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Navigating otherness and belonging: A comparative case study of IMGs' professional integration in Canada and Sweden

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abstract

This paper explores the *othering* processes and feelings of *belonging* among international medical graduates (IMGs) who seek to practise medicine in Canada and Sweden. Building on the theoretical literature on *othering, belonging,* and the conceptualisation of status dilemmas, we explore how IMGs in Canada and Sweden negotiate their professional identity, how they cope with being *othered* and how they establish a path to *belonging*. Analysing qualitative interviews with 15 Swedish and 67 Canadian immigrant physicians, who are either practising medicine or are in the process of professional integration, we demonstrate that the construction of professional identity among IMGs necessitates constant comparison between the differences and similarities among 'us' – immigrant physicians, and 'them' – local doctors. In this process, one's ethnicity, gender, and professional status are intertwined with the experience of being seen as 'the Other'. We also show that in negotiating their professional status, IMGs actively interpret the meaning of being a Canadian/Swedish physician. We conclude that feelings of belonging to a professional group (Canadian or Swedish) do not seem to be static but rather fluid, ephemeral and changing, depending on the context. Our analysis suggests that more attention should be paid to the social context in which experiences of processes of being *othered* and feeling *belonging* are being constructed and interpreted by people themselves.

Introduction

One of the notable features of the contemporary global health care workforce is its increased mobility. Indeed, the skills of the internationally educated physicians, nurses, and other health professionals make internationally educated health professionals a particularly attractive group of highly skilled migrants.

Like many other high income countries, Canada and Sweden have a long history of offering unfilled positions in medicine to international medical graduates (IMGs). In both countries, roughly 20-25% of practising physicians have been trained abroad (CIHI, 2012; National Board of Health and Welfare, 2010).

Traditionally, IMGs are offered positions in their destination countries in areas that are undesirable to local medical graduates; this can create a sense of social exclusion among IMGs (Bernstein and Shuval, 1998; Bourgeault et al., 2010; Chen et al., 2011). While local health care systems depend on immigrant physicians, the interplay between the ideology of nationalism and racism sets a context in which IMGs must establish their professional status and path to *belonging* to their new nation (Kyriakides and Virdee, 2003). Coming to a new country, IMGs are entering two new cultural worlds – of the local culture of medicine and of a larger society. In both, they must negotiate their sense of self and their social status. In both, they are expected to belong but at the same time they are *othered* by the virtue of the location of their professional training and, in many cases, their ethnicity.

In this paper we examine how IMGs experience *othering* and negotiate their sense of *belonging* while striving for professional integration in Canada and Sweden. Drawing on Anthias' (1998) notion of 'construction of otherness and sameness' and Gilroy's (1997) notion that in every formation of a 'we' (created on the basis of similarities) there is also an excluding 'them' (on the basis of difference), we explore how these notions become prominent in immigrant doctors' stories. We analyse the differences and similarities of the experiences of being othered in two professional contexts, Canada and Sweden. Utilising the sociological literature on othering, this paper focuses on the strategies used by IMGs to cope with being *othered* and establish path to *belonging* to a host professional community.

According to Johnson et al. (2004: 253) 'othering is a process that identifies those that are thought to be different from oneself or the mainstream and it can reinforce and reproduce positions of domination and subordination'. Weis (1995) notes that the experience of *othering* is intrinsically linked to the construction of one's identity. In this paper we treat *othering* as an active process, where the agency of an individual is enacted to establish one's sense of self. *Belonging*, according to Anthias (2006: 21), is 'about experiences of being a part of the social fabric and should not be thought of in exclusively ethnic terms'. In a professional context as the one we explore in this article, *belonging* is also crucial in a literal sense, since you cannot practise as a physician if you do not *belong* to the profession and your credentials have not been recognised. Therefore, *belonging* in this article builds on the conceptualisation given by Anthias (2006), but views

belonging as a performative process where the physicians actively make a space for themselves in 'the social fabric' of the profession. Moreover, we see the social context in which the *othering* and *belonging* are negotiated as shaping the strategies utilised by individuals to construct their sense of self in relation to others (e.g. Bell, 1999).

Analysing how IMGs in Canada and Sweden construct their sense of *belonging* and how this *belonging* is intertwined with the experiences of being *othered* in different health care contexts, allows us to examine the role of different migration policies and culture in shaping the experiences of IMGs in the two countries. Our analysis is based on qualitative interviews with 15 Swedish practising IMGs and 67 Canadian immigrant doctors who at the time of the interview were either in practice or on the way to professional integration. Focusing on two countries with similar proportions of IMGs but different immigration policies and geographic context allows us to examine the universal and context-specific experiences of *othering* and *belonging* in different health care settings. We demonstrate that IMGs actively relate to *othering* processes which seem influenced by the local migration policy context. IMGs also seem to negotiate these processes in social interactions. Our paper contributes to the literature on *othering* by highlighting contextual, subjective and metamorphic nature of this process using the specific case of IMGs; to the literature on IMGs, this analysis contributes a deeper understanding of the social and cultural dimensions of the integration process.

