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Professional Integration Experiences of International Medical Graduates in Ireland and Canada

A Doctoral Thesis Submitted to the School of Applied Social Studies, University College Cork

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Dedication

This thesis is dedicated to my father-in-law, late Chief Oye Tinuoye whose exemplary life taught me that with steadfastness and consistency, ones life golas can be achieved. Also, I dedicated this work to my wife, Remi, children: Joshua, Judah, Joanna and Japheth whose lives are a burning blaze to my heart. Lastly, I dedicate this work to all migrants who constantly have to fight for cultural, economic, political and social inclusion in the countries they have adopted as home. I say, "Aluta Continua, Victoria Acerta"!

Abstract

International migration of health professionals, specifically, doctors, especially from the technologically developing countries to developing ones is a phenomenon that is has received considerable attention from researchers, media and policy makers in the lately. This form of migration has sparked many questions both in the academia and world of policy making. It has been examined from the supply side and demand side. Many researchers documented the vacuum migration of doctors from developing countries creates both in terms of shortage of doctors to the subsequent effect on the healthcare provisions and developments of such nations. Other researchers have documented the immense contributions of migrant doctors to the healthcare provision and development of their host countries. Although, an aspect of doctor's migration researched on and written is their migration from their native countries or countries of training, especially in Ireland, very little has been written on the integration of migrant doctors into the medical professional field or benchmarking their professional integration experiences with other countries that received large numbers of migrant doctors. Thus, this thesis asked the question, are our international medical graduates integrated into the medical professional field in Ireland. To answer this quest, an exploratory study of the professional integration of non-EU/EEA/Western trained doctors in Ireland was carried out. It then benchmarked their experiences with non-EU/EEA/Western medical professionals in Canada. It conducted both face-to-face and telephone interviews with 48 doctors and employer representatives. Using content analysis to analyse data gathered, the study found out that Ireland and Canada receive doctors from outside of the EU/EEA, however, they maintain systems that makes accessing and progressing arduous for doctors trained in specific geographical locations. Also, many doctors from outside of the EU/EEA are preferred to fill up positions that are hard to fill within the health systems of both countries. The thesis concluded on the note that even though, there are policies that aim at fair access and inclusion of minority ethnic groups, race, class and gender remain a basis for professional exclusion within the field of medicine in Ireland and Canada. To overcome this challenge for migrant doctors, the laws governing registration of these doctors must be changed. In-terms of monitoring and implementing inclusion policies and practices for the medical professions in the two countries, there must be proper mechanism put in place and adhered to.

Glossary of Terms

Act	An Act is a bill which has passed through the various legislative steps required for it and which has become law.
African	An African is a person who were born in Africa or live in Africa or trace their ancestry to indigenous inhabitants of Africa.
Androcentricism	A view dominated by or emphasizing masculine interests or a masculine point of view.
Asian	Asian is a person who was born or lived or descended from Asia.
Asylum seekers	Persons seeking to be recognised as convention refugees under the Geneva Convention 1951
Capitalism	An economic system in which investment in and ownership of the means of production, distribution, and exchange of wealth is made and maintained chiefly by private individuals or corporations, especially as contrasted to cooperatively or state-owned means of wealth.
Carer	An individual who is looking after a person who needs support because of age, disability or illness (including mental illness).
Class	Refers to differences based on wealth, income, occupation, status, group identification, level of consumption, and family background.
Colonisation	To illegally and forcefully occupy other people's land, dominate them and send people to live there.
Commodification	To turn something with hitherto an intrinsic value into a commodity for the purpose of selling it for profit.
Commonwealth	A voluntary association of 52 independent and sovereign states. Most are former British colonies or dependencies of these colonies. No one government in the Commonwealth exercises power over the others as is the case in a political union
Credential	Testimonials or certified documents showing that a person is entitled to credit or has a right to exercise official power or perform a job.
Cultural capital	Refers to high cultural knowledge that ultimately redounds to the owner's financial and social advantage.
Culture	The sum total of ideas, customs, practices and social behaviour of a particular profession within the society
Discrimination	The less favourable treatment of one person over another.
Ethnicity	Cultural practices and outlooks that distinguish a given community of people
Exclusion	When a group of people are effectively prevented from participating in the benefit of citizenship or membership of society owing to a number of barriers
Gender	Refers to the varied and complex arrangements between men and women, encompassing the organization of reproduction, the sexual divisions of labour and cultural definitions of femininity and masculinity.

Global Care Chain	Women supplying their own care labour while consuming other women's care labour. This can be paid or unpaid.
Globalisation	Globalisation is the term used to describe the increasing political, social and economic inter-connection of people and countries internationally.
God-father	A man who informally acts as an advisor or mentor to another person in a workplace.
Immigrants	People who permanently or semi-permanently take up residence in another country.
Integration	Integration refers to the ability of a person to participate fully in all aspect of the life of a community where they live.
Interpretivism	Interpretivism refers to the research paradigm which sees social research as not just gathering of facts and measurement of the frequency or pattern of certain occurrence(s), but the appreciation of different constructions and meanings that people place upon their experiences.
Legislation	A law or set of laws suggested by a government and made official by a parliament of a country.
Marginalisation	The process of being excluded.
Medicalisation	Medicalisation is the process by which human conditions and problems come to be defined and treated as medical conditions, and thus become the subject of medical study, diagnosis, prevention, or treatment.
Methodology	Methodology refers to a system of methods used in a area of study or activity.
Migration	Migration refers to the movement of people to a new area or country to find work or better living conditions.
Multiculturalism	Multiculturalism is a model of integration that attempts to achieve co-existence of differing cultures in the same society, with core shared values
Occupation	An occupation refers to a person's work or business through which he earns salary.
Patriarchy	A system of society or government in which men hold the power and women are largely excluded from it.
Patronage	Patronage is the power to appoint to office or grant other favours to someone.
Positivism	Is a research paradigm that seeks to create knowledge via the natural science model of collecting facts about social world and then building up these facts in a chain of causality to explain social reality
Post-modernism	Post-modernism is a research paradigm that aims at digging beneath and exposing the forces of history that restrict human freedom and the ideological justification of those forces.
Profession	A profession is an occupation that requires special education, training, or skills.

Qualification	Qualification is a credential attesting to the qualification for an achievement.
Race	Race can mean the grouping together of people with the same physical and cultural characteristics.
Racism	Racism is any theory which involves the claim that racial or ethnic groups are inherently superior or inferior, thus implying that some would be entitled to dominate or eliminate others, presumed to be inferior, or which bases value judgements on racial differentiation, has no scientific foundation and is contrary to the moral and ethical principles of humanity.
Refugees	Persons recognised as being refugees under the criteria set down in the 1951 Geneva Convention relating to the Status of Refugees
Skilled migration	Skilled migration refers to movement of people in occupations that are most valued in monetary terms and are consequently often also designated as highly skilled, rather than just ordinarily skilled, such as teaching across national territories or intra-nationally.
Social capital	Social capital is defined as the process by which social collectives seek to maximize rewards by restricting access to resources and opportunities to a limited circle of eligible.
Social closure	This is the process of subordination within a hierarchy, in which a group closes off opportunities to another group of outsiders beneath it which it defines as inferior and ineligible.
Social network	Social network is the sum of the resources, actual or virtual, that accrue to an individual or a group by virtue of possessing a durable network of, more or less, institutionalized relationships of mutual acquaintance and recognition.
Sponsorship	A process of a more experienced, sometime older colleague nominating or supporting a protégé's promotion.

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What is significant with the increase in international migration of IEHPs is their new pattern of migration. Previously, shortages of health workers in traditional immigrant receiving societies such as Australia, Canada, New Zealand and the USA were usually filled by doctors and nurses trained in Ireland and the UK. Conversely, this trend changed in the last two decades because of the decline in the movement of doctors from most of these traditional Western European source countries. Presently, existing available data indicates a significant increase in the volume of IEHPs from countries of the 'global south' to the healthcare sectors of core industrial countries of the 'global north'. Migration of IMGs to Ireland and Canada 24

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Introduction

What are the professional integration experiences of International Medical Graduates within the profession of medicine in Ireland and Canada? An international medical gradtuate, here and after referred to as an IMG is a physician who graduated from a medical school outside of the country where they are practicing or intends to practice.

It is no longer hearsay that globalisation, together with unprecedented advancement in communication technology, has given non-EU/Western workers more opportunities than before to compete in the global job market, emigrate and take up jobs in technologically advanced Western countries. However, this transnational movement of migrants is not without its tensions. Tensions such as the pathologisation of migrants, discrimination and exploitation of migrant workers and pushing of migrants to the margins of the labour markets of host countries have become common occurrences. These tensions most often result in the inability of many migrant workers to successfully integrate into the labour market of their host countries or participate fully in their chosen professions. For example, in Ireland, Kolawole (2009) examined workplace inclusion of ethnic minorities in Ireland using An Post[1], as a case study. He found that barriers to the integration and progression of migrant employees in the workplace can be due to lack of: mentors, access to powerful informal networks, effective communications methodology and efficient mechanisms to implement and monitor equality policies and diversity management initiatives. Beside the findings of Kolawole, recent research in Ireland on migrants and labour market also confirms that migrant workers are not integrating into the Irish workplaces when compared with their Irish counterparts. Barrett and McCarthy (2007) stated there is an 'occupational gap' between natives and migrant workers (p. 791). Other researchers such as Crowley (2011); McGinnity et al. (2009); Coakley and MacEinri (2007) MRCI (2006) argued that migrants occupy a weak labour market position when compared with their native counterparts. Furthermore, migrants are found, on average, to earn 19% less than Irish nationals with non-improvement to this occupational disadvantage even after 5 to 10 years of residence in Ireland (Barrett and Duffy, 2008). Migrant workers are found to face higher risks of unemployment, are less likely to secure higher level occupations, are under-represented in managerial jobs and over-represented in lower level jobs (O'Connell and McGinnity, 2008).

In Canada, research reveals that recent migrants to Canada experience labour market disadvantages, and that substantial discrimination against applicants with foreign names exists (Oreopoulos, 2009). More so, researchers have argued that devaluation, and lack of recognition of foreign qualifications and

[1] An Post is the semi-sate owned major commercial organisation providing a wide range of services which encompass postal, communication, retail and financial services in Ireland.

labour market discrimination against migrants all contribute to the inability of migrants to integrate into the Canadian labour market (Bauder, 2003; Li, 2003, 2001; Pendakur, 2000 and Pendakur and Pendakur, 1998).

In the healthcare sector, the medicalisation of Irish and Canadian societies, like other western societies, the ageing population structure and an inability to train and retain sufficient numbers of health professionals (Bidwell, et al., 2012; Bourgeault et al., 2010) has led to the continued drive for the recruitment of Internationally Educated Healthcare Professionals (IEHPs). Thus, Ireland and Canada, in healthcare, have relied on the recruitment of International Medical Graduates IMGs), a category of IEHP. Canada relies on IMGs especially, in some provinces, such as Saskatchewan and Manitoba, where the percentage of IMGs are respectfully, more than 50% and 40% of the total number of practicing physicians (CMA, 2013). In Ireland, recent statistics reveals that the numbers of IMGs practicing in Ireland are at 35% (Medical Council, 2015). This reliance on foreign-trained medical graduates in Ireland and Canada requires us to ask if these healthcare professionals are integrating into their professional fields. In the context of this study, professional integration refers to the abilities of IMGs to participate fully in all professional, occupational and workplace activities which advance progression within medical professional practice in Ireland and Canada. Even though there are quite several studies in Canada that tried to investigate this question, in Ireland, this area of academic study is still under-researched. For example, in Ireland, Yeates (2009) and MRCI (2004) suggested that migrant women experience discrimination and racism in the care industry. As for the IMGs, it was argued that they experience unfavourable employment conditions when compared with their Irish counterparts (Bidwell et al., 2013, 2014; Altaf, 2008; Birchard, 2001).

Similarly, in Canada, studies within the health provision sector found that non-Western nurses, especially those of Asian and African origin, often encounter workplace racism and discrimination (see Das Gupta, 2009, 2007, 1996; Etowa, 2005; Hagey et al., 2001 Calliste, 1996; Giri, 1998). Furthermore, a report on experiences of newcomer IEHPs revealed that despite the heterogeneity of the group, they regularly experience remarkably similar processes of struggling to become licensed, exclusion from other members of their profession, and reported discrimination in their new workplace (Bourgeault et al, 2010).

Currently, in this academic field, there is an understanding that the professional experiences of IMGs within medicine in both Ireland and Canada are not favourable when their access to practice and outcome are compared with those of their locally trained counterparts. However, in Ireland, there is a dearth of social analysis of these experiences to identify the factors responsible and to inform policies that can have the potential to enable effective integration of this category of migrants in Ireland and Canada. Therefore, the overall aim of this study is to find out how well IMGs are professionally

integrated into the profession of medicine in Ireland and Canada. In other words, this study aims to find out the perceptions of a sample of IMGs in Ireland and Canada about the structure of access and progression and processes put in place to maintain this structure. Furthermore, it asks if the experiences of IMGs of these processes compare favourably with those of their locally trained counterparts in Ireland and Canada.

It is important to note here that even though, this study is not a class analysis of IMGs and the practice within the medical profession in Ireland and Canada, it does refer to it to make sense of some of the processes of professional access and progression within it.

It is important to state at this juncture that this study is situated within the context of labour market integration processes and experiences of migrants, with specific focus on IMGs in Ireland and Canada.

Why benchmark Ireland against Canada?

Even though Canada is historically and contextually different to Ireland, it was chosen because of both the differences and its perceived socio-economic and cultural similarities. Both Ireland and Canada were under British rule for a prolonged period. Both countries have, and continue to attract, heavy foreign direct investment from multinationals. Additionally, Canada's dependence on foreign labour to satisfy labour shortages created by a burgeoning economy compares with the labour shortage created by the more recent neo-liberal, globalised capitalist economy in Ireland. Like Canada, Ireland relies on foreign-trained health workers to sustain its citizens healthcare needs, especially in the remote rural areas. Also, both countries have universal healthcare systems, even though it is different in implementation.

