus, the cluster of practitioners in so called, "female dominated specialties", is not simply a function of gender but a practical and oftentimes constrained decision for many immigrants who wish to integrate themselves into the profession. It would have been interesting to have the opportunity to examine the experiences of immigrants who were practicing medicine in more "high status" specialties and contrast them to the experiences of immigrants in specialties such as family medicine and psychiatry. Nevertheless, this shortcoming is once again a function of the small sample size, voluntary response, and selection bias.

Also relevant to selection bias, it is significant to note that members of racialized minorities were more difficult to recruit. In fact, most of those included in the sample were purposively selected. As participant recruitment began, the voluntary participation process seemed to be biased toward the response of white Europeans. Thus, it is possible that members of racial minorities were less willing to share their experiences. This may suggest that their experiences may differ in some way and these individuals may be outliers. Additionally, it is notable that all the men in the study were members of ethnic

minority groups. Perhaps if white men had been included, we may have witnessed greater differences with regards to the experiences of disadvantage. Additionally, it may have provided a more appropriate comparison for those white European women in the sample.

Another limitation related to the voluntary response selection bias was the problem of nonresponse. Once participants were randomly selected as part of the sample, there was a very high level of nonresponse. The most likely explanation for this trend is that physicians are simply very busy professionals. As mentioned above, it was no surprise that most participants tended to come from specialties that offer more flexibility such as family medicine. Nevertheless, it is still important to keep in mind that because this study attracted a certain "type" of foreign-trained medical professional, these results may be skewed in some way and are unrepresentative of the larger population of foreign-trained medical professionals. Furthermore, the responses and opinions of the study participants may be different than other foreign-trained medical professionals.

Future Research

As was already mentioned, more research is required to fully understand the complex experiences of disadvantage and advantage faced by foreign-trained professionals (especially women). While I have proposed that the best way to conceptualize the experiences of foreign-trained females is by considering a wider scope of variables, taking into consideration advantage and disadvantage, more research is needed in this area to refine this idea theoretically. Moreover, in order to create a truly theoretically sound concept of foreign-trained females' experiences of disadvantage, research needs to be conducted across different professions. Additionally, more work in the area of immigration and feminization of the medical profession is needed to

understand the structural changes that may take place in the future due to the influx of foreign-trained females. Furthermore, now that we have an understanding of general themes related to the experiences of this demographic, more large-scale representative studies may be conducted on this topic.

The feminization of medicine continues to be a topic that is worthy of investigation. However, now with the entry of large numbers of foreign-trained females into the medical profession, we must examine how this trend is changing the profession. As mentioned earlier, great strides have been made for women in medicine over the past few decades. Despite this, women in medicine still need to strive for greater structural changes. As many previous studies have suggested, the structure of the medical profession still continues to be suited for the life of a man; at least this still appears to hold true for many traditionally male dominated specialties (Acker, 1990; Bourne & Wikler, 1978). Furthermore, it is evident that the entry of foreign-trained women into the medical profession is quite significant. Moreover, we know that immigrant status is very significant to women's experiences of disadvantage. That said, it is theoretically important and practical for policy considerations to examine the issue of feminization further, given the more recent trend of the entry of foreign-trained females. It will be significant to continue to investigate their experiences in the profession as well as the potential changes this trend may bring to the delivery of health care. Thus, in the future it will be important to study the two trends of feminization and immigration hand in hand as they are interrelated.

Methodologically, it is clear that the qualitative and exploratory nature of this study is limited in scope and generalizability. As mentioned above, significant roadblocks

I encountered during the course of this study include nonresponse, selection, and volunteer bias. Since doctors are generally very busy people, it has been difficult to meet with enough individuals to make my research methodologically sound. Furthermore, those doctors that I have been able to interview may differ on some characteristics when compared to those who have chosen not to participate. Particularly, because these participants were "successful" in gaining access to the profession, in the future it would be worthwhile to examine the experiences of those who were unsuccessful or are still attempting to enter the profession. It is clear that based on my results those who are successful are biased with an individual attitude towards success. Since these individuals exhibit a structural blindness, that is they are blind to the many inequalities rooted in the structure of the organization, they continue to reproduce such inequalities by not defining them as such. Thus, in the future it would be of interest of contrast the experiences of successful and unsuccessful foreign medical graduates if true evidence based policy recommendations are to be made.