Research on *othering* and IMG integration

Hughes (1945) was one of the first to show *othering* processes among doctors through introducing the concept of 'status dilemmas' – a collision of high and low social positions, which can create contradictions. These insights were derived from Hughes' (1945) examination of the position of African-American physicians, whose racial/ethnic identity and professional status created a tension in racially stratified American society of the 1940s. The racial/ethnic identity, Hughes (1945) suggested, is more of a master status of an individual, but professional identity of a doctor comes with a dominant social position.

The major link between the work of Hughes (1945) and more contemporary approaches to theorising *othering* processes is a recognition of the dynamic relationship between one's agency, the social interactions in which this agency can be exercised, and the constraints of social context, which shapes the 'choices' that individuals make (Anthias, 1998; Bell, 1999). In this framework, *belonging* and *othering* are never fixed; they are achieved through performance and

validated in social interactions (Bell, 1999). Hughes' (1945) analysis reflects the dynamic nature of such processes by showing how African-American doctors resolve their status dilemma in communication with other (white) doctors, patients, and nurses. In each social context, they have to negotiate their social status vis-à-vis social expectations set by the individuals around them.

While Hughes' classic work analysed *othering* process of medical doctors in the context of highly racialised American society of the 1940s, recent research on the experiences of immigrant and visible minority doctors shows that they are still subjected to discrimination and social exclusion in host countries. The tension between one's status as a doctor and one's 'ethnic' status is experienced in communication with patients, colleagues and other members of health care organizations. Work by D. Hughes (1988) in the context of the NHS in the UK showed that the status of an Asian immigrant doctor challenged the respect of nurses for these physicians. Noting similar *othering* processes between immigrant physicians and local nurses in an Irish hospital, Porter (1993) examined how doctors from ethnic minority groups employed various strategies to cope with being *othered*, reaffirming their professional status in communication with nurses. Porter (1993) suggested that contemporary health care settings are characterised by a 'backstage racism', which is expressed in informal settings, such as coffee breaks or professional lounges, and extends to locally trained physicians from minority groups. Overall, this research suggests that *belonging* – both to local community/nation and to the professional group – is not automatically present once doctors receive their medical licence, but has to be constantly accomplished and validated through social interactions (Bell, 1999). The path to *belonging*, however, is constrained by one's ability to choose from the intersecting 'layers' of identities (e.g. one's ethnicity, gender, or professional status) and by power hierarchies which situate the significance of those identity 'layers' in social context (Anthias, 1998). Hence, while the physicians in Porter's (1993) study insist on being perceived as 'doctors', the nurses perceive these physicians as 'immigrants'. The *othering* processes are also situated in a larger cultural context in which the 'immigrant doctor' is denied the same level of competency and respect as locally trained physician.

Research on the *othering* processes between local and foreign trained physicians echoes ethnic and racial tensions. Immigrant physicians often report discrimination at the workplace and in communication with colleagues (Giri, 1998; Huijskens et al., 2010; Neiterman and Bourgeault, 2015). While IMGs are often reluctant to admit to racial tensions experienced in communication with patients (Bourgeault et al., 2010), scholars show that doctors' ethnicity (along with age and gender) can negatively impact patients' perceptions of physician's

competence and skills (Ashton et al., 2003; Betancourt et al., 2005; Cooper et al., 2005; Meeuwesen et al., 2006; Miller et al., 2011).

The literature suggests that physicians from visible minority groups continue to face *othering* processes, although the meaning attached to these processes varies by context and over time. It can be structured around doctor's skin colour (Giri, 1998; Kyriakides and Virdee, 2003), accent and ethnic background (Neiterman and Bourgeault, 2012), religious affiliation (Huijskens et al., 2010), gender (Shah and Ogden, 2006) or foreign training (Cooke et al., 2003; Salmonsson, 2014; Shuval, 2000). Important for this study is that IMGs seem to experience processes of being *othered* and that the *othering* processes seem to be further amplified when these dimensions intersect (Giri, 1998; Huijskens et al., 2010).

Thus, in this paper we focus on the intersection of ethnicity, gender, immigrant background, and professional status examining how IMGs experience *othering* and how they negotiate a sense of *belonging* to their professional group and larger community. Our emphasis in this paper is on immigrant physicians, both 'white' immigrants and members of visible minorities. This adds an additional layer of complexity to establishing the path to *belonging* to the host country and to the professional community while negotiating the meaning of ethnicity and gender in forming professional and social ties in the new country.

Contextual differences and similarities between Canada and Sweden

The migration across nation-states is characterised by complex relations between governments' need to address shortages in labour market and the inherent desire to protect the nations' symbolic boundaries. This uneasy balance is actualised in racist and discriminatory practices employed by countries to 'protect' the national identity by placing restrictions on workers from nations deemed particularly 'undeserving' of entering the country (Miles and Brown, 2004). Both Canada's and Sweden's immigration history are marked by the reliance on foreign workers and racialised ideology identifying 'desirable' and 'undesirable' immigrants (Henry and Tator, 2009; Miles and Brown, 2004). In Canada, the 'undesirable immigrants' over the course of 20th century came to include not only members of visible minority groups (e.g. Asian and Chinese immigrants) but also Eastern European immigrants (Miles and Brown, 2004). In the 1970s, the Canadian government officially adopted the policy of multiculturalism, stressing the importance of diversifying Canadian society through immigration. In the past decades, Asian, South Pacific, and Middle Eastern states were top source countries for new immigrants to Canada (CIC, 2013a). In 2011, approximately 20% of Canadian population was foreign-born and 19% self-identified as

members of visible minority groups. Among the 6,264,800 population of Canadian visible minority groups, over 65% were immigrants (Statistics Canada, 2013).