It is also important to point out the roles and relationships of different actors and the role of migration policicies in both countries play. Ireland is comparable to Canada in certain aspects and incomparable in other. For example, they are comparable in the area of licensure policy and impcomaparable in the area of immigration policy. In Canada, like Ireland, professional organisations, training bodies and government play significant roles in shaping immigration policies to favour the filling of gaps that could not be filled by local doctors. As a result, immigration and licensure policies reflect the influence of these actors. This is further discussed in Page 38-42.

They are both similar also in that they are technologically advanced and the healthcare sectors have benefitted immensely from recent technological innovations which has increased the quality of healthcare available to citizens. Furthermore, both countries have equality legislations which are supposed to guide employment processes and practices.

However, both countries are incomparable in the area of formulating a national policy of licensure because licensure policies in Canada which is provincially controlled. This is different from that of Ireland which is controlled nationally. The diffrences are further explored in Page 46-56.

Nevertheless, the comparison is important in this study because Canada has a long history of immigration, a formal policy of multiculturalism and a large body of research into this field which could benefit Ireland.

Why the Healthcare Provision Sector?

It is mainly delivered by the public sector, which is obliged to implement employment equality legislation.

The global shortage of workers within the health industry might lead one to assume that there will be an optimal integration of these IMGs into their workplaces. In other words, the healthcare sectors in Ireland and Canada can be conceptualised as potential examples of best practice.

To gain the kind of insight this study aims to gain, it asked a specific meta-question. That is, what are the professional integration experiences of IMGs of processes and practices of access and progression within medicine in Ireland and Canada? This meta-question generated following sub-questions:

1. What are the processes shaping access into and progress within medicine in Ireland and Canada?
2. What are the experiences of access to professional practice by IMGs?
3. What are the in-practice experiences of IMGs?
4. What are the perceived challenges and barriers to access and progress for IMGs?
5. How are these barriers produced and sustained?
6. How can these barriers be surmounted?

To effectively achieve the aim of this research and answer these questions, the following objectives were set and reached:

1. Conducted a review of existing literature on this topic in Ireland and Canada.

2. Identified appropriate theories through which data will be interpreted.

3. Gathered data by interviewing IMGs and representatives of other stakeholders such as healthcare employers, professional organisations and training institutions through face-to-face, telephone or Voice over Internet Protocol (VoIP) calls.

4. Conducted documentary analysis of available literature on medical councils' websites, and media coverages of issues relating to IMGs in Ireland and Canada.

5. Carried out a critical analysis of data gathered to find out whether IMGs are integrated professionally and, if they are not, identified factors impeding their inability to integrate.

At the heart of this study is the desire to inform the development of tools and resources to support the participation and full integration of foreign-trained medical professionals into the Irish and Canadian health industries and to add to existing knowledge of labour market integration of migrants in both Ireland and Canada.

Therefore, to achieve the aim of this study initially, a literature review was conducted. This was followed by the identification and gaining a good understanding of a theoretical framework which would serve as a lens through which the experiences of interviewees would be interpreted. Following this was the identification of a research methodology which was aimed at aiding an effective data gathering and analysis processes. This data gathering included the identification and carrying out face-to-face and telephone interview with forty-seven interviewees in Ireland and Canada. These interviewees included forty-five IMGs and two health care employer representatives.

This work is presented in nine chapters in addition to the conclusion and recommendations. Chapter One, titled: 'Migration and Integration of Internationally Educated Healthcare Professionals: A review of Literature on Medical Graduates (IMGs) in Ireland and Canada', through a review of existing literature on IMGs in Ireland and Canada, offers broad insight into the political economy of the migration of IEHPs, and particularly, IMGs. Secondly, it tries to understand patterns and forms of migration of IMGs, and the extent to which their professional experiences are shaped by initial patterns of migration. Lastly, it seeks to review existing literature on the professional and workplace integration experiences of IMGs in Ireland and Canada. It concludes by acknowledging the presence of sufficient literature on IMGs and their professional integration experiences in Canada, but identified an insufficient literature in Ireland. More so, it identifies that studies that engaged in critical analysis and interpretation of the experiences of IMGs in both countries, including the analysis of the professional policies and practices that either exclude or include IMGs within medicine in the contexts of both countries, are not in abundance.

Chapter Two, titled: 'Professionalisation, Social Closure and the Medical Profession: Experiences of International Medical Graduates in Ireland and Canada', discusses all concepts and theoretical tools used in this study. It analyses, describes and critiques the concept of the profession as initially conceptualised by Max Weber (1978) and later developed by Frank Parkin (1979) and its operational strategies. Then, it proceeds to situate occupational areas within professions historically and the social conditions that prevail in those occupational areas. Following this is the description of the concept of social closure as conceptualised by Weber (1978) and Murphy (1988). This is followed by a discussion of the concepts of 'difference' and 'otherness' and how these concepts are constructed, articulated and utilised as the basis for professional closure within professional spheres. Furthermore, it lays emphasis on how markers of difference such as race, class and gender serve as axes upon which professional

closure rests.

Chapter Three, titled: 'Interpretative Sociology as a Methodology and Professional Integration of International Medical Graduates in Ireland and Canada', discusses the background to this study, the methods employed to address the research problem, techniques employed to collect and analyse data and the rationality behind the choice of methodology, the critiques of the chosen methodology and how these methodological shortcomings are dealt with.

Chapter four to Chapter Nine present the findings of this study. Chapter Four is titled: 'IMGs and the Medical Profession in Ireland and Canada: A Structure of Access, Progression and Outcome'. This chapter presents a clear picture of the medical professional structure in Ireland and Canada. It discusses the structure of medical training in the countries, the access and outcome realities of IMGs and the role traditional professional structures and practices play in shaping the professional experiences of IMGs in both countries. It does this by discussing the origins and early development of medical professions in Ireland and Canada. It also compares access routes to practice and pathways of progression for IMGs and local medical graduates, and includes a statistical breakdown, according to division registration and specialty, of IMGs in Ireland and Canada.

Chapter Five titled: 'Professional Cultures and Strategies of Exclusion and Inclusion within the Irish and Canadian Medical Profession', identifies and discusses closure strategies utilised within the medical professions of Ireland and Canada. It presents and discusses, from the perspectives of the interviewees, the prevailing professional cultures within medicine in relation to access into and promotion within medicine. It discusses how these professional cultures may serve as strategies of inclusion for the members of the insider group and exclusion of members perceived to belong to the outsider group.

Chapter Six, titled: 'Social Closure: A Strategy of Inclusion and Exclusion in the Irish and Canadian Medical Professions, presents a discourse on how social closure is used as a strategy to exclude members of the medical profession perceived to belong to the outsider group. This is done firstly, via analysis of some aspects of the experiences of IMGs within medicine in both countries through the lens of social closure. It also looks at how social identities such as ethnicity, gender, class and country of medical graduation are utilised to differentiate 'insiders' from 'outsiders'. Lastly, it examines and discusses how access and promotional opportunities are granted or denied to social groups based on differentiation and otherness within medicine in Ireland and Canada.

Chapter Seven, titled: 'Credentialism and social closure: The case of Irish and Canadian Medical Profession', presents an examination of credentialism, in the form of recognition of qualifications and certification and how they impact on access into and progression within medical practice for IMGs in Ireland and Canada. It further specifically scrutinises how possession of foreign qualifications from certain countries forms the basis of disadvantage when it comes to access to specific occupational

positions within the medical profession in both countries.

In Chapter Eight, titled: 'Informal Social Networks, Sponsorship and Patronage as forms of Professional Closure: The Case of Irish and Canadian Medical Professions', I discuss the role access to informal social networks, sponsorship and patronage of senior and eminent members of these networks, plays in relation to the professional integration of International Medical Graduates (IMGs) into the medical professions of Ireland and Canada. To effectively do this, I pay a particular attention to how access to informal social networks, sponsorship and patronage can be utilised as closure strategies from the perceptions of interviewees.

Having understood the role played by informal social networks, sponsorship and patronage within medicine in Ireland and Canada, other concepts, such as, race, class and gender were examined to find out if, and how, they help shape the integration experiences o IMGs into medicine. As a result, Chapter Nine titled: 'The Impacts of Race, Class and Gender on the Experiences of IMGs in Medicine in Ireland and Canada' is devoted to discussing the concepts of race, class and gender as the axes upon which differences and otherness rotates and their impact on everyday professional experiences of IMGs. It then goes on to present the perceptions of IMGs on how they perceive race, class and gender in shaping their professional experience.

Finally, the thesis concludes that evidence from the research suggests that IMGs in Ireland and Canada occupy a disadvantaged position within the profession because there appears to be a kind of closure around the profession. However, the response of both countries to these professional barriers differs. Canada, seems to have been able to overcome in-practice barriers, but still struggles with barriers at entrance to the profession. As a result, there is an enormous barrier in accessing practice for IMGs in Canada, but as soon as they are able, they fair like everyone else. Contrastingly, in Ireland, the barriers seem to be prevalent at both access, depending on the kind of medical post involved, and progression levels. It is nearly impossible for IMGs to access training posts (explained in detail in Chapter Seven), while it is relatively easy to access service posts.

Chapter One

Migration and Integration of Internationally Educated Healthcare Professionals: A review of Literature on Medical Graduates in Ireland and Canada

Introduction

The purpose of this chapter is firstly, to gain a broad insight into the political economy of the migration of Internationally Educated Healthcare Professionals, and particularly, International Medical Graduates. Secondly, it tries to understand patterns and forms of migration of the IMGs, and the extent to which their professional experiences are shaped by initial patterns of migration. Lastly, it seeks to review existing literature on the professional and workplace integration experiences of IMGs in Ireland and Canada. Integration, in this context, refers to abilities of IEHPs to participate fully in all professional, occupational and workplace activities which advance progression within medical professional practice in Ireland and Canada. This definition will form the framework of research on the dynamics of integration of IMGs into the professional medical sphere in Ireland and Canada.

This chapter begins by presenting a comprehensive overview global migration of IEHPs. It then proceeds to review existing literature on IMGs' migration more particularly. This is done through analyses of factors that are purported to influence the demand for IMGs in the 'global north'; supply of IMGs from the 'global south' and the current pattern of international migration of IMGs. The 'global north' refers to the 57 countries with high Western education. Most, but not all, of these countries are in the Northern Hemisphere (UNDP, 2005). The 'global south' refers to countries, most of which are in the Southern Hemisphere. It includes both countries with medium education and low education (UNDP, 2005).

In addition, this chapter goes on to review literature on experiences of professional integration by IMGs in the medical spheres in Ireland and Canada, and strategies of inclusion and exclusion utilised within the medical profession in both countries and coping strategies of IMGs.

In an attempt to quantify trends and the scale of current migration of IMGs into Ireland and Canada from outside the European Union (EU) and US in Canada, this section presents national statistics on work visas issued and doctors' registrations with the Medical Councils in Ireland and Canada. The section also acknowledges the deficiencies in the available Irish data in relation to occupational distribution of IMGs. It concludes with a review of existing literature on the professional integration of IMGs into medical professional spheres in Ireland and Canada, highlighting the gaps that exist in Ireland and the lacunae the overall project aims to fill.

IEHPs Migration: An Overview

For the purpose of this study, health professionals are defined as people engaged in actions whose primary intent is to enhance health (WHO, 2010). Health professionals are referred to as internationally-trained when they migrate and engage in primary health care practice in a country other than their country of origin or training. The international migration of healthcare professionals is not a new phenomenon. In post WWII England, nurses were brought in from the Caribbean to work in the newly established and understaffed National Health Service (NHS). Even though the precise figure is hard to ascertain, it is believed that from about the mid-1960s, the NHS became heavily dependent on non-British and non-Irish doctors. Prior to this period, the British health service was partly reliant on Irish doctors and nurses. For example, by 1966, 8,785 doctors from the global south were working in Britain. Of these doctors, 70% were from the Indian sub-continent (Wright et al. 2008). A review of migration policies in most Western countries during the mid-1960s acknowledged the need to focus on immigration of highly trained professionals to, at least partially, solve national health worker shortages. It also suggested how to facilitate migration of these professionals. Subsequently, policies were formulated across several countries to facilitate the migration of hundreds of thousands of healthcare workers from the 'global south' to the 'global north'. The United States alone was said to have accepted over 60,000 foreign-medical graduates (FMGs) between 1963 and 1979 (Shuval and Bernstein, 1997). Canada admitted 12,000 IMGs between 1961 and 1975 (Choy, 2003), and between 1966 and 1974, Great Britain licensed 12,640 foreign-trained doctors, excluding doctors from the Republic of Ireland (Maynard, 1974). As far back as the 1970s, researchers, such as Stevens et al (1972, 1974), conducted research and published academic papers on international medical graduates in the USA. Mejia (1978) in a study of doctors and nurses' migration to the USA, emphasised adverse effects of increased health worker migration on sending countries, especially poor ones. He decried the lack of reliable migration data and highlighted its implications for workforce planning in the USA.

Today, for several reasons, international migration of health workers persists at an unprecedented scale. Core amongst these reasons are:

Medicalisation of western societies, ageing population structures of particular western societies and an inability to train and retain sufficient numbers of health professionals (Bidwell, et al., 2012) within the healthcare sectors of many countries of the 'global north'.

Unfavourable economic, political and educational conditions in sending societies (Hagopian et al., 2005; Syed et al., 2008).