Additionally, because of the aforementioned biases it has been a challenge to obtain a sample that is representative of all genders, specialties and countries of origin. Nevertheless, now that we have a general understanding of the experiences of foreign-trained female medical professionals, and themes related to their experiences, more generalizable, purposive research can be conducted on this topic. In order to obtain more generalizable results, a more quantitative or mixed methods approach would be desirable. Specifically, in order to build upon existing themes, a short web-based survey could be created and administered to a representative group of foreign-trained medical professionals. Additionally, if a more large-scale quantitative study on foreign-trained

medical professionals could be conducted, it would be worthwhile investigating how different periods of arrival can impact experiences. Specific variables of interest may include the percent of females in the profession at given time period, as well as regulatory standards at that time. By analyzing these variables by classifying international medical graduates into comparative cohorts, we may gain more insight on the factors that influence experiences of disadvantage. Similarly, it may be worthwhile comparing groups of professionals based on their country of origin. This may shed light on how the status of the profession in the home country might affect experiences of foreign-trained medical professionals in Canada. By incorporating such ideas into future research, more effective generalizations can be made about the experiences and professional trajectories of foreign-trained medical professionals. As a result, more accurate predictions and policy related remedies might be proposed. Furthermore, this research can help us gain a better understanding of feminization trends and their implications for professions while shedding some light on the changing significance of gender and ethnicity for employment.

Conclusion

In sum, this study has contributed to the sociological literature by enhancing understanding of the experiences of foreign-trained females in the medical profession and contributed to the understanding of professions, gender and work. Moreover, this research contributed to the sociological literature on feminization by moving beyond the current understanding of feminization, incorporating the added variable of immigration. More practically this research has the potential to inform regulatory bodies and immigration policy, to enhance equality for foreign-trained professionals in Canada. It

was found that immigrant status is highly significant to one's experiences in the medical profession in Canada. This finding is notable, as foreign-trained professionals will play a significant role in the future of the Canadian economy. However, they continue to face a myriad of barriers in comparison to Canadian trained professionals. Based on this study it is evident that there are many variables that influence the experiences of foreign-trained female medical professional; understanding these experiences is essential if we wish to use the skills and knowledge of these foreign professionals to the fullest extent. This is of great importance to the medical profession, as the population of medical professionals in Canada will continue to diversify in the future. More specifically, it appears as though foreign-trained females will have a significant role in the delivery of health care in Canada, and in shaping the future of the Canadian medical profession. Thus, further investigation on this topic will be paramount to maintaining Canada's world-class standing in health care and as well as attracting skilled immigrants and utilizing their knowledge to the greatest potential.

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Appendix A: Ethics Protocol

Appendix B: Interview Questions

- How long have you been practicing?
- What is your specialty?
- What were your motivations for becoming a physician?
- What were your motivations for immigration and subsequent reaccreditation?
- Can you please tell me about the process of immigration and reaccreditation that you went through
- Nature of reaccreditation process
    - What difficulties or barriers accompanied it?
    - Did women experience gender specific barriers?
- Choice of speciality→ how was specialty in Canada determined?
    - Did cost, time, gender, ethnicity, or citizenship status or other factors shape the decision made?
    - What factors shaped specialty choice?
- What is the significance of gender to the profession (in country of origin and Canada?
    - Are there differences between your country of origin and Canada?
- What is your family status? (married, single, children etc.)
    - How does family status combine with gender to shape employment decisions, reaccreditation and practice experiences?
- Practice
    - What type of practice is conducted?
    - Who do you work with?

    - Is it private or hospital based?
    - Do you have employees? (how many?)
    - Does immigrant status, family status, or gender shape practice decisions?
        - Does it shape the type of practice engaged in?
        - Does it shape patient base?
- Have you ever faced discrimination or prejudice from patients, colleagues, administrators, or other professionals?
- Do you face unequal treatment?
    - Any examples
- What types of challenges did you face initially?
    - Have these challenges been worked out?
    - If so how?
    - Are there things that could have been done to prevent these things from happening/remedies?
    - What would you like to see improved in this whole process?
- Do you feel as though you currently face any barriers or challenges stemming from race, ethnicity, gender, and country of training?
    - Society's perceptions/biases?
- What factors do you believe contributed to setting up and maintaining successful practice in Canada?
- All together would you say your experience with immigration/reaccreditation experience has been a positive or negative?
    - Why/why not?

  - Function of ethnicity, race, gender?
- Do you believe gender influences or affects one's outcome in this process in terms of opportunity?
  - Do men and women have different experiences? In terms of experiences of opportunity, disadvantage, discrimination?
- Is there anything else about the immigration/reaccreditation experience you would like to add?

Curriculum Vitae

Vanessa Dolishny

Education

The University of Western Ontario
London, ON

- 2009 - Honours B.A. Psychology/Sociology
- 2012 – Post Graduate Diploma in Public Relations
- 2012 – MA Sociology Candidate

Teaching

The University of Western Ontario

- 2009-2010- Teaching Assistant for Sociology 1021E (first year sociology)

Lashbrook Marketing and Public Relations

- 2012- Develop and delivered media education sessions

Research

Research Interests

- Work, professions, health professions, immigrant integration, work and immigration, inequality at work, work and identity, gender and work, technology and society, media and society

Current Research

- MA thesis: Gender and Foreign-Trained Doctors in Medical Practice

Research Assistant

- Professor Tracey Adams, The University of Western Ontario (2009-2011)