The majority of Canadian immigrants are highly skilled professionals or economic immigrants who receive permanent residence based on the suitability of their skills and qualifications for the Canadian labour market (Kapur and McHale, 2005). In 2013, it was projected that skilled/economic immigrants will constitute approximately 62% of total immigration, 27% will comprise of family members seeking to reunite with their immediate family living in Canada, and the remaining 11% will be refugees (CIC, 2013b). The official ideology is that immigrants contribute to the economic growth of Canada and fill labour shortages in most understaffed areas (CIC, 2013b). This is particularly true in the case of health care – immigrant health care professionals are routinely recruited to work in Canada, although recently, due to ethical concerns about 'poaching' health care professionals from the global south (McIntosh et al., 2007), the recruitment practices have become somewhat muted.

In Sweden, the majority of newcomers are family unification immigrants and refugees who receive permanent residence based on their need for asylum. Swedish immigration policy today focuses on refugee and asylum seeking migrants but this has not always been the case. In the 1950s and 60s, Sweden had a vast labour migration but it was restricted in the 1970s when immigration policy has focused on refugee immigration. New rules for labour migration were introduced in December 2008, aiming to facilitate recruitment of labour from developing countries. In 2012, 1,5 million people in Sweden were born somewhere else. While about half of these immigrants came from other European countries, 1/3 came from Asia. Iraq is the third most common country of birth for this group (Statistics Sweden, 2012). Marie (2001) suggests that obtaining employment is harder for the members of visible minorities groups than to Swedes and non-visible minorities. Diaz (1993) and Hosseini-Kaladjahi (1997) found that in comparison to Swedes, immigrants had harder time to move upward in the social hierarchy. Refugees and, to a lesser extent, labour migrants, tend to be overqualified for their jobs when compared to Swedes (Hosseini-Kaladjahi, 1997; Ålund and Schierup, 1991; Diaz, 1993). These findings suggest that Sweden is undergoing a segmentation of the labour market along ethnic lines. Immigrants in Sweden are seen more as *people in need*. While the official rhetoric in Canada stresses that immigrants *belong* to Canadian society, in Sweden they are seen as *strangers*. The ideology of multiculturalism and ethnic diversity are usually used to exemplify that Canada can become home to any immigrant, that all cultures are welcomed and celebrated in Canadian society (CIC, 2013b). In Sweden, multiculturalism has not had the same impact on

shaping the Swedish identity, yet the ideology of equality is usually used to exemplify that in Sweden everyone is treated equally (Pred, 2000). Despite these ideological premises, however, immigrants in both Canada and Sweden, and especially members of visible minority groups, still experience racism and discrimination, both institutionally enforced and informally conveyed in interactions with others (Ålund and Schierup, 1991; Henry and Tator, 2009).

Internationally educated health care professionals are not immune to the experiences of racism and discrimination (Bourgeault et al., 2010). While the total physician workforce in Canada has been relatively consistently comprised of about 1/4 IMGs during the past 50 years (CIHI, 2010), the demographic profile of immigrant doctors has changed significantly. In the 1970s IMGs in Canada were predominantly coming from European, English-speaking countries, such as England or Ireland, but their numbers had fallen from 35% to just five percent of total practising IMGs in 2000, and currently physicians' workforce in Canada is much more ethnically diverse and source countries tend to be low to middle income (Bourgeault et al., 2010). This transition can be partially explained by the change in immigration policy, which placed more emphasis on skilled migration and lifted restriction on entrance of visible minorities groups into Canada[1]. It also reflects the changes introduced by professional regulatory bodies to facilitate professional integration of IMGs.

A similar trend in diversity of IMGs can be seen in Sweden where before 1990s most IMGs came from the Nordic countries, but after European Economic Area Agreement came into force in January 1994, The Physician directive[2] as a part of EEA agreement stipulated that any doctor trained within EU borders has the right to practise medicine in other EU-countries. Additional changes to immigration regulations in 2008[3] permitted immigrants from non-EU countries with a work offer to apply for a work permit. Today, most IMGs in Sweden are from European countries, but the change in policy may result in a higher proportion of practicing IMGs coming from developing countries on work visas or as political refugees.

1 Canada's Immigration and Refugee Protection Act (2002) revised the point system used to determine eligibility of an applicant to receive a status of permanent resident in Canada. In the past decade, China, Philippines, and India were three top source countries for immigrants to Canada (CIC, 2013a).

2 Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.