IEHPs are argued to be responding to opportunities created by expanding industrialisation, globalisation, unprecedented advancement in communication technology and cheaper costs of transportation (Hatton and Williamson, 2005, MacÉinri, 2003). This argument is validated by the

commonality of migrants in this category crossing international borders to take up professional work in a country other than their countries of origin or training (Mac Éinri, 2003).

As a result, international migration and integration of foreign trained healthcare professionals are beginning to receive some attention from academics and policy makers globally. In the last two decades, IMGs in immigrant receiving societies such as the USA, UK and Canada have received significant attention from several researchers *vis-a-vis* the how, why and forms of their migration and in some instances, their integration into the host society professionally, socially, culturally and politically. In contrast, in Ireland, this area remains significantly and relatively under-researched. The dearth of research in this area in Ireland might be because of assumptions that:

Since the expertise of this category of migrant workers is generally perceived as needed, there would be an optimal integration of them into their professions. In order words, their employers' employment practices might be expected to be examples of best practices.

The healthcare provision in Ireland, like that of most technologically advanced western countries is mainly delivered in the public sectors. Since the government makes laws, it is assumed that public sector organisations will obey them. Hence, there might be an assumption that the professional experiences of these migrants would be positive.

Consequently, to gain an insight into the migration dynamics of IEHPs, their experiences of professional inclusion and career trajectories, it is necessary to examine their existing migratory patterns and trends, the factors that push them from their home countries, those that pull them to their destination countries and factors that impact on their professional inclusion or exclusion.

Present Trends and Patterns of IEHPs' Migration

The acute shortage of healthcare workers is currently receiving both global and country-specific acknowledgement. For example, in 2010, the World Health Organisation (WHO) estimated a global shortage of 4.3 million health workers globally (WHO, 2010). Likewise, the European Commission (EC) (2011), forecasted that the EU will face a shortage of 1 million health professionals by 2020, if existing workforce problems are not addressed. Locally in Ireland, it is anticipated that, if as projected, GP consultation hours increase by 12% overall, Ireland would face an estimated shortfall of 1,800 GPs by 2021 (Thomas and Layte, 2009, p. 58).

Consequently, many technologically advanced countries, such as Ireland and Canada, turned to the recruitment of IEHPs to, at least partially, address these shortages. IEHPs are recruited from other EU countries and poorer periphery countries of the 'global south' to work in the healthcare sectors of rich and technologically advanced core countries of the 'global north'. Additionally, IEHPs from the 'global south' as mentioned earlier, are continually attracted to the 'global north' for many reasons that range from political to economic as well as opportunities for personal development.

This kind of recruitment methods and subsequent patterns of migration of health workers, often referred to as 'Brain Drain' (Hagopian et al., 2004, 2005; Chen and Bufford, 2005; Bourgealt et al. 2010) is argued to have detrimental effects on the health systems of the sending countries. However, it continues at unprecedented levels. It was claimed in 2005 that an estimated 20,000 health professionals migrated from Africa annually (Aredo, 2005). Nurses from the Philippines (110,000), and doctors from India (56,000) constitute the largest proportion of IEHPs in OECD countries (WHO, 2012). According to a 2010 *Health Policy Brief* by OECD/WHO, the percentage of foreign-trained doctors and nurses registered in OECD countries have become quite significant. For example, in the United States, the number of IMGs passing Step 3 of the United States Medical Licensing Examination (USMLE)[2] increased by 70% between 2001 and 2008. Over the same time, temporary migration of doctors increased two-fold in Australia and by 40% in Canada. In 2008, foreign-trained doctors made up 39% of the medical workforce in New Zealand (see charts 1 and 2).

[2]USMLE is the stepping stone examination to full registration to work as a medical doctor in the United States.

Table 1. Foreign-trained doctors working in 26 OECD countries, 2000, 2006 and 2012-14

Country of residence	2000				2006				2012-2014			
	Year	Total	Foreign-trained	% of total	Year	Total	Foreign-trained	% of total	Year	Total	Foreign-trained	% of total
Australia	2000	...	...	...	2005	.	...	*25.0%*	2013	82 498	25 153	30.5%
Austria	2000	25 611e	461	1.8%	2006	30	88	*2.9%*	2014	35 844	1 640	4.6%
Belgium	2000	44 380	1 934	4.4%	2006	49	2 636	*5.3%*	2014	59 070	6 732	11.4%
Canada	2000	64 462	13	21.3%	2006	70	15 237	*21.5%*	2013	90 205	21 225	23.5%
Chile	2000	...	...	...	2006	.	...	...	2014	36 013	5 489	15.2%
Czech Republic	2000	43 765	*579*	1.3%	2006	44	1 744	*4.0%*	2014	41 671	1 135	2.7%
Denmark	2000	15 551	681	4.4%	2006	18	1 145	*6.2%*	2012	20 250	1 127	5.6%
Estonia	2002	2 259	0	0.0%	2006	5	30	*0.6%*	2014	6 294	16	2.6%
Finland	2000	...	...	...	2005	.	...	...	2012	20 866	4 154	19.9%
France	2000	199	7 795	3.9%	2006	212	12 261	*5.8%*	2013	219 833	20 275	9.2%
Germany[1]	2000	267	9 971	3.7%	2006	284	14 703	*5.2%*	2013	326 945	28 901	8.8%
Hungary	2000	...	...	...	2006	37	2 917	*7.7%*	2013	32 668	2 470	7.6%
Ireland	2000	12 242e	1 359	11.1%	2006	15	4 663	*30.1%*	2014	19 066	6 877	36.1%
Israel	2000	21 869	14	64.4%	2006	23	14 746	*61.7%*	2014	25 570	14 839	58.0%
Netherlands	2001	39 772	706	1.8%	2006	45	94	*2.1%*	2011	51 939	1 352	2.6%
New Zealand	2000	9 890	3 756	38.0%	2006	11	4 833	*40.7%*	2014	14 786	6 298	42.6%
Norway	2000	...	...	...	2008	18	5 996	*32.3%*	2014	22 659	8 447	37.3%
Poland	2000	...	...	...	2008	119	2 529	*2.1%*	2012	125 073	2 203	1.8%
Slovak Republic	2000	18 571e	130	0.7%	2004	17	13	*0.8%*	2011	16 899	50	3.0%
Slovenia	2000	...	...	...	2006	.	...	...	2013	5 416	78	14.4%
Spain	2000	...	...	...	2006	.	...	...	2011	207 042	19 462	9.4%
Sweden	2000	27 502	3 827	13.9%	2006	32	6 321	*19.3%*	2012	38 144	9 283	24.3%
Switzerland	2000	25 272e	2 982	11.8%	2008	29	6 479	*21.8%*	2012	31 858	8 617	27.0%
Turkey	2000	85 242	55	0.1%	2006	104	24	*0.2%*	2013	133 775	26	0.2%
United Kingdom[2]	2000	...	...	...	2008	146 834	43 885	*29.9%*	2014	172 561	48 766	28.3%
United States[3]	2000	...	...	25.5%	2006	664 814	166 810	*25.1%*	2013	859 470	214 438	25.0%
OECD Total (26 countries)										**2 696 415**	**460 597**	**17.1%**

Note: Doctors whose place of training is unknown have been excluded from the calculation of the percentage of foreign-trained doctors (Netherlands, Slovak Republic, Slovenia and United Kingdom).

1. The data refer to foreign citizens (not necessarily foreign-trained).
2. Data cover England, Wales and Scotland (but not Northern Ireland).
3. The percentage in 2000 is calculated based on all doctors registered to practise. Data for 2006 and 2013 refer to doctors who are professionally active.
4. e: estimation.

Source: See Annex 4.A1 in chapter 4 of OECD (2016), Health Workforce Policies in OECD countries: Right Jobs, right Skills, Right Places

Table 2. Foreign-trained nurses working in 25 OECD countries, 2000, 2006 and 2012-14

Country of	200				200				2012-			
	Year	Total	Foreign-	% of	Year	Total	Foreign-	% of	Year	Total	Foreign-	% of
Australia	2000	...	...	...	2007	263	38	14.5%	2013	296 029	47 507	16.0%
Belgium	2000	130 560	679	0.5%	2006	150	1 290	0.9%	2014	186 278	5 411	2.9%
Canada	2000	232 566	14	6.1%	2006	326	21	6.6%	2013	375 768	28 330	7.5%
Chile	2000	...	...	...	2006		...	...	2014	34 674	702	2.0%
Denmark[1]	2000	49 694	889	1.8%	2006	51 840	818	1.6%	2012	55 037	724	1.3%
Estonia	2000	...	...	...	2006	10 264	...	...	2014	12 519	4	0.0%
Finland[2]	2000	...	...	0.2%	2005		...	0.3%	2012	72 471	1 293	1.8%
France	2000	404 564	7 016	1.7%	2006	493	11	2.4%	2014	622 052	17 692	2.8%
Germany[3]	2000	...	...	...	2006		...	...	2010	1 211	70 000	5.8%
Hungary	2000	...	...	...	2006		...	...	2013	53 323	650	1.2%
Ireland	2000	...	...	...	2004	60	8 758	14.4%	2013	..	...	...
Israel	2000	39 064	7 277	18.6%	2006	43 481	6 077	14.0%	2014	45 982	4 528	9.8%
Italy	2000	304 159	1 825	0.6%	2006	358	15	4.2%	2014	424 813	20 072	4.7%
Netherlands	2001	169 580	1 495	0.9%	2006	186	2 149	1.1%	2011	198 694	1 358	0.7%
New Zealand	2002	33 027	4 860	14.7%	2008	39 247	8 931	22.8%	2014	45 572	11 170	24.5%
Norway	2000	...	...	...	2008	70 575	5 022	7.1%	2014	83 647	7 640	9.1%
Poland	2000	...	...	...	2008	268	5	0.0%	2012	278 496	7	0.0%
Portugal	2002	41 902	1 954	4.7%	2006	51 095	2 285	4.5%	2013	65 868	1 947	3.0%
Slovenia	2000	...	...	...	2006		...	...	2013	4 797	20	0.4%
Spain	2000	...	...	...	2006		...	...	2011	250 277	5 247	2.1%
Sweden	2000	88 302	2 358	2.7%	2006	98 905	2 789	2.8%	2012	106 176	2 882	2.7%
Switzerland	2000	...	...	...	2006		...	...	2012	61 609	11 536	18.7%
Turkey	2000	69 550	11	0.0%	2006	82 626	79	0.1%	2013	139 544	239	0.2%
United Kingdom[4]	2001	632 050[e]	50 564	8.0%	2006	659 470	88 609	13.4%	2014	683 625	86 668	12.7%
United States[5]	2000	...	...	...	2006		...	...	2012	4 104 854[e]	246 291[e]	6.0%
OECD Total (25 countries)										**9 413 105**	**571 918**	**6.1%**

Note: Nurses whose place of training is unknown are excluded from the calculation of the percentage of foreign-trained nurses (e.g. Switzerland).

1. The data only include professional nurses (and exclude associate professionalnurses).
2. The data refer only to generalnurses.
3. The data refer to citizens born abroad, not German by birth (except ethnic German repatriates) and the highest degree in nursing acquired in a foreign country.
4. Different source in 2001 (Aiken et al., 2004).
5. Data refer to all nurses registered to practice.
6. e: estimation.

Source: See Annex 4.A1 in chapter 4 of OECD (2016), Health Workforce Policies in OECD countries: Right Jobs, right Skills, Right Pla

Correspondingly, Ireland, a previous net exporter of nurses and doctors to attractive labour destinations such as the USA and UK in the 1980s and the early 1990s, began to encounter acute health worker shortages from late 1990s. With this shortage of local healthcare workers, employers turned to countries outside the EU/EEA to fill these positions. For instance, international recruitment campaigns were initiated to promote recruitment of qualified nurses mainly from India and the Philippines and doctors mainly from South Africa, India and Pakistan. Countries outside the EU/EEA were targeted despite the policy of the state to prioritise workers from other EU/EEA states because there is acute shortage of health workers available to hire in those countries. According to Dumont and Lafortune (2016) (see Table 2 above), the latest data available on foreign-trained nurses on Ireland reveals that Ireland as at 2006, has one of the highest percentages of foreign-qualified nurses within its nursing workforce and one of the highest share of IMGs besides New Zealand. What is worth noting in the case of Ireland is, despite having a short history of recruiting IEHPs, the speed at which IEHPs were recruited in recent years is momentous. A particular recruitment drive for health workers in July 2011 saw Ireland recruiting 280 doctors from India and Pakistan (Gartland, 2011, Sept 23rd). As a result of a series of recruitments, the proportion of foreign trained doctors registered in Ireland more than tripled from just over 11% of the overall medical register in 2000 to 36% by 2008 and remains at 36% in 2014 (see Table 1).

Similarly, in Canada, according to the Canadian Institute for Health Information (CIHI), in 2015, there are 20,924 out of 82,198 phycisians in Canada, classsifed as IMG (see Table 3). This represents 25.5% of the total number of active physicians in Canada in that year. The proportion of IMGs in the physician workforce in Canada varies significantly across jurisdictions, ranging from 11% in Quebec to 47.1% in Saskatchewan. Similar to the IMGs in Canada were, figures for internationally educated nurses (IENs) whose number increased to about 8% of the population of registered nurses in 2010 (last year of available statistics).

What is significant with the increase in international migration of IEHPs is their new pattern of migration. Previously, shortages of health workers in traditional immigrant receiving societies such as Australia, Canada, New Zealand and the USA were usually filled by doctors and nurses trained in Ireland and the UK. Conversely, this trend changed in the last two decades because of the decline in the movement of doctors from most of these traditional Western European source countries. Presently, existing available data indicates a significant increase in the volume of IEHPs from countries of the ‘global south’ to the healthcare sectors of core industrial countries of the ‘global north’. Migration of IMGs to Ireland and Canada

As discussed above, IMGs constitute a considerable number of IEHPs migrating from outside of the EU/EEA to technologically advanced countries of the West, such as Ireland and Canada. As

mentioned earlier, Ireland previously used to be an exporter of its health workers. However, the trend changed in the last two decades and it now recruits doctors from all over the world especially, countries outside of the EU/EEA. Table one illustrates the trend of recruitment of IMGs into Ireland and Table 2, that of Canada. It is important to note that prior to 2013, there was no statistics on non-EU/EEA IMGs. IMGs, in Ireland up until 2013 include doctors from the EU and EEA countries.