3 Information on the new rules is only in Swedish and can be found at: http://www.regeringen.se/sb/d/9685/a/90346.

Although IMGs both in Canada and Sweden constitute a vital part of the physicians' labour force, they report feelings of alienation and discrimination (Johnson et al., 2004; Neiterman and Bourgeault, 2015; Salmonsson, 2014). IMGs claim that social exclusion and discrimination are formally enforced by the system of credential verification and assessment of professional qualifications and is also practised informally in job interviews, professional training, and interpersonal communication (Bourgeault et al., 2010). The processes of obtaining a medical licence in Canada and Sweden have at least one thing in common – they are very long, complicated bureaucratic processes. In addition to the assessment of education credentials, IMGs need to pass several professional and language proficiency examinations and find residency training in their field. Due to limited number of available residencies, many IMGs are unable to secure the residency training and thus cannot complete all the requirements for professional licensure (Bourgeault et al., 2010). This further exacerbates the feeling of unfairness and social exclusion among IMGs (Neiterman and Bourgeault, 2012). It can be argued, therefore, that IMGs in Canada and Sweden are both welcome and unwelcome. Their professional training becomes a route to belong to the Canadian/Swedish nation. Yet, over the course of professional integration, and also once in practice, their credentials and skills are scrutinised and undervalued (Bourgeault et al., 2010). Immigrant health care professionals are often underemployed and segregated into less lucrative positions within the health sector or outside of it entirely (Boyd and Schellenberg, 2008). IMGs' cultural and ethnic identities are celebrated by contributing to the policy of multiculturalism in Canada and equality in Sweden, but at the same time they experience racism and discrimination in the workplace (Bourgeault et al., 2010).

In this paper, we examine how IMGs in Canada and Sweden construct their sense of *belonging*. Our analysis reveals how this *belonging* is intertwined with notions about *othering* processes in different health care contexts. Comparing the experiences of IMGs from two countries, we show how the experiences of being *othered* are influenced by immigration and professional integration policy processes.

Methodology

This paper is based on a conceptually guided qualitative content analysis of 82 semi-structured interviews conducted with Canadian and Swedish IMGs. The interviews were conducted as part of two separate studies funded by Social Sciences and Humanities Research Council of Canada and by the Department of Sociology at Uppsala University. The Canadian project aimed to explore the experiences of internationally educated doctors, nurses and midwives who

arrived in Canada and included a sub-sample of 67 IMGs. The Swedish project was aimed to explore the experiences of 15 internationally educated medical graduates who worked in Sweden. The differences in sample sizes coincidentally mirror the differences in absolute numbers of IMGs in Canada and Sweden;[4] both reflect the saturation point of the specific research questions in both projects. Both projects examined, among other issues, the barriers and facilitators to professional integration.

Participants were recruited in their respective host countries via advertisements in professional and immigrant associations, local newspapers, and employing snowball sampling. Ethics clearance for the projects was obtained from McMaster University Research Ethics Board and Uppsala Regional Ethical Review Board (Regionala Etikprövningsnämnden, 2010-05-18). The interviews drew upon different interview guides but resulted in similar themes upon independent content analysis; in both cases, interviews lasted approximately 60-90 minutes and were recorded and transcribed verbatim. Semi-structured interview guides focused on IMGs' experiences of immigration and professional integration, barriers and facilitators for obtaining medical licence, and workplace relations.

Canadian IMGs were recruited from the provinces of British Columbia, Manitoba, Ontario, and Quebec. At the time of the interview (2007-2009), they were less than ten years in Canada and were either practising medicine or in the process of obtaining medical license. 35 IMGs in the Canadian sample were female (12 not practising medicine and five practising) and 32 IMGs were male, of which 23 were practising. These IMGs came from Africa (Algeria, Ghana, Nigeria, South Africa), Asia and Pacific (China, Japan, Philippines), Eastern Europe (Bosnia, Bulgaria, Macedonia, Romania, Russia, Serbia), Western Europe (Germany, Italy, Netherlands, Spain, United Kingdom), Middle East (Afghanistan, Iran, Lebanon, Pakistan, Syria), South America (Colombia, Venezuela), and other countries. Most IMGs were married (54 out of 67) and had children (51 out of 67). The majority were skilled/economic immigrants (n=47), 16 came to Canada through family unification programme or as spouses of skilled workers, and four were refugees.

Swedish IMGs were recruited in Stockholm county council or from the region of Västernorrland. A total of 15 interviews were conducted with doctors who came to

4 There are approximately 27,500 doctors practising in Sweden (UEMO, 2013). The data on non-practising IMGs in Sweden is unavailable. In Canada, there are approximately 65,440 practising physicians (CIHI, 2012) and according to some sources, about 1200 IMGs who were not successful in obtaining professional licence (Kamloops, 2013).

Sweden between 2000-2010. The majority of Swedish IMGs came from the Middle East (Iran, Iraq, Jordan, and Syria; n=9), two were from Hungary, and the rest arrived from Cuba, Chile, Somalia and Poland. The sample included four female and 11 male physicians. Ten IMGs were married and the rest were single. All IMGs were licensed to practise and six were undergoing specialty training. The age of participants ranged from 35 to 63 years. All except two had come to Sweden as refugees.

Whereas the Canadian interviews were conducted by three research assistants, the Swedish interviews were conducted and analysed by one individual. The data analysis was conducted by the authors of this paper in three phases. First, Canadian and Swedish datasets were analysed separately and the coding schemes were inductively derived from the data. This stage of analysis revealed general themes in both datasets, including motivation and process of migration, process of professional integration, barriers and facilitators for professional integration, and workplace/social relations. During phase II, both datasets were combined and analysed together, as one large dataset to identify any differences/similarities between the experiences of Canadian and Swedish IMGs. The theme of *othering* was identified during this stage of the analysis. This theme was present in participants' accounts of professional and personal integration, their communication with other Canadians/Swedes in the workplace and in everyday life. During phase III, the theme of *othering* was further developed and the similarities and differences in experiences of being *othered* between and within Canadian and Swedish datasets were identified and analysed. During this phase, we also analysed the relationship between ethnic and gender identity and how it related to the experiences of being *othered*. In what follows, we present our findings.

Findings

Reflecting on the array of identities that an individual can possess Anthias (1998) suggests that it is prudent to see them as permanent layers that can be worn in a different order in various social contexts. Our analysis revealed that ethnicity, gender and professional status were neither fixed nor completely removable in self-presentation of IMGs. All three shaped the experiences of being *othered* and feeling of *belonging* for IMGs but the social context defined which one was used to construct legitimate claims for belonging. IMGs claimed their professional status employing three different strategies for establishing these claims. These strategies were not used exclusively. During the interviews IMGs often described their experiences of entering the local professional contexts using two or more of these strategies to cope with the experiences of being *othered*. The first strategy,

predominantly used by Canadian IMGs who did not yet receive professional recognition, was to emphasise similarities with locally trained doctors. Using this strategy, IMGs utilised their professional status as a master status and defined their sense of *belonging* to professional world via their training in medicine. The second strategy highlighted the sameness of IMGs vis-à-vis local professional group. Employing this strategy, IMGs both in Canada and Sweden used their professional status of an 'international medical graduate' in constructing sameness within their professional group and otherness from locally trained doctors. The third strategy marked the otherness of IMGs from both other international medical graduates and local physicians. Employing this strategy, IMGs saw their ethnic/gender identity as a master status, which defined their sense of *belonging* to the local professional community and Canadian/Swedish society. Below we summarise our findings alongside these three major themes.

Medical doctor as a master status

While the presumed universality of medical training creates the demand for immigrant physicians, medical knowledge and cultural competence of internationally trained doctors are scrutinised during the licensure process (Neiterman and Bourgeault, 2015). Foreign training is evaluated against the local education and practice standards and is often perceived by local physicians as less rigorous and thorough, which leads to formal and informal segregation of IMGs into less desirable positions in the field of medicine (Shuval, 1995, 1998). In this context, IMGs tend to claim their professional competence, seeking to prove that their skills and qualifications match those of locally trained physicians (Remennick and Shtarkshall, 1997).

Our Canadian interviewees, especially those who were still in re-training, often stressed the importance that medicine had for their sense of self. They described medicine as their 'purpose', being a doctor as being 'who they are', and inability to practise medicine as a feeling of being a 'fish out of water'. During the interviews, they defined themselves as first and foremost *physicians*, signifying their professional identity as a focal point for their sense of self. Many IMGs highlighted their rich experience in medicine, their training and qualifications. Commiserating about his inability to receive a medical licence in Canada, one of the respondents, for instance, noted:

> They don't have enough pathologists in Canada... [and] it's really pitiful because I have huge experience, real experience, unique experience. I am a very good forensic pathologist. World-level forensic pathologist... And now unfortunately my huge experience [is lost]. (not practising Canadian IMG from Eastern Europe)

Despite no longer working as a forensic pathologist this study participant continues to define himself as a doctor and cherish his experience of a pathologist. He did not lose his status of a physician – he still sees himself as a doctor – but he feels that the Canadian health care system lost his skills that are not utilised in the field where he is an expert. By not recognising his skills and professional experiences, he seems to feel like his professional experience is being devalued because it was not gained in Canada.

The inability to secure residency training or complete the long array of medical examinations to pass the licensure led many Canadian IMGs to find employment in other field, preferably health-related. What our respondents revealed was that even when they did not practise medicine, they still saw themselves as doctors and often were seen as doctors by others. The quote below from an IMG who is currently working as a nursing coordinator in a long-term care facility describes a typical situation in which immigrant physicians are recognised by people around them as doctors:

> Sometimes they ask me: what do you think the patient has?... Sometimes they'll bring a nurse in for needles and, because they [patients] are old, they have tiny veins, they [nurses] cannot set IVs and the patient needs an IV... So, then they call me and... I cannot do it myself because it's not legal... but I go there and I look for a bigger vein and I tell them... (not practising Canadian IMG from Romania)

The majority of our Canadian respondents secured their permanent residency status as economic immigrants, or skilled workers. The immigration category of a skilled worker places particularly strong significance on the applicant's education, training, and occupation (Kapur and McHale, 2005). Because Canada experiences shortages of physicians in certain rural/remote communities, medical doctors have been listed among the occupations that are in demand; thus medical education and training are being given priority in the assessment of applicants for permanent residency (Bourgeault et al., 2010). Many of our respondents suggested that this creates an illusion that immigrant physicians will have no problem finding a job in Canada. Moreover, for many IMGs seeking to emigrate, Canada became a country of choice because of the perceived shortages of physicians. The status of a medical doctor became a path to *belonging* to the Canadian society – the skills and qualifications of physicians made it possible to receive Canadian permanent residency and the prospects of finding employment in medicine made Canada an attractive country of destination.