Table 3: Numbers of foreign doctors registered with the Medical Council of Ireland from 2000-2015

Year	International Medical Graduates	Foreign-Trained doctors (%) of all registrations
2000	1,746	13.0
2001	2,128	15.2
2002	2,753	18.4
2003	3,097	20.0
2004	3,542	22.3
2005	4,257	25.3
2006	4,558	28.1
2007	5,435	31.8
2008	6,110	34.1
2009	6,569	36.3
2010	6,274	33.4
2011	6,724	35.8
2012	6,325	34.8
2013	5,558	34.3 (23% are non-EU/EEA)
2014	5,947	35.7 ((23% are non-EU/EEA))
2015	7,954	39.0 (29% are non-EU/EEA)

Source: Irish Medical Council (2015)

Table 4: Numbers of IMGs registered practicing in Canada from 2002-2015

Year	Number of IMGs in Canada	IMG% of all registration
2002	13,913	23.4
2003	14,250	23.4
2004	14,362	23
2005	14,253	23
2006	14,514	23
2007	14,523	23
2008	14,904	23
2009	15,221	22
2010	15,759	23
2011	16,707	24
2012	17,407	24
2013	17,992	24
2014	18,048	24
2015	20924	25.5

Source: CMA Master File (2014) (Available on: http://www.royalcollege.ca/portal/page/portal/rc/common/documents/policy/imgs_in_canada_feb-2014_steve_slade.pdf)

The two tables reveal a similarity in the reliance on IMGs by both Ireland and Canada. It can be seen up to 2011 that both countries have high percentages of their physician workforce as IMGs, 35% and 23%. From 2013, when data became available on non-EU/EEA IMGs in Ireland, 23% of the registered doctors in Ireland had their training from a non-EU/EEA medical school. This is same for 2014.

Factors that Encourage Migration and Integration of IMGs

To obtain a deeper understanding of the migration and professional integration of IMGs in their destination countries, it is essential to examine the social, political and economic factors that encourage their migration in the first place. This section reviews existing literature on factors that influence IMGS to migrate including policies and practices aimed at attracting and integrating them into the medical professional field in Ireland and Canada regarding access and promotion opportunities. Literature is reviewed thematically by analysing:

Globalisation, the structural economic inequality between 'global south' and 'north' and the impact of this inequality on the movement of IMGs from the 'global south' to the 'global north' focusing mainly on migration of IMGs to Ireland and Canada.

The relationship the between globalisation and healthcare development in Ireland and Canada.

Globalisation and commodification of IMGs. This theme will specifically examine the role race, gender and class play in the medical professional sphere in Ireland and Canada.

Migration of IMGs to Ireland and Canada, policies to manage this kind of migration, professional registration, migratory and licensure routes for IMGs and challenges limiting their professional integration.

The above-mentioned factors, according to Parsi (2008), seem to influence majority of IMGs to

migrate and take up employment in countries other than their countries of training.

Globalisation and Migration

Globalisation lacks a definite definition and the debates on it often conflict. On the one hand, it is interpreted as the intensification of relations between diverse cultures in a time-space compression (Robertson, 1997). On the other hand, it is viewed as the spreading out of cultures into the global realm (Featherstone, 1995). Summing both interpretations up, Held et al (1999) offer a broad conceptualisation of globalisation. They describe globalisation as '… the broadening, deepening and speeding up of worldwide interconnectedness in all aspects of life, from the cultural to the criminal, the financial to the environmental' *(*p. 2*).* According to them, globalisation can be:

'… conceived as a process (or set of processes) which embodies a transformation in the spatial organization of social relations and transactions, generating transcontinental or interregional flows and networks of activity, interaction and power' (p. 16).

Held and McGrew (2003) also argued that globalisation brings about four types of changes. Firstly, they claim it stretches social, political and economic activities beyond national and regional boundaries. Secondly, they argued that globalisation proposes the intensification of interconnectedness and flows of trade, investment, finance, migration and culture inter-continentally. Thirdly, they asserted that such intensification leads to the speeding up of global interactions and processes because of the phenomenal advancement of international transportation and communication systems, which increase the speed with which ideas, goods, information, capital, and people get diffused. Lastly, because of this growing intensity and velocity of global interactions, boundaries between domestic matters and global affairs can become increasingly blurred.

One of the crucial features of globalisation according to these definitions and characteristics as mentioned above, is the weakening of the importance of the nation state because of the rise of dominant transnational structures and processes (Lentin and McVeigh, 2006). For Lentin and McVeigh (2006), 'globalisation is moving us towards a situation in which most crucial social structures and processes will be defined globally rather than by national borders' (p. 19). The ambivalence of this argument is, as the importance of nation states is downgraded (Lentin and McVeigh, 2006, p. 23) because of globalisation, nation states appear to be strengthening themselves in other ways. One of the areas in which modern states have strengthened themselves is in migration. Nation states have sought, more than ever before, to exercise more control on who comes in through their national borders. For example, in Europe, the idea of 'Fortress Europe' has become very popular amongst many European nations that persistently seek to fortify the borders of Europe against unwanted migrants. An example of this in most recent times, is the sluggishness with which Europe is responding to the crisis of refugees from Syria and the hypocrisy that surrounds this response.

Another significant feature of globalisation, albeit, with a major criticism, is the pursuance of policies that impoverish technologically developing countries (Stiglitz, 2002). According to Stiglitz, policies pursued by transnational organisations such as the International Monetary Organisation (IMF) and the World Bank, such as structural adjustment programmes (SAP) and capital market liberalisation, ultimately lead to uneven economic growth between the 'global north' and 'south'. Prior to Stiglitz's argument, it was maintained by dependency theorists such as Dos Santos (1973) and Amir (1974), that globalisation and its principles were behind the underdevelopment of countries of the 'global south'. According to Dos Santos (1973) quoted in Todaro and Smith (2009, p. 123):

> Underdevelopment, far from constituting a state of backwardness prior to capitalism is rather a consequence and a particular kind of capitalist development known as dependent capitalism. … Dependence is a conditioning circumstance in which the economies of one group of countries are conditioned by the growth and expansion of others.

Subsequently, it is agreed that countries occupying positions of dependency because of colonisation or neo-colonisation (Wallerstein, 1974) can only develop as a reflection of the growth of dominant nations. As he further claims in his World System Theory, colonisation, an epoch in the development of global capitalism, is the key factor behind the lack of economic and industrial development of colonised countries. Hence, technological backwardness and exploited situations of dependent countries is argued to be a result of their relationships with dominant nations (Wallerstein, 1974). One of the many direct consequences of the lack of development experienced in colonised countries is the pushing of people from these former colonies to the imperialist nations (Massey, 1993). According to this view, migration of people from the poorer peripheral countries of the 'global south' is a 'natural' product of economic globalisation and market penetration across national boundaries (Wallerstein 1974).

In recent times, international migration constitutes one of the mechanisms through which inequalities between the 'global north' and 'south' are perpetuated and reinforced, especially through Brain Drain (Arrango, 2000). Harris (2002) buttresses this line of thought by claiming that immigration is the lifeline of economies of developed countries. According to her, immigrants facilitate native workers or their children, with steadily higher educational qualifications, to transfer to well-remunerated and cleaner jobs. She claims that without the army of semi-skilled and unskilled labourers who are predominantly, immigrants in industrialised countries, skilled workers would not last long.

An example of how immigration benefits technologically developed countries can be seen in Ireland and Canada where medicalisation of both societies and developments of modern healthcare systems have created labour market gaps for healthcare workers that could not be filled by local graduates. Then, as mentioned in the introduction, authorities in both countries turn their attention to medical

graduates of the 'global south' to fill these gaps and medical graduates from the 'global south' respond by migrating, with the intention of taking up opportunities presented.

Medicalisation, Development of Modern Healthcare Systems and Immigration of IMGs into Ireland and Canada

Medicalisation of healthcare can be described as the 'defining and treatment of previously non-medical problems as medical problems, usually in terms of illnesses or disorders, with the aim of using medical intervention to treat it' (Conrad, 2005, p. 3). As Clarke et al (2003, p. 161) claimed, 'the growth of medical jurisdiction is one of the most potent transformations of the last half of the twentieth century in the West'. Sociologists and other analysts have identified direct factors that support medicalisation. These factors can be categorised as supply side and demand side ones. On the supply side is the prestige and power of the medical profession (Conrad and Leiter, 2004). In the last three quarters of a century, the authority and power gained by the medical profession is well documented. It is acknowledged that it attained professional dominance (Freidson 1970) and cultural authority over time (Starr 1982), giving it jurisdiction over virtually anything to which the label 'health' or 'illness' could be attached (Freidson 1970). On the demand side, the reduction in the public's tolerance for mild symptoms and benign problems has led to an increase in consumer demand for medical solutions (Barsky and Borus, 1995). Furthermore, the decline of religion; growing belief in science, rationality, and development; an increased dependence on experts; a general humanitarian trend in Western societies and the rise in the power of multinational pharmaceutical corporations (Conrad, 1992, p. 213) are other factors that have set the context in which medicalization occurs in western societies.

Concurrent with the medicalisation of Western society is the development of the modern healthcare system. Healthcare systems in many Western societies, a system of health care funding and delivery aimed at meeting the cost of all or most health care needs of citizens from a publicly managed fund, can be schematised into two models. The first model can be traced to Chancellor Otto Von Bismarck who introduced legislation on social security in the 1880s in Germany. This model ensures that all working members of the country are provided with minimum health services. This system is funded by employees as well as employers' contributions to a 'Statutory Health Insurance' (SHI) scheme and government subsidies. The scale of government subsidy is determined by levels of income. At the center of this system is the presence of private health insurers who were created by or linked to employers, funded by workers and employers and regulated by the state. What the insurers do is to buy health services from private providers such as doctors and public providers such as state hospitals, to cover the needs of workers and their families.

The second model was named after Lord William Beveridge, who formalised his proposals for the British National Health Service (NHS) in 1942. At the heart of the Beveridge system is the state's

provision of comprehensive health insurance and services to all citizens, with no intermediaries (Colombatto, 2011). According to this system, healthcare becomes universal and client centered. The state is required to fund this system via general taxation. Within this context, private providers are subsidiaries of public providers.

It is important to acknowledge a significant factor that aided the development of healthcare systems in advanced Western societies. This factor is the constant acquisition of new medical knowledge and the development of new drugs and technologies for the treatment of medical conditions. The establishment of medical schools to equip students with new medical knowledge and to train them in the practice of medicine, nursing and other para-medical professions, also plays an essential role in the development of modern health systems in industrialised Western societies.

Like other industrialised Western countries, Ireland and Canada with the development of modern healthcare systems that made provision of healthcare universal, created significant numbers of vacancies for doctors within the medical profession. It is to these health systems that we turn to in the next section.

An Overview of the Healthcare System in Ireland

Ireland has a modern health system which is a mix of public and private funded systems delivered by public, private and voluntary providers (Burke, 2009). The public healthcare system, funded by the state through taxation, is governed by the Health Act 2004. Prior to 2004, the public healthcare system was governed by the Health Act 1970. The 1970 Act created eight Health Boards[3]. Preceding the 1970 Health Act was the 1947 Health Act. This Act saw the city council or county council of an area as the health authority for a functional area. Significantly, the 2004 Health Act changed these previous arrangements by establishing the Health Service Executive (HSE) in 2005. The HSE is a single body that manages and delivers health and personal social services in the Republic of Ireland. The public healthcare system in Ireland, depending on income, age, illness or disability entitles people resident in Ireland to receive health care through the public health care system. Within the public healthcare system, individuals and families are means-tested[4] and if incomes and circumstances fall

[3] The Health Board system of Ireland was created by the 1970 Health Act. This system was initially created with eight health boards, each of which were prescribed a functional area in which they operated. These Health Boards were the Eastern Health Board, Midland Health Board, Mid-Western Health Board, North-Eastern Health Board, North-Western Health Board, South-Eastern Health Board, Southern Health Board, and Western Health Board.The system was reformed in 1999 from eight to eleven regional bodies.

[4] A means test is a way of checking if you have enough means to support yourself and what amount of payment, if any, you may qualify for (DSP, 2016).

within thresholds set by the state, Medical Cards[5] or GP Visit Cards[6] are issued to them.

Besides public funded healthcare in Ireland, there is Private Health Insurance (PHI). This privately-funded healthcare, also subsidised by the state, exists for those who can buy extra healthcare services through health insurance companies such as VHI[7], LAYA Healthcare and Hibernia Aviva. PHI, besides, providing the healthcare users with a private alternative to the public healthcare system, also provides the state with a means of funding and sharing costs associated with health services not covered by the public system. As at the end of March 2014, the number of people in Ireland with one form of private health insurance policy or other, stood at 2,031 million (Martin, 2014, June 3rd). This is nearly 40% of the population of Ireland.

Healthcare Delivery

Public healthcare is provided through health centers, hospitals and General Practitioner (GP) services. GPs in Ireland deliver a wide-ranging primary care and public services in towns and villages throughout Ireland. Hospitals can be accessed via Accident and Emergency departments or through referral by a GP (Burke, 2009). Health centers are managed by the HSE and GPs, nurses and social workers provide primary care within these centers.