In the past few years, the Canadian society has been concerned with what has been termed a 'brain waste' problem – underemployment of highly skilled immigrants who are taking low-skill jobs due to an inability to find employment in their own field (Bourgeault, 2007). Physicians driving taxis or delivering

pizzas had become a symbol of underemployment of immigrant professionals whose qualifications are in demand in the labour market but who remain unlicensed (Bourgeault et al., 2010). Building on this image, many of our Canadian respondents claimed that their professional status should be recognised as valid in Canada. They constructed their sense of self around their professional status and their *belonging* to Canadian society was paved through the ability to practise medicine and to cope with being *othered*. Their foreign training, education, or ethnicity were overshadowed by the master status of a physician – they perceived themselves as doctors and believed that others should perceive them as doctors as well.

While the importance of professional identity for the physician's sense of self has been noted by scholars (Remennick and Shakhar, 2003), our findings demonstrate that immigration policy focus (labour vs. humanitarian focus) may further strengthen the importance of professional status for the sense of self. When an immigrant physician repatriates[5] to another country – as were Israeli Russian physicians studied by Remennick and Shakhar (2003) – or when the doctors are granted citizenship as refugees/family members – as were our Swedish doctors – the status of a doctor is not directly linked to the sense of *belonging* to the new nation. When, however, the status of a physician becomes a focal point for admission into a country – as was the case with the physicians who came to Canada as skilled workers – the very entrance into a country is determined by one's professional skills and qualifications. In this context, one's professional identity seems to become a master status and used as a claim for *belonging*. The denial of professional recognition, on the other hand, results in the perceived exclusion not only from the professional world, but also from the Canadian society. The same tendency was not evident in the interviews with Swedish doctors who came to Sweden as refugee or through a family unification programme and therefore might have been perceived as 'migrants' first and foremost whereas their professional identity became somewhat secondary in the light of the migration policy focus.

IMG as a master status

Our analysis revealed that when IMGs constructed their professional status, they often did so reflecting on their relationship with local physicians. IMGs rarely saw themselves as full members of local doctors' professional group. Scrutiny of

5 Israel adopts the immigration policy of repatriation and accepts immigrants based on their ethnicity – all those who have Jewish ethnic origin are granted Israeli citizenship regardless of their employment status, age, or any other characteristic. The physicians in Remennick's sample are Jewish immigrants who came to Israel from Russia, thus they are referred to as 'Russians'.

medical qualifications during the process of obtaining the licence, requirement to practise under the supervision of locally trained physicians (a condition for receiving full license), and segregation into less lucrative fields contributed to the feeling that IMGs are not considered equal to locally trained physicians. Thus, the vast majority of our interviewees constructed their professional status relying on the perceived *differences* between immigrant doctors and the local professional group. IMGs' sense of sameness was formed around common professional identity shared among immigrant doctors, which also signified their otherness from locally trained physicians. One of the Swedish respondents recalled:

> It is not easy to enter the group [of local doctors]. There is no feeling of belonging with them. There is nothing that unites us except for the fact that we are doctors... [And that] is not enough... there must be something additional that unifies us. Something we can become a team around. It is not medical, it is something else... Thanks to my boss we got a doctor from Eritrea to work for us and when he came we did not need anything... it just clicked... we are both doctors and we are both... refugees... or whatever you call it. We have similar backgrounds and affinity straight away. (Swedish IMG from Somalia)

In this narrative the sense of *belonging* is constructed as an opposite of being a physician and a Swede. According to this respondent, shared professional identity is not enough to claim the sense of sameness with local physicians. He identifies himself as 'the Other' and can only build the sense of shared experience with an immigrant physician from another country, the one that is also positioned as 'the Other'. This IMG is vocal about his non-Swedishness, which signifies him as a refugee. At the same time, he does not desire to share the identity of a Swedish doctor. Instead, he joins the professional diaspora of immigrant physicians, forming a sense of unity with another IMG at his workplace, who is also *othered* by virtue of his foreign credentials and training. Paradoxically, belonging to a professional diaspora also provides access to developing a sense of *belonging* to the local group of physicians. The community of other immigrant doctors becomes a group of reference in which the status of Canadian/Swedish physician could be fostered.

In the case of Canada, we have argued that exclusion from medical community facilitated the emergence of professional diaspora among Canadian IMGs (Neiterman and Bourgeault, 2012). While our respondents indeed felt excluded from the local professional community, they nevertheless did not necessarily develop a sense of professional inferiority. Rather, they saw IMGs as possessing more cultural and professional knowledge, more wisdom, and more skills:

> We [IMGs] have more knowledge than these [Canadian-trained] doctors... We have more knowledge... we are clinical. We use more our clinical skills... (not practising Canadian IMG from Colombia)

> Down there [home country] we don't have [technology]... If you are practising there, you make more use of your brain because when you don't have the facilities to make a diagnosis, your brain is the only place to rely upon. (practicing Canadian IMG from Nigeria)

For these respondents, the skills and abilities of IMGs are placing them *above* locally trained doctors. In both quotes, the respondents build the dichotomy between 'we' – IMGs – and 'they' – the doctors who were trained in Canada. The perceived 'deficiencies' of IMGs' training, such as inexperience with advanced medical technology, are constructed as advantages, something that sharpened the non-technical clinical skills of immigrant doctors. These respondents' sense of *belonging* was formed around their professional identity, that of a doctor, but at the same time, the identity of an IMG, shared among the participants, was also depicting their shared otherness from locally trained doctors.

The sense of distinctiveness of IMGs from locally trained doctors was reinforced in the context of interactions in the workplace. The local medical culture was seen as a derivative of cultural norms of the Canadian/Swedish society and the differences did not only signify professional barriers but also cultural barriers experienced by IMGs:

> If you come from a vertical culture where the doctor decides everything, then you collide both culturally and professionally. Many nurses [in Sweden] are managers and decide a lot over how you work and under what conditions. You just have to accept this. I think it is positive, and when you get that insight, it is good to work in teams... but of course... it 'itches' when a nurse comes and says 'you should do this'... A bit hard. (Swedish IMG from Iraq)

Situated in the professional world of Swedish medical practice, this respondent interprets the professional role of the nurse as the notion of what it means to be 'Swedish'. The cultural norms of Sweden are manifested by the voice of the (female) nurse, telling the (male) doctor what to do. Similar issues were voiced by other Swedish and Canadian IMGs who were trained and worked in more hierarchical workplaces. Navigating through new terrain of interprofessional relations, the IMGs' positionality was negotiated together with gendered professional boundaries at work.

Ethnicity and gender as a master status

In addition to seeing the IMG status as one that unites all immigrant doctors, our respondents also distinguished themselves from the rest of IMGs, identifying how their particular ethnic and gender experiences uniquely impact their workplace relations. The diversity among IMGs was considerable, and although they shared the feeling of collective identity, country of education, ethnicity and gender also played a vital role in how they defined their

professional status. Some of the respondents, for instance, highlighted their education and training as indicative of their (higher) status within the group of immigrant doctors. Others were bitter that IMGs from countries where the educational standards reflect the curriculum of the host country receive preferential treatment in the process of professional integration. Thus, the country of training and education became a marker of one's otherness.

Even more pronounced among IMGs was the feeling that their ethnic and cultural identities mark their otherness from other members of the health care team. One of our Swedish IMGs recalled:

> The other day, at my new workplace, I got a question from a female anaesthesiology nurse. It was about a young man... [who]... needed a KD-catheter... The nurse asked me, 'Should I do it or do you want to do it yourself?'... I said, 'Why do you ask me?'... She said, 'But he is a young man and I am a young woman'... And I said, 'But he is Swedish and you are born in Sweden, it will be no problem, you have no such prejudices'. If the patient had been from another country, then I would have considered it but he was Swedish. (Swedish IMG from Cuba)

In this account, the shared gender between the (male) patient and (male) physician becomes a reason for the (female) nurse's request to attend to the patient. Our respondent, however, highlights the shared Swedish background of the nurse and the patient to construct (ethnic) similarities that should overshadow (gender) differences between the patient and the nurse. Emphasising his status of 'the Other', he delineates the differences between Swedes and non-Swedes as more profound that gender differences among Swedes.

The ethnic identity was seen, simultaneously, as a marker of otherness and as a symbol of *belonging* to one's ethnic group. One of our Canadian respondents said:

> I hope that I can help many people here because here there is a factory... and there are many people from Colombia. These people can't go to the doctor because they don't know the language... There are thousands of people that need my help. (not practising Canadian male IMG from Colombia)

By identifying a group of potential patients who supposedly share similar ethnic backgrounds and have similar language barriers, this doctor seems to see immigrants from Colombia as giving him a specific purpose to fulfil in the Canadian society. His medical training becomes defined as essential for helping fellow Canadians who are not fluent in English. This doctor's ethnic background – the one that *othered* him and makes it harder for him to enter medical profession – seems to be redefined as a path to *belonging* through his ability to offer medical services to the group of Colombian immigrants.

In the narratives of our respondents, the barriers to integration they experienced as a result of their ethnic identity intersected with other structures of inequality. As the literature on intersectionality suggests, hierarchies of inequalities operate simultaneously to shape the experiences of individuals (Hancock, 2007; Nash, 2008). Reflecting on their otherness, IMGs often stressed the interaction of gender and ethnic discrimination. The following quote from an interview with a female Canadian IMG from Lebanon illustrates this:

> I am wearing a scarf. And there is a big reason for that... I had migraine [and] then I start[ed] covering my head... [It is also] a religious and cultural belief I always respected. It is part of my culture... but I mean they [Canadians] are thinking maybe we are radicals... We are just physicians... I have so much bad, bad experiences in Canada. [During the training] I wanted to ask something from my programme director, [Jewish last name]... And then I came to know that... he is a Jewish person. Maybe he is really nice with other candidates but for me he was not. So he gave me zero...

This respondent believes that others perceive her as a Muslim first, signified by wearing traditional Muslim attire for women. Her way of dressing unites her with the group of Middle Eastern immigrants who are often perceived as a cultural or security threat in a North American context. Hence, her attire is used to construct her as 'the Other', while she defines herself as first and foremost a physician, and not a Muslim. At the same time, she interprets her relationship with the programme director as stemming from him being a Jew (as opposed to his status as a doctor). This quote illuminates the intersecting positionalities of religion, gender, profession and appearance that were often present in the accounts of our respondents.