Hospital System

Hospital care in Ireland is provided by public, private and voluntary hospitals. The origin of public hospitals in Ireland can be traced back to 19th century workhouses or infirmaries attached to workhouses (O'Morain, 2007). The workhouse was an institutional system that ran in Ireland for about 80 years, from the early 1840s to the early 1920s. This system, established by the British, allowed people who could not support themselves, to come into a workhouse and work in return for food. By the 1920s, workhouses were abolished and replaced by a system of county homes for poor older people with care needs and hospitals for the sick (O'Morain, 2007).

Besides public hospitals, there are voluntary hospitals which date back to the 18th century. These hospitals are partially established and managed, mostly, by charitable organisations and churches, but financed by the state. Some of the voluntary hospitals also provide private health care but they must clearly distinguish between public and private beds. Then there are Private hospitals which are mostly founded by religious orders. They are funded partially by the state and through payments for

[5] A Medical Card is a card issued by the HSE. People who hold a Medical Card are entitled to a range of health services free of charge

[6] A GP Visit Cards allows individuals and families in Ireland to visit their family doctor for free. Only the cost of visits to your family doctor is free; similar to others who do not have a Medical Card, prescribed drugs, medicines and other health services are paid for by the holder of a GP Visit Card.

[7] The Voluntary Health Insurance Board (VHI) is state-owned and was established in 1957 to render private health insurance to part of the population not eligible for public hospital coverage as a result of their income and wealth.

services by health insurance companies. They sometimes, operate on the same site as public hospitals (O'Morain, 2007). Also, public hospitals are incorporated by charter or statute and the Minister for Health then appoints boards that run them. Many specialist/teaching hospitals are in urban centres and big towns while the non-specialist/teaching hospitals tend to be in more rural areas. The specialist/teaching hospitals tend to command higher degrees of prestige and respect compared with rural hospitals because of the specialist services they deliver, such as cancer diagnostics and treatment; specialist children care, etc.; the medical training they render and the presence of many medical specialists and consultants to deliver training to medical students. The range of services offered by these hospitals contributes towards professional prestige and privileges for doctos than doctors practicing in rural hospitals that provide less services.

It is also worth noting that a set percentage of beds in public hospitals are designated for private patients. This means some private practices operate out of public hospitals. This has led to one of the strongest critiques of Irish health system: the two-tier system of healthcare where private patients get easier and quicker access to consultants and services than public patients in public hospitals (Burke, 2009). Having said that, it is essential to point out that several private hospitals operate independently of public funds. The clients of these hospitals must pay the full cost of medical services rendered to them by such hospitals.

Summarily, while the Irish healthcare has its challenges, it also has its usefulness. The present healthcare system in Ireland, even though ranked 21st in the 2016 Euro Health Consumer Index (Björnberg, 2017, p. 15), when compared to previous years, gives more people access to quality healthcare, albeit, the well-offs, who got their access as a result of the introduction of health insurance (Nolan and Nolan, 2004). This has resulted in people living longer and consequently needing more care and being further reliant on medical care. To supply the much-needed care, healthcare workers such as doctors are required. The local supply of graduate doctors does not meet the demand. Consequently, the recruitment of IMGs has become a necessity.

An Overview of the Healthcare System in Canada

Presently, Canada operates a healthcare system that is, for the most part, paid for by public funds with the private sector providing most of the services. This system, known as 'Medicare', was established by legislation passed in 1957[8], 1966[9] and 1984[10] (Lewis et al., 2001). The system is a

[8] Hospital Insurance and Diagnostic Act (HIDS) 1957. This Act outlined five conditions for healthcare delivery in Canada: public administration, comprehensiveness, universality, portability, and accessibility states that the federal government funds 50percent of the cost of such programmes for any provincial government that adopts them.

[9] Medicare Act 1966

[10] The Canada Health Act 1984

single-payer system that is patient-centered. In theory, patient-centred services mean that patients have a free choice of physician and hospital (Kraker, 2002). The system provides Canadian residents, regardless of their ability to pay, access to universal, comprehensive coverage for medically necessary hospital and physician services. Within this system, essential services are provided by private doctors and the entire fee is paid for by the state. Most doctors do not receive monthly or annual salaries, but they receive fees per visit or service. It is also worth noting that one third of the Canadian population have some form of additional private health insurance to cover services not covered or only partially covered by Medicare, such as prescription drugs and some kinds of Dental and Optometric care. Significantly, many Canadians with private insurance cover obtain it through their employers.

Instead of one national plan such as the National Health Service (NHS) in the UK, the health care system in Canada is made up of provincial and territorial health insurance plans, all of which share certain common features and standards. Canada's public health care system is administered by its ten provinces and three territories. It is important to point out that the federal government of Canada has authority in 'specific aspects of health care which includes prescription drug regulation and safety; the financing and administration of a range of health benefits and services for eligible First Nations people and Inuit; and public health insurance coverage for members of the Canadian armed forces, veterans, inmates in federal penitentiaries and eligible refugee claimants' (Marchildon, 2013, p.20)

Historical Development of Canadian Healthcare System

Historically, the Canadian health system was not always an all-inclusive healthcare system. The poor and minority groups such as the First Nations people lacked access to adequate and quality healthcare until the late 1940s. Prior to the 1940s, hospitals were places which cared for sickly poor people. Others were cared for at home. Then hospitals received financial assistance from the state and were made up of non-profit organisations, run by charity organisations and religious denominations. As Canada developed industrially, its health system developed with it. For example, the discovery of anesthetics and antiseptics in the 1840s, insulin in 1922 and Dr Wilder Penfield's successful surgical treatment for epilepsy called the 'Montreal procedure' in 1934, contributed to the medicalisation of Canadian society in the late 19th and 20th centuries and the subsequent comprehensive call for a public-funded health system.

In terms of public funding of the health system in Canada, it is important to note that prior to World War II (WWII), healthcare was largely privately funded (Health Canada, 2011). However, after the WWII, this changed. In 1947, Saskatchewan, a Canadian Province that had long suffered an acute shortage of doctors, introduced near universal health coverage. This was based on the Saskatchewan

Hospitalisation Act 1946[11]. This Act guaranteed free hospital care to the population and resulted in the creation of Municipal Doctor Programs (Vayda and Deber, 1984). This programme, primarily, meant that a town in the province would subsidize a doctor to practice there through its municipal funds.

In 1948, the province of Alberta emulated Saskatchewan and created Medical Services (Alberta) Incorporated (MS(A)I). This provided patients with affordable coverage for necessary hospital services. It ultimately delivered healthcare to over 90% of the population. By 1950, a public health care plan was introduced by Alberta's Social Credit party. It is important to mention that in 1949, the Government of British Columbia introduced a universal hospital insurance scheme based on the Saskatchewan model. However, the inability of the government to collect premiums resulted in a new administration which was elected in 1952 and totally overhauled the programme (Marchildon and O'Byrne, 2009). In 1957, the federal government introduced the HIDS Act. This Act reimbursed one-half of provincial and territorial costs for hospital and diagnostic services administered under provincial and territorial health insurance programs (Health Canada, 2012). By 1961, this Act had been adopted by the 10 provinces in Canada. In 1962, cover was extended to include physicians in Saskatchewan (Steveson et al., 1988).

It was the success of these programmes in, especially Saskatchewan that led the federal government, led by Lester B. Pearson, to introduce the Medical Care Act in 1966 (Marchildon, 2009). This Act extended the previous HIDS Act of cost sharing to facilitate the establishment of a universal health care plan in each Canadian province. In 1984, the Medicare system was introduced through the Canada Health Act. This Act sets out under the Canada Health Transfer, the conditions which must be satisfied by provinces and territories to be able to obtain Federal Transfer payments. The Act categorically states that the fundamental purpose of Canadian healthcare policy is to protect, promote and restore the physical and mental health of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

Healthcare Delivery System

Healthcare services are now delivered to Canadians through primary healthcare, hospital care and community care (CIHI, 2013).

Primary Care

In Canada, primary care is delivered through nurse practitioners, general practitioners or family

[11] This Act was passed in 1946, became effective January 1, 1947, and introduced the Saskatchewan Hospitalisation Insurance Plan (SHIP). This healthcare plan was a compulsory plan that provided healthcare treatment to those needing it within the province, without any charge.

physicians, dietitians, physiotherapists and social workers. Primary healthcare, which includes routine care, care for urgent but minor or common health problems, mental health care, maternity and child care, etc., is an important source of chronic disease prevention and management in Canada.

Hospital Care

Hospital care in Canada is divided into:

1. Emergency and ambulatory care which are vital parts of health services in Canada and deliver medical care on an outpatient basis.

2. Acute care offers necessary treatment for diseases or serious illness for a short period of time, with the purpose of discharging patients as soon as their situation becomes steady (CIHI, 2013*).*

3. Continuing care. This is also known as extended care and provides professional health care services to people who may not be well enough to be discharged from acute hospitals, but do not need acute care services.

4. Rehabilitation care which cares for both short and long-term stay rehabilitation patients.

Community Care

Community care programmes are designed to maintain optimal health among the population, reduce waiting lists and providing services to patients on discharge from hospitals. It is delivered in private homes, retirement communities, residential or long-term care homes and community clinics all around Canada.

Hospital System in Canada

Both historically and currently, like Ireland, hospitals in Canada are established and managed by a mix of public, voluntary and private bodies. The public general hospitals were initially established to serve the middle and upper classes. This led to a two-tiered care system where private and semi-private wards in hospitals were meant to cater to for the fee-paying patient and poor patients were kept in public wards. The voluntary hospitals were initially set up and run initially by charitable organisations aimed at treating the poor and the underclass (Gagan and Gagan, 2002). Presently, primary care physicians provide basic medical treatments and preventative care. On the other hand, specialists do not provide the care primary care physicians provide. Usually, the doctor of a patient will refer them to specialists as required. Large private entities such as the Workers Compensation Board (WCB) in British Columbia can buy priority access to medical services in Canada. The WCB provides for the delivery of health care to workers with occupational injuries and diseases. Subject to some restrictions, the WCB pay for services rendered by physicians, hospitals, various ‘qualified practitioners’, and other treatment and service providers.

Private hospitals in Canada are supposed to, mainly, operate as private clinics and offer specialised

services such as MRI Scans.

Accessing Healthcare in Canada

To access the health care system in Canada, one must have a Provincial Health Card. Once this card is approved and assigned, patients can use it to access a physician or health care provider whenever the need arises. All Canadian citizens and permanent residents may apply for a public health card. However, it is worth noting that the requirement in each province and territory differs. For example in Ontario, to be eligible for coverage, one must:

1. Be a Canadian citizen, permanent resident or among one of the newcomer to Canada groups who are eligible for OHIP as set out in *Ontario's Health Insurance Act*.
2. Be physically present in Ontario for 153 days in any 12-month period.
3. Be physically present in Ontario for at least 153 days of the first 183 days immediately after establishing residency in the province.
4. Be primarily resident in Ontario.

Whereas in Alberta, to be eligible, one must be:

1. Legally entitled to be or to remain in Canada and be permanently resident in Alberta.
2. Committed to being physically present in Alberta for at least 183 days in a 12 month period.
3. Not claiming residency or obtaining benefits under a claim of residency in another province, territory or country.
4. Any other person deemed by the regulations to be a resident not including a tourist, transient or visitor to Alberta.

Other Factors Pulling IMGs to Ireland and Canada

Enhanced career opportunities, better salaries and better working conditions and the possibility of acquiring new skills offered by the health systems of technologically advanced Western societies cannot be over-emphasised when researching factors that attract IMGs to Ireland and Canada. Conclusively, each of the factors mentioned play a vital role in the complex, multifaceted requirement and attraction of IMGs in Ireland and Canada. For example, the increase in the incidences of chronic diseases like diabetes and heart disease in Ireland and Canada, labelling of previously non-medical conditions such as depression, eating disorders and mental illnesses as treatable medical conditions have increased the numbers of people accessing medical treatments. This, in turn, increased the need for more doctors. Some of these doctors need to be recruited from

outside of Canada and Ireland because both countries cannot train and retain enough locals. Additionally, the emergence of medical markets and consumers purchasing of medical products and services, or treatments to improve their health, appearance, or well-being have converged to create increase demand for healthcare services in both countries.

Globalisation and Commodification of IMGs

Having identified some of the pull factors in relation to immigration of IMGs to Ireland and Canada, it is essential to understand how globalisation has influenced government policies in the sending and receiving countries. Also, an understanding of the professional integration experiences of IMGs was sought. This sub-section discusses the commodification of IMGs from some source countries such as Cuba, India and the Philippines. These countries were selected because of their deliberate pursuance of educational policies that over-produced and exported medical health workers to other countries (OECD, 2008; Yeates, 2008).

Commodification of IMGs from some source countries

The shortage of medical professionals in advanced healthcare systems in technologically advanced nations of the west, has been recognised by some countries in the 'global south'. These countries have responded by formulating policies to train and export some of their medical graduates to countries with acute shortages of health workers. Countries such as the Philippines, India, Cuba and recently Pakistan, have intentionally invested in the training of health workers for export (OECD, 2010). In the last two to three decades, these countries have deliberately pursued educational policies that over-produced and exported medical health workers (see Yeates, 2009; Adkoli, 2006; Khadria, 2004; Buchan et al., 2003). Private medical schools were established to provide medical training for students, with the hope of exporting them to wealthy countries with an acute shortage of healthcare workers. Countries such as India, Pakistan, Thailand, Sri Lanka, Bangladesh and Indonesia have all set up agencies that actively participate in the international health professional recruitment market (Hugo and Stahl, 2004).

The advantages of this kind of market-led training and exportation of IMGs include:

1. Potential earnings of foreign exchange for the exchequers of sending countries through remittances by these groups of migrants back to their home countries (Kline, 2003; Connell and Stilwell, 2006).

2. Immediate relief of pressure on the internal labour market of sending countries is also regarded as a merit of these programmes (Yeates, 2009).

3. Experience, skill and expertise that returned migrants possess on their return, have also been deemed as highly valuable (Castles, 2000).

The main critiques of the commodification of IMGs are:

1. The potential for mass export of IMGs from poorer countries to richer countries further perpetuates economic inequalities. It is also argued that, like every other gain of capitalism, economically richer countries gain by saving millions in 'reaping where they have not sown'. In other words, they reap the investments of sending countries on these health workers and save monetarily by not investing in their training (Castles, 2000).

2. It was also argued that migration of healthcare workers from poorer countries in most cases creates an acute shortage of health workers in sending countries which may undermine the countries' ability to deliver quality healthcare (Stilwell et al., 2004). This economic and social imbalance could further be associated with the existing debates on the effects of the 'global care chain' (Hochschild 2000, p. 131) on the sending countries of global healthcare professionals. Global care chains, a globalisation–migration–care nexus, do more than establish the links between personal lives and global politics; they explicate the structures and processes that reproduce and perpetuate the unequal distribution of resources globally (Yeates, 2004).

Other Push Factors

Besides the economic factors mentioned earlier in this chapter, other push factors include poor wages and conditions of employment, inadequate post-graduate training opportunities and unstable political and economic conditions in sending countries (Astor et al., 2005; Pang et al., 2002). In addition, a long history of medical migration from sending countries to receiving countries is also a factor. For example, in the case of Irish doctors migrating to the UK, factors such as a psychological legacy of colonisation cannot be over-emphasised. For example, discussing about Nigeria, Hagopian et al. (2005) argue that a colonial legacy, which directs the migration of colonised subjects to their colonial 'mecca' as the greatest career achievement is embedded in the culture of migration from the colonies upon the completion of their education is embedded in the psyche of physicians. According to them, this legacy of colonisation significantly influences the decision to migrate to the industrialised countries of the 'global north' of some health workers' (Hagopian et al., 2005). These factors, combined with the pull factors mentioned earlier have undeniably contributed to an unprecedented migration of IMGs, in high numbers, from the 'global south' to, Ireland and Canada. Worth noting is that, this migration is not without regulation and control on the part of receiving countries. The next section reviews the literature on immigration policies and regulations in Ireland and Canada.

Immigration Policies in Ireland and the Immigration of IMG

Some globalisation theorists argue that as economies become interconnected, movements of factors

of production such as capital, labour and entrepreneurs will become easier. While this seems applicable to capital and entrepreneurs, it is paradoxically untrue about the movement of workers, especially workers from the 'global south' who wish to make the south-north movement. In fact, increasingly, nation states refuse to surrender management of immigration to the caprices of liberal economic theories, of non-interventionism in the market. Rather, many nation states are intervening by reinventing old and inventing new draconian means of controlling and regulating migration. As a result, countries such as Ireland and Canada now formulate immigration policies around 'desirable' and 'undesirable' immigrants.

In Ireland, labour migration policy is designed primarily to attract workers from other EU countries to meet skill needs (Bacik, 2004). Immigration policies *vis-à-vis* non-EEA nationals were specifically formulated to meet gaps, especially, jobs that require high expertise, which cannot be met from within the EU. It is in response to this gap that many highly skilled migrants such as the IMGs migrate and hope to take up employment in Ireland (Quinn, 2006). Prior to 2003, IMGs could come and work in Ireland only through an employment permit system which had two components:

1. Work permits.

2. Working visa/authorisations issued to suitably qualified persons in areas of skill shortages

Work Permits

This permit system used to be employer-led with almost no government intervention (Ruhs, 2005). This system was criticised as a form of bonded labour because of it used to tie an employee to an employer (Ruhs, 2005; Lentin and McVeigh, 2006). However, in 2007, the Employment Permits Act 2006 updated the Employment Permits Act 2003[12]. The significant aspect of this Act is its introduction of the Green Card Permit (GCP), Intra-Company Transfer Permit and revised legislation on work permits and spousal permits. This new legislative framework provided that permissions, similar to Green Cards are given by the Department of Jobs Enterprise and Innovation (DJEI) to workers with highly sought-after skills who earn more than €60,000 a year. They are also allowed to bring their spouses with them. The intra-company transfers allow multinational organisations based outside Europe to transfer staff to work in Ireland. However, the transferred workers must be earning over €40,000 annually, and must have been employed the company for at least a year.

[12] This Act was introduced to facilitate free access to the Irish labour market by citizens of the new EU Accession States after 1 May 2004. There are, therefore, no longer any requirements for citizens of those Member States to have work permits or visas. The Act also allows the Minister for Enterprise, Trade and Employment to re-impose a requirement for employment permits in respect of nationals of the Accession States post-2004, if the labour market is experiencing or is likely to experience a 'disturbance'. The Act also incorporates a provision whereby, for the first time, the requirements for employment permits in respect of non-Irish nationals working in Ireland are set out in primary legislation, together with penalties for non-compliance by both employers and employees.

However, the GCP was discontinued by the DJEI on the 30th of September 2014 and was replaced by a new Employment Permit known as Critical Skills Employment Permit (CSEP).

Critical Skills Employment Permit (CSEP).

The CSEP introduced by the Employment Permits (Amendment) Act 2014 changed the previous employment permits system. It retained two categories of eligible occupations. That is jobs with annual salaries of €60,000 or more and jobs with annual salaries of €30,000 or more, but introduced nine different types of employment permits. These are:

1. Critical Skills Employment Permit
2. Intra-Company Transfer Employment Permit
3. Dependant/Partner/Spouse Employment Permit
4. General Employment Permit
5. Contract for Services Employment Permit
6. Reactivation Employment Permit
7. Internship Employment Permit
8. Sport & Cultural Employment Permit
9. Exchange Agreement Employment Permit

Under CSEP, employment permits are valid for two years and are granted by the DJEI in respect of high skill occupations. Application for a CSEP by a migrant worker must be based on an offer of employment and either the employer or the migrant worker can apply for the permit. A migrant worker working on an employment permit is protected by employment legislation in exactly the same way as local employees.

It is important to note that under the new Employment Permits (Amendment) Act 2014, provision is made for migrant workers to take civil action against an employer for compensation for work done or services rendered in instances where the worker has taken reasonable steps to, but could not obtain a permit.

With all these changes, it is significant to point out that since the start of the present economic recession, the numbers of employment permits issued by the DJEI to migrant workers have decreased (see chart below).

Immigration of IMGs into Ireland

Migration of doctors of non-EEA/Western origin into Ireland was through the work permit/authorisation and tied to employers prior to 2007. From 2007 and September 2014, it was through GCS. Table 5 below shows numbers of permits issued to IMGs by the DJEI between 2007 and 2013 June, the latest date from which figures are accessible to me.

Table 5: Number of Work Permits Issued to IMGs by DJEI between 2007 and 2013 (JUNE)

Year	Total
2007	548
2008	582
2009	679
2010	307
2011	289
2012	152
2013	36

Source: Department of Jobs, Enterprise and Innovation (2013)

The table in the next page shows the total number of foreign-trained doctors registered with the Medical Council of Ireland between 2002 and 2014. It is important to note that prior to 2013, data and statistics available on foreign-trained doctors in Ireland has only one category of foreign-trained doctors. This category consisted of all doctors trained outside of Ireland including EEA doctors. However, in 2016, the Medical Council released statistics that broke down foreign-trained doctors into EU Citizen qualified in EU/EEA, Non-EU Citizen qualified in EU/EEA and Qualified outside EU/ EEA. According to the definition of IMG adopted in this study, only the last 2 categories qualifies as IMGs.

Table 6: Total number of foreign doctors Registered with MCI from 2002-2015

Year	Foreign-Trained doctors registered in Ireland	% of Total Registration
2002	2753	18.4
2003	3097	20
2004	3542	22.3
2005	4257	25.3
2006	4558	28.1
2007	5435	31.8
2008	6110	34.1
2009	6569	36.3
2010	6429	34.3
2011	6724	34.2
2012	6325	34.1
2013	6,188	34.0 (25% are IMGs)
2014	6,845	36.0 (26% are IMGs)
2015	7,954	39.0 (29% are IMGs)

Source: www.medicalcouncil.ie

The table above shows the trends and numbers of IMGs migrating into Ireland. IMGs made up about 26% of the total number of registered doctors in Ireland in 2014 and this has risen to 29% in 2015.

Attention will now be turned to Canada to review existing literature on its immigration policies and practices especially, in relation to IMGs.

Immigration Policies in Canada and Immigration of IMGs

Immigration policies in Canada, as argued by Boyd and Alboim (2011, p. 1), have always been formulated to meet three specific gaps:

1. The need to populate sparsely populated areas.
2. To stimulate demands for goods and services within the country. The idea that people are consumers of goods and services and that a growing immigrant population will help grow the entire population is perceived as important.
3. To meet shortages of workers.

Canada has always been selective in the immigrants it admits. In the 1950s, it excluded non-British Black people by prohibiting their landing in Canada through the Order-in-Council, P.C. 2856, 1950. The Order-in-Council P.C. 2856 passed in 1950, provided a rigid definition of the British subjects eligible for admission into Canada. Only those persons who were 'born or naturalized in the United Kingdom, Australia, New Zealand or the Union of South Africa, a citizen of Ireland or a person who became a citizen of the United Kingdom by registration under the British Nationality Act of 1948' were eligible for admission. In 1967, it introduced a point system which was aimed at assisting in

determining immigration criteria. It applies to those who are not immediate family members of a legal resident in Canada or a Canadian citizen (Hawkins, 1991). It awards points for particular skills, background, and Canadian links (Troper, 1993). In addition to education and employment experience, points are also assigned for character, market demand for skills and English- and French-language proficiency (Khan, 2004). According to this point system, potential migrants are graded and given up to 100 points (Borjas, 1991). The pass mark, at which applicants are deemed eligible for immigration, is 67 points (see the table 5 below for grading system).

Table 7: Point System in Canada from 1967

Criteria	Points
Age	**Up to 10 points**
Close relatives	**Up to 5 points***
Education	**Up to 25 Points**
Education in the country	**Up to 5 points***
Job offer	**Up to 10 points**
Language	**Up to 24 points**
Spouse/partner characteristics	**Up to 5 points***
Work experience	**Up to 21 points**
Work experience in the country	**Up to 5 points***
Pass park	**67**
Total points available	**100**

Source: http://www.centreforum.org/assets/pubs/points-based-system.pdf

Currently, in parallel with historical immigration policies that were characterised by discrimination based on ethnicity and nationality (Lacovetta et al, 1996), immigration policies are argued to be class biased and economic-centric. Examples of these economic-centric immigration policies include the introduction of the Foreign Domestic Workers (FDW) Program in 1981. This programme was designed to recruit domestic workers to provide childcare and other services on a live-in basis to Canadian families (Calliste, 1991). It was subsequently replaced by the Live-in Caregiver Program in 1992 (Boyd and Albiom, 2011). The Live-in Caregiver Program (LCP) allows families to hire a foreign live-in caregiver, usually called a nanny, when Canadian citizens and permanent residents are not available.

In 2002, the Immigration and Refugee Protection Act (IRPA) 2002, like previous immigration legislation in Canada made it imperative for Canada to recruit skilled foreign workers to maintain its economic prosperity. According to Gignac (2013) in his column in the Globe and Mail of the 7th of October, many immigrants to Canada fall into population aged between 20 and 44, which forms the

majority in the labour force. As stated by him, this cohort of people is the 'one that creates new households, buys new houses, has children and pays the greater part of taxation revenue' (Gignac, 2013). Therefore, immigrantion helps sustains Canada's economic growth.

The Refugee Protection Act 2002 (IRPA) came into effect on June 28, 2002. This Act set the rules that guided the admission of refuges into Canada and describes grounds of inadmissibility. It provided the regulation that facilitates the 'entry into Canada of immigrants who are better prepared to adapt to Canada's labour market needs and those who can contribute to the economy through investments and the establishments of new businesses' (CIC, 2005: Note 5). Therefore, this Act laid emphasis on potential economic contributions of migrants to Canada (Khan, 2004) and operated like the 1967 Act, on a point system'.

Of relevance, also is the development of policies that promote regionalisation of migration. These programmes started in the 1990s, and became mainstreamed in 2008 when the Immigration and Refugee Protection Act (IRPA) 2002 was amended and replaced by Bill C-50, the Budget and Implementation Act, 2008. This Act recognised immigration as an crucial factor for socio-cultural, economic and demographic revitalisation of Canadian rural areas suffering from declining populations as a result of an ageing population, lower birth-rates and rural-urban migration of youth. Consequently, it introduced the 'provincial nominee program'. This is a mechanism through which provinces select for admission, immigrants who meet their special demographic and labour market needs, as permanent residents in Canada.