Similarly, gender is a central factor in identifying the positioning of our female participants:

> It's well-known... [that] if a new [immigrant] doctor makes a mistake, it becomes a big issue... My feeling is that one might relate everything to the fact that you come from somewhere else but maybe that is not the whole truth. In anaesthesiology we are as many women as men, for example, but it is well known that it is harder for women than for men... It is a bit strange that it is foremost female nurses that react badly or... discriminate [against] female doctors. (Swedish IMG from Syria)

This respondent talks about two factors that signify her as 'the Other' – her ethnic background and her gender. Her gender, however, can potentially become a route to *belonging* to the community of women in the workplace, marking her sameness with other female health professionals while demarcating her otherness from male anaesthesiologists. While she sees her gender as a route to *belonging*, she admits that for her colleagues her gender is intertwined with her

professional status and her ethnicity, and as such it further labels her as 'the Other'.

What was also evident from the responses of our participants is that the marginal status of women in the medical profession built continuity in the expectations female IMGs had about their prospects of obtaining proper employment in the new country. Explaining her decision to switch from surgical specialty to geriatrics, a Swedish IMG from Chile noted:

> It [geriatrics] is more relaxed... One colleague told me that when I started as a surgeon, 'You will always have to show that you know more than everybody else because you are a girl and that is how it is'. It is the same thing here [in Sweden] because I have a friend who works as a surgeon and he says he feels bad for the girls as they always get the hardest jobs.

This IMG identifies gender as a common denominator between Swedish and non-Swedish women practising medicine. The necessity to 'prove oneself' in the workplace is something that unites *all* female physicians. Gender identity, therefore, seems to become a master status for female physicians as they have to negotiate their position at the workplace and the experiences of being *othered* stemming from gender and ethnic relations.

Discussion

By drawing upon Hughes' (1945) conceptualisation of status dilemma, we showed how IMGs balance the contradictions between their status of a doctor and their status of an immigrant, visible minority or woman. While the identity of a doctor is often perceived as a 'master status' (Remennick and Shakhar, 2003), the contribution of our paper lies in demonstrating that the intersecting identities of IMGs – ethnicity and gender – can at times overshadow professional identity. Drawing upon the theoretical conceptualisation of positionality, Anthias (1998) suggests that the array of social labels, such as gender or ethnicity, may be used by individuals to position themselves in the social context by choosing them as 'layers' that can be put 'on the top' or hidden among other layers. Although she recognises that the social context constrains the ability of individuals to choose among these layers, she does not depict how this actually occurs (Anthias, 1998). Combining Anthias' (1998) framework with Hughes' (1945) conceptualisation of the status dilemmas allowed us to examine how social interactions and the social context shape the performative dynamics of othering and belonging processes.

Three major insights can be derived from our study. First, we want to emphasise that the experiences of being *othered* are not static; they are fluid and dynamic.

The social context can enable the use of strategies by individuals to negotiate the experiences of being *othered*. The negotiation of othering seems to occur through social interactions and hence not only those individuals who are *othered,* but also people around them are actively engaged in negotiating *othering* and *belonging*. Second, while *othering* can be a marginalising experience, it is not a unidirectional process performed by the dominant group (Anthias, 1998; Gilroy, 1997). Our respondents were certainly affected by what they perceived to be discrimination and racism, which signified their otherness from the group of 'white'/local physicians. At the same time, they were actively engaged in constructing their own sense of otherness. This otherness was not perceived as always marking IMGs' marginality; it was also used to demonstrate their sense of superiority over local doctors and to establish *belonging* to the members of the in-group signified by being *othered*. Finally, we suggest that the focus on immigration policies (skilled labour vs. humanitarian) can shape the way in which individuals cope with *othering* processes. When the entrance into the country is granted due to humanitarian reasons, as is the case with the Swedish IMGs, the claims for professional recognition and social inclusion seem to become secondary. When, on the other hand, immigrants are granted permanent residency based on their education and qualifications, as is the case with the majority of the Canadian IMGs (and some other professionals in Canada), the demands for professional recognition and social inclusion can be more prominent. These differences in immigration policy focus could therefore shape the way in which *othering* processes are experienced by immigrants.

Due to the limitations of our data, we were unable to examine how the formation of the ethnically diverse professional group may impact the notion of otherness and *belonging* in relation to larger society. We believe that longitudinal studies may be more equipped to address this question. This can be a promising direction for future research.

Conclusion

This paper examined the experiences of being *othered* and feelings of *belonging* among international medical graduates (IMGs) who strive for professional integration in Canada and Sweden. Building on the theoretical conceptualisation of *othering*, we explored how IMGs in Canada and Sweden negotiate their professional identity and how they cope with experiences of being *othered*. Our analysis revealed that IMGs establish their sense of *belonging* to the new society and to the local professional world of medicine by utilising their professional, ethnic and gender identities. The social context in which IMGs establish their

claims for professional recognition shapes the order in which they present their identities and establish the legitimacy of their claims.

Focusing on contextual differences between the experiences of professional recognition of Canadian and Swedish IMGs, we demonstrated that the context of immigration policies may shape the way IMGs cope with being *othered* in the new country. The impact of immigration policies on the experiences of being *othered* and feeling of *belonging* should be further explored in future research. We believe it will shed additional light on the complex processes of constructing otherness, sameness and belonging.

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