Presently, because of this emphasis on economic, socio-cultural and demographic contributions of immigrants, Canada tends to attract many immigrants from non-traditional source countries in Latin America, Asia and Africa. Immigrants into Canada now, can be broadly classified into three categories: the economic, family and refugee categories. The economic category can be further divided into six sub-categories. A description of the two categories and sub-categories of the three categories are presented in table 8 in the next page:

Table 8: Categories of immigrants migrating into Canada

Economic Categories	Family categories and Refugees
Federal Skilled Workers: The Federal Skilled Worker Program supports Canada's economic growth by selecting immigrants with essential and transferable skills who have the potential to contribute to success and adaptability in the Canadian labour market.	The family category includes spouses or partners, dependent children, parents, grandparents and other close relatives of Canadian citizens and permanent residents. Members of this category may be sponsored by their Canadian citizens' family members to become permanent residents. Sponsors must undertake to provide for the basic requirements of the sponsored person and his or her family members for a specified period. Sponsors of parents and grandparents and some other relatives must also meet a minimum necessary income test. *It worth noting that there was a temporary pause for 24 months for new sponsorship from November 2011 to October 2013.
Quebec Skilled Worker: Under the terms of the Canada-Quebec Accord, Quebec has full responsibility for selecting its immigrants, except for members of the Family Class and refugees whose status is defined by the Federal Government. Quebec sets its own annual immigration targets, including those it selects to meet its economic needs from the Skilled Worker Class and the Business Class (see below).	Refugees are persons who are recognised as being refugees under the criteria set down in the 1951 Geneva Convention relating to the Status of Refugees and are allowed into Canada for reasons of settlement.
The Provincial Nominee: The Provincial Nominee Program (PNP) gives provinces and territories an active role in immigrant selection as it authorises them to nominate, for permanent residence, individuals who meet their specific local labour market or regional economic development needs. The PNP is designed to help spread the benefits of immigration across Canada by encouraging migration to areas which are not traditional immigrant destinations.	
Canadian Experience category (CEC): This class, launched in September 2008, was designed to facilitate the retention of certain Temporary Foreign Workers and international graduates with relevant skill, work experience and set of Canadian credentials to permanent resident status without having to leave Canada.	
Live-in Caregiver Class: The Live-in Caregiver Program (LCP) allows families to hire a foreign live-in caregiver, usually called a nanny, when Canadian citizens and permanent residents are not available.	
Business Immigration (Investor, Entrepreneur and Self-Employed Persons) and their accompanying family	

members: Business Class immigrants are selected on the basis of their ability to create jobs for themselves and Canadian citizens or permanent residents, contribute capital to the Canadian economy, and stimulate economic activity. The three categories of Business Class immigration are as follows:
The Entrepreneur Program: This was designed to attract immigrants with business experience that can be utilized in Canada. Within three years of their arrival, entrepreneur immigrants must hold at least one-third of the equity of a qualifying Canadian business, be actively involved in the management of that business, and create at least one additional full-time job for Canadian citizens or permanent residents.
Self-employed: These migrants must demonstrate their ability and their intention to be self-employed upon arrival and to make a significant contribution to particular economic activities in Canada in the sectors of sports, culture or farm management.
The Immigrant Investor Program (IIP). This scheme seeks to attract immigrants with capital and business management experience. Applicants must demonstrate that they have business experience and a minimum net worth of $1,600,000. They are expected to make an investment of Canadian $800,000 which is used for economic development and job creation

Conclusively, immigration policies in Canada that favour the immigration of high skilled workers have facilitated migration of many IMGs into Canada. Worth noting also is the fact that the majority of IMGs in Canada migrated into Canada on economic visas, family sponsorship, or in few cases, as refugees and asylum seekers (Bourgealt, 2010).

Professional Integration of IMGs ans Government's Role in Ireland and Canada

Governments of Ireland and Canada play active roles in managing the immigration and professional integration of IMGs into the medical professional fields of both countries. The interaction between the states and the medical professional bodies of both countries in the area of regulation and control of access to medical practice is becoming significant. In Ireland, the government confers the legal monopoly of granting access to individuals who wish to practice medicine, on the Medical Council of Ireland (MCI). MCI sets requirements, assess and admits new members into the profession. It also formulates policies that guide recruitment and retention of doctors.

In Canada, even though the Medical Council of Canada (MCC) plays an important role in the assessment of physicians, it does not grant licences to physicians. The provincial and territorial medical regulatory authorities do so. These provincial and territorial medical regulatory authorities

are referred to as the Federation of Medical Regulatory Authorities of Canada (FMRAC[13]).

The policies and processes of governments' roles in facilitating professional integration, or otherwise, in Ireland and Canada is presented in the next section.

Pathway to Registration for Practice in Ireland

According to information available on the website of the Medical Council of Ireland (MCI)[14], all IMGs wishing to practice medicine in the Republic of Ireland must register with the Medical Council and indicate in which specialty they wish to be registered (Table 9 below shows country of qualification and division of registration of IMGs in Ireland).

Table 9: Country of qualification and division registration of doctors in Ireland in 2015

	Graduates of Irish medical schools		Graduates of a medical school outside Ireland		percent of division who graduated
Division	N	%	N	%	%
General Registration	3197	29.7	3836	65.0	**54.4**
Specialist Registration	6047	56.2	1642	27.8	**21.4**
Supervised Registration	0	0.0	6	0.1	**100.0**
Trainee Specialist	**1525**	**14.2**	**417**	**7.1**	**21.5**

However, in the end, it is the MCI that determines the specialty. For registration, IMGs are required to undergo and pass or be exempted, from the Council's Pre-Registration Examination System (PRES) which consists of three levels:

Level 1 - involves assessment and verification of the documentation of an IMG. Subsequently, eligible IMGs will then be either required to sit or be exempted from PRES Levels 2 and 3 explained below.

PRES Level 2 - is a computer based examination focused on the clinical knowledge of the candidate. It is currently in the form of a Multiple-Choice Questions (MCQ) examination. IMGs must attempt and pass Level 3 within two years from the date of passing Level 2.

PRES Level 3 - is an assessment of doctor's clinical skills, practical and communication skills, and data interpretation skills. It is a clinical examination using real clinical scenarios. It is usually held two to three times per year depending on demand.

[13] Collège des médecins du Québec, College of Physicians and Surgeons of Alberta, College of Physicians and Surgeons of British Columbia, College of Physicians and Surgeons of Manitoba, College of Physicians and Surgeons of New Brunswick, College of Physicians and Surgeons of Newfoundland & Labrador, College of Physicians and Surgeons of Nova Scotia, College of Physicians and Surgeons of Ontario, College of Physicians and Surgeons of Prince Edward Island, College of Physicians and Surgeons of Saskatchewan, Government of the Northwest Territories, Nunavut Department of Health and Social Services, Medical Registration Committee, Yukon Medical Council (Medical Regulatory Authorities, 2016).

[14] www.medicalcouncil.ie

Source: Medical Workforce Report 2015 (p.43)

IMGs are responsible for ensuring that their registration is current and suitable for their individual circumstances within one the following divisions:

General Division

This is the only form of registration available to doctors who do not practice in individually numbered, identifiable training posts, who have not been proposed for a post in the Supervised

Source: www.medicalcouncil.ie

Division, and who have not completed recognised specialist medical training (MCI, 2016). A training post is a post specifically designed to provide a career pathway for junior doctors who have successfully completed their internship towards achieving specialist registration. Supervised division Registration is granted to doctors who have been offered a post that has been approved by the national Health Service Executive (HSE), which has specific supervisory arrangements (it is further explained below).

Many IMGs in Ireland are registered in this division and many hospital posts in rural Ireland are filled by doctors registered in the general division (see Table 9). According to the latest *Medical Workforce Intelligence Report 2016* released by the Medical Council, 65% of IMGs are registered in this division compared with 28% of doctors who graduated from Irish medical schools (Medical Council, 2015, p. 40). For IMGs to become registered in this division, they must go through the three levels of PRES mentioned earlier, except when they are exempted from a level.

Training Specialist Division

An IMG can register in this division if he/she is in an approved postgraduate training post. This training is usually located in a hospital, health institution, clinic, medical practice or other health service setting approved by the Medical Council. All applicants in this division, including IMGs must have been awarded a document, which is at least the equivalent of the Certificate of Experience (Internship Certificate) from the Medical Council. The Certificate of Experience is a document which confirms that a doctor has successfully completed their internship to the standards set by the Medical Council (MCI, 2016). According to the *Medical Workforce Intelligence Report 2016*, there were 1,589 Irish doctors compared with 397 IMGs doctors in this division then. This translates to 14.6% of Irish doctors compared with only 6.0% of IMGs are presently in training to become specialists (MCI, 2016, p. 46).

Specialist Division

This includes IMGs, who have completed specialist training discussed above and can then practise, independently as a specialist. In this division, there are 6,319 Irish graduates compared with 1,880 IMGs. This means, 58% of the specialists are Irish graduates, while 28% are IMGs (MCI, 43, p. 43).

Supervised Division

The supervised Division is specifically designed for and opened only to IMGs, who have obtained a post in Ireland in the following areas of specialisation: General Internal Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Psychiatry, Emergency Medicine, or Anesthesia. Like candidates for the General Division, all applicants for the Supervised Division must then undergo the Level One assessment and verification of their documentation. Additionally, IMGs applying for registration into the Supervised Division must apply to the HSE. The HSE must then propose the candidate to the Medical Council. This proposal must include the specialty of the post, the duties the doctor will be charged with and the supervisory arrangements which will be in place. Then, the candidate must sit and pass the PRES Level 3 examination set by the Medical Council that tests his or her competence in clinical judgement, communications, and data interpretation in their specialty. This examination is set at the level of intern exit/entry to basic specialist training. After necessary verification, the HSE proposes the candidate to the Medical Council and after sitting and passing the examination, an IMG can register in the division. The registration is only for two years, after which the IMG can either transfer to the general division or the trainee specialist division. According to the *Medical Workforce Intelligence Report 2016*, this division has 103 doctors registered on it and all of them are IMGs. This represents a significant drop from its peak in 2012 when 287 doctors, all, IMGs were registered on it.

Pathway to Registration (Licensure) in Canada

According to information available on the website of the Medical Council of Canada[15], IMGs wishing to practice in Canada are advised to begin the process of registration by contacting the Medical Regulatory Authority in the province or territory in which they would like to practice. They should also contact the International Medical Graduate Programme in that province, if such a programme exists. There are specific steps that should be considered by IMGs looking to practice in Canada. Some of those steps can be taken prior to arriving in Canada and others, are taken post-arrival. Those steps are listed and explained below:

1. Confirmation that a primary medical degree is from a recognised medical school. This can be done by visiting the International Medical Education Directory (IMED), part of the Foundation for Advancement of International Medical Education and Research (FAIMER) website. To be admitted starting the registration process in Canada, the medical school, the name of the medical degree and the year of graduation must be listed on FAIMER's International Medical Education Directory. To test his/her readiness to practice in Canada, a prospective IMG takes the Medical Council of Canada's Self-Administered Evaluating Examination (SAE – EE). This is an online self-assessment examination of the Medical Council

[15] http://mcc.ca/about/mcc-and-route-to-licensure/licensure-process-for-imgs/

of Canada's Evaluating Examination (MCCEE)[16]. IMGs, who sit the examination receive results as well as feedback that includes a percentile table that compares their performance to the results achieved by other MCCEE candidates. If the IMG is deemed ready, he/she then submits their credentials to the Medical Council of Canada (MCC) via The Physician Credentials Repository of MCC. IMGs can establish a confidential, professional electronic portfolio of their credentials, prior to arriving in Canada and can share this portfolio with provincial/territorial medical regulatory authorities and certifying and qualifying bodies. The MCC requires that IMGs, who apply for the first time to the MCCEE, send copies of their final medical degrees to the MCC Physician Credentials Repository. The degrees must be source-verified through the Repository, for the candidate to be eligible for the Medical Council of Canada Qualifying Examination (MCCQE) Part II. If an IMG obtained an American Board of Medical Specialty (ABMS) certification[17] from the USA, then, an application may be made to MCC for an exemption from the MCCEE.

2. Payment of fees: To access the Repository services, IMGs must open a 'physiciansapply.ca' account and a one-time account fee is associated with the creation of this account. Additional document fees are also charged for each medical document submitted for source verification.

3. Taking the Medical Council of Canada Evaluating Examination (MCCEE). IMGs who aim to acquire full licensure are required to pass the Medical Council of Canada Qualifying Examination (MCCQE) Part I and Part II (additional fees apply). Besides MCCQE, all provinces have the right to request additional assessments to qualify for residency positions in their province. These assessments may include the National Assessment Collaboration (NAC) examination, which is only administered in Canada. Candidates must take the MCCEE before

[16] The Medical Council of Canada Evaluating Examination (MCCEE) is a four-hour, computer-based examination that can be taken in English or French. It can be taken at more than 500 centres in 80 countries worldwide and it is a prerequisite for eligibility to the Medical Council of Canada Qualifying Examinations. It assesses a candidate's basic medical skills in the primary medical disciplines. This examination is set at the level of intern exit/entry to postgraduate training.

[17] The American Board of Medical Specialties (ABMS) works in collaboration with 24 specialty Member Boards to maintain the standards for physician certification in the USA. A physician or surgeon is Board Certified by an ABMS specialty board when he or she has chosen to achieve expertise in a medical specialty or subspecialty by meeting the profession-driven standards and requirements of one (or more) of the 24 ABMS certifying boards (ABMS, 2016).

being eligible to take the NAC examination, and certain jurisdictions may add other region-specific eligibility criteria for certain provincially funded training positions.

Full licensure to practice independently can then be obtained depending on the province, upon completing one or two years of 'residency program'[18]. This can be applied for through the Canadian Resident Matching Service (CaRMS). An IMG may enter a 'return-for-service' programme in any of the provinces. The Return-for-service program/agreement, was introduced in the 1980s in almost all the provinces in Canada. It aims at attracting and retaining doctors to rural and underserved communities in Canada. It is known by different names depending on the province. For example, it is referred to as *Diplomes hors Canada et Etats-Unis (DHCEU)* in Quebec (Simard, 2009) and return-for-service in Ontario (*OntarioHealthForce, 2011*). It comes in the form of conditional scholarships, return-in-service bursaries, loan forgiveness programmes, and provision to support medical students and post-graduate residents with financial assistance in exchange for a commitment to practice in an underserved community — usually one year of service for each year they received assistance. It is aimed at attracting and retaining physicians in Canadian's rural and underserved communities. In the case of IMGs, many of them are mandated to take a return-for-service agreement to obtain a residency position in Canada.

IMG must sit and pass the Medical Council of Canada (MCC) Qualifying Examination (MCCQE) Part I and II. MCCQE (Part 1) is a one-day, computer-based test that assesses knowledge, clinical skills and attitudes of candidates who have obtained their medical degree, for entry into supervised clinical practice in postgraduate training programmes as outlined by MCC Objectives. MCCQE (Part 2) assesses the competence of candidates, specifically the knowledge, skills, and attitudes essential for medical licensure in Canada prior to entry into independent clinical practice. The examination questions include problems in Medicine, Paediatrics, Obstetrics and Gynaecology, Preventive Medicine and Community Health, Psychiatry and Surgery. It also includes parallel disciplines considered crucial for competence in general medicine and health care.

Also, IMGs must sit and pass an appropriate speciality certification examination and obtain certification by either the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC). Then they can apply to the appropriate body for Independent Practice Certificate of Registration or depending on the province, enter into a 'return-of-service' contract. For example, in Ontario, an IMG must fulfil a five-year return-for-service contract to practice in an underserved community in Ontario (HealthForceOntario, 2011).

[18] postgraduate training or active medical practice in Canada, or completion of a full clinical clerkship at an accredited Canadian medical school (HealthForceOntario, 2011)

Professional Integration of IMGs in Ireland and Canada

Many existing studies on access and inclusion practices of the medical profession in Ireland and Canada continue to reveal that the experiences of these highly skilled migrant health workers may not be all that favourable. Even though there are few studies in Ireland, the available ones reveal access to practice, especially, access to the training posts, for IMGs can be extremely difficult (Bidwell, et al, 2012 and 13). It has also been highlighted that there are differential outcomes for IMGs when compared with their Irish and European counterparts. IMGs are found to be disproportionately represented in the Non-Consultant Hospital Doctors' (NCHD) positions in Ireland (Humphries, 2014). Additionally, the *Medical Workforce Intelligence Report 2016* reveals that even though 38% of doctors retaining registration with the Medical Council are IMGs, 76.8% of doctors who work as non-consultant hospital doctors and occupy service posts were IMGs.

Likewise, in Canada, studies have revealed the practices surrounding access to medical practice in Canada to be unnecessarily cumbersome, time-consuming and limiting (Lofters et al., 2014; Bourgeault et al. 2010). Furthermore, IMGS are found to face numerous challenges and institutional barriers in attempting to access practice as a doctor in Canada (Foster, 2008). According to Foster (2008), many IMGs noticed they are perceived and treated 'differently in the application and assessment process through rules and procedures that are culturally biased and arbitrary' (p. 12).

The question existing findings ignites is: what are the criteria for access into and progression within the medical professions in Ireland and Canada and how are these criteria applied? To answer this question, this study examines existing literature on policies and practices in professional integration, that is, access into and progression within medicine in Ireland and Canada.

Professional Integration of IMG in Ireland

In Ireland, there is a dearth of literature on access and progression policies and practices within the medical profession. Until 2007, a unified database for IMGs who reside and practice in Ireland did not exist in Ireland. What existed were fragmented records of separate departments dealing with recruiting and granting visas to IMGs. Significantly, health information systems in Ireland do not hold a record of where non-EU migrant doctors work within the Irish health system. However, in 2007, the HSE conducted a National Audit of Senior House Officers (SHO) and Registrar Posts in Ireland (HSE, 2008). The national audit report captured the numbers of IMGs working with the HSE at that time. It found that 58% of doctors on basic specialist training programmes were Irish, whereas only 25% of doctors occupying service posts were Irish (Royal College of Physicians, 2007). Service posts, unlike training posts, as stated earlier, are posts that are not recognised for training purposes because no career progression is possible outside the structured training programmes. As stated by Humphries (2014 p. 237) 'doctors occupying these posts are not part of the career pathway from internship through initial specialist training, higher specialist training to consultant level'. NCHDs in service

posts, which are usually located in smaller non-specialist hospitals, like their counterparts in training posts, undertake many of the basic hospital clinical activities. However, their clinical experiences are not recognised for training purposes because staffing, supervision and facilities in these hospitals are regarded as not meeting those required in a structured training programme. It is important to note that recommendations were made by Buttimer (2006) in a report titled: *Preparing Ireland's Doctors to meet the Health Needs of the 21st Century'*. The report recommended that NCHD posts with limited training potential should be phased out. Also, it was recommended that all NCHDs should work in recognized, structured training posts. These recommendations, after a decade, have not been implemented. Besides non-implementation of the recommendations of this report, the report is limited in the sense that it only captured the statistics of IMGs working as NCHDs. Consultants were not included in the audit. As a result, the report does not present accurate numbers of IMGs practicing in Ireland. This further perpetuates a primary challenge faced by IMGs in Ireland: statistical invisibility. This statistical invisibility inhibits the formulation of any policies to address their professional integration, especially, into the position of a consultant.

On the integration of IMGs in Ireland, a recent academic paper by Bidwell et al. (2012) obtained and analysed statistics on IMGs in Ireland from 2000-2010. In this paper, non-identification and analysis of challenges, especially access to practice and progression experienced by IMGs were identified as factors limiting full professional integration of IMGs into the medical practice in Ireland. However, they acknowledged Ireland's increasing and potentially unsustainable dependence on foreign-trained doctors. They also highlighted the need for more relevant techniques to measure migratory flows of doctors because these kinds of techniques are necessary for national workforce planning.

Apart from this paper by Bidwell et al. (2012), a small number of articles have uncovered the same pattern of exclusion suffered by migrants primarily, of non-EEA/EU descent, within the overall Irish labour market (MRCI, 2010; McGinnity et al., 2009; Coakley and MacEinri, 2009; Kolawole, 2009; Barrett and McCarthy, 2007; MacEinri, 2006). Researching into experiences of IMGs in Cork, Altaf (2008) in her study on the experiences of migrant doctors in Cork found marginalisation of IMGs prevalent especially, when it comes to the positions of consultants within the HSE. Agreeing with Altaf, Cheema et al. (2011) argue that besides exclusion of IMGs from the position of consultant, other factors such as bullying and racial discrimination against IMGs is rampant within the Irish medical profession. In addition, Birchard (2001), earlier in the decade, argued that presence of few non-Irish consultants is indicative of a glass ceiling within the medical profession. According to her, in 2001, IMGs within the Irish medical profession made up nearly half of junior doctors, but constituted only about 1% of consultants.

Conversely, professional integration experiences of IMGs in Ireland as documented by existing

literature, are analogous to the findings within the mainstream Irish labour market. Within the Irish labour market, positions of migrants are found to be weak compared with their native counterparts (Barrett and McCarthy, 2007). As Barrett and Duffy (2008) claim, migrants earn 19% less on average than Irish nationals. Furthermore, migrants have been found to face higher risks of unemployment, are less likely to secure higher level occupations, are under-represented in managerial jobs and over-represented in lower level jobs (O'Connell and McGinnity, 2008).

Additionally, Macdonald and Butler (2006) wrote an article in the *Sunday Times* about the Irish Public health service, titled: 'Race 'block' on Ireland's hospital'. In this article, they claimed that the public health service in Ireland is rife with cronyism and nepotism. They argued that foreign doctors, who staffed more than half of all hospital jobs, say that they are blocked from consultant positions because Irish doctors 'look after their own' (Macdonald and Butler, 2006, April 23rd). In this same article, the writers quoted Dr Altaf Naqvi, a consultant surgeon, founder and past president of the Overseas Medics of Ireland. Dr Naqvi claims that the treatment of foreign doctors by consultants and health service employers was tantamount to 'medical mafiasm' and that 'overseas doctors are the victims of institutional racism and discrimination just because they are black' (Macdonald and Butler, 2006, 23rd April).

Besides the experiences of the broad IMG group, almost nothing is known about the female sub-group of IMGs in Ireland. Although, no studies have been conducted on the experiences of female IMGs in Ireland, a few studies conducted on the experiences of female healthcare workers offer an insight into professional experiences of women within the sector in Ireland. O'Connor (2001) in her study of two Health Boards[19] suggests that organisations such as Health Boards are significantly, gendered in their organisational practices. She argues that they are organisationally gendered because their hierarchical structure is characterised by one-way communication, a retentive attitude to information; where women's 'proper' place is not considered to be in management; and where the 'normal' pattern of succession is along a male line.

Parallel to the supposition of O'Connor, is the *Medical Manpower Forum Report (2001).* This report also acknowledges a gender imbalance in the medical career development of doctors within Irish hospitals. It stated that as at 2001, even though women made up 53% of Non-Consultant Hospital Doctors' posts, they made up only 28% of the 384 new consultants who had taken up duty since 1996, while 72% were men (Medical Manpower Report, 2001, p. 50).

Additionally, Cannon (2003), in her study of experiences of motherhood combined with professional practice and training among female Senior House Officers (SHO) reveals that the comparison of

[19] The Health Boards were created in 1970 for the administration of the health services in the State. 8 Health Boards were initially created in 1970.

figures of female SHOs and registrars *vis-à-vis* male SHO and registrars implied a barrier to career progression of female SHOs. She further claims that policies and practices within the Irish healthcare system such as excessive working hours, rotation around hospitals and lack of flexible training schemes in some specialties bear negatively on career progression of female doctors.
Conclusively, even though some academic journal and newspaper articles have acknowledged and highlighted the experiences of IMGs in relation to access and progression within their profession, there are few existing works that offers a comprehensive, holistic and critical analysis of the professional integration experiences of IMGs in Ireland. Also, there are few studies that engaged in critical analysis of the processes that produce and reinforce closure around certain prestigious and desirable occupational grades on the one hand, but help include/exclude members of some social groups on the other hand.

The Integration of IMGs in Canada

Even though Canada has always relied on foreign trained doctors as a short-term solution to its shortage of doctors, especially the hard-to-fill positions and rural and under-served communities, its selection processes were not all inclusive. Some literature on the ability of IMGs to access and integrate into the Canadian medical profession reveal that initially, recruitment of IMGs from countries outside of the EU was rigorously discouraged because of the racist perception that non-EU/Western migrants were unsuitable for Canada. For example, according to Calliste (1993, p. 88), although, the Canadian government in the 1950s, regarded immigration as a solution to labour shortages and as a source of future permanent citizens, it excluded non-British Black people by prohibiting their landing in Canada through the Order-in-Council, P.C. 2856 of 1950.
Significantly, an increasing number of researchers, policy makers and academics began the exploration of the 'absorption' of migrants into social, cultural, economic and political life of Canada. A significant strand of this growing body of research considers the professional integration of IMGs. Much of the empirical and theoretical research examines the experiences of IMGs in relation to accessing professional practice and outcomes. Specific questions about barriers to access and progression for IMGs are presently being asked by researchers in Canada.
Consequently, researchers, such as Bourgeault et al. (2010) have identified several barriers confronting IMGs in Canada. These barriers include expensive and time consuming Medical Licensure exams; restricted access to residency posts and 'source-country discrimination' against IMGs especially IMGs from the 'global south' (Bourgeault et al., 2010, p. 72). Another challenge facing IMGs in Canada, identified in recent times, is what is described as cultural competency (Bourgeault and Neiterman, 2013; Bourgeault and Baumann, 2011; Hall et al., 2004). Cultural competency is supposed to have been acquired by an IMG when he/she understands fully the nuances of professional and cultural practices within the Canadian health sector and hospital or community

contexts where he/she practices. The lack of understanding of these cultural practices has been argued to infringe on the successful integration of IMGs in Canada (Foster, 2008).

Additionally, Wong and Lohfeld (2008) describe the requirement for IMGs to recertify before they can practice in Canada, despite having previous clinical and practical experiences in their countries of origin as that of a three-phase process of loss, disorientation and adaptation (p. 53). Unfortunately, many IMGs never experienced the last phase, adaptation, because they became completely disoriented by the process. This inability to eventually adapt to the medical profession by IMGs were interpreted as Brain Waste by Bourgreault (2010) and racism by Dove, (2009) and De Carvalho (2007).

Conclusively, integration experiences of IMGs in Ireland and Canada cannot be said to be without tensions. Tensions such as exclusion from licensure to practice, as mentioned earlier, were identified and in some instances, strategies used to include and exclude IMGs were also identified by several research studies and literature (Foster, 2008; Bellange, 2010; Taghizadegan, 2013).

Another gap identified in existing studies especially, in Ireland, is very little analyses of professional integration experiences of IMGs within the medical profession in Ireland and Canada, particularly, in relation to how IMGs experience the processes of accessing professional practice and how professional structure influences and shapes their progression. Lastly, there are also the lacunae on what strategies are used to produce and maintain existing professional structures and cultures and how the IMGs perceive and interpret their experiences of these structures and cultures.

In the light of these gaps, this study aims to explore the professional integration experiences of IMGs in Ireland and Canada in relation to access and outcome within the medical profession, from the perspective of the IMGs. In order to do this effectively, I will critically evaluate the present professional structures, policies, processes and cultural practices within medicine in both countries.

Chapter Two

Professionalisation, Social Closure, Race, Class, Gender and the Medical Profession: Experiences of International Medical Graduates in Ireland and Canada

Introduction

To understand the specificities of the inclusionary and exclusionary practices of dominant social groups within contemporary medical professional spheres, especially, the monopolisation of some occupational niches within this profession; how are these strategies of inclusion and exclusion constructed, why they are created and how they are sustained in both Ireland and Canada, there is a need for appropriate theoretical approaches and the use of more precise conceptual tools. Consequently, this chapter is divided into two parts. The first part presents my attempt at analyzing and describing the profession. This is done by trying at situating occupational areas within professions historically and explaining the social conditions that prevail in those occupational areas. The second part of this chapter is the theoretical framework. It presents and discusses the critique of the profession and all the concepts used for analysis in this study. It describes and analyses how the notions of 'difference' and 'otherness' are constructed and articulated within professional spheres and specifically, within the medical professional sphere in both Ireland and Canada. This is followed by a careful examination and analysis of the concept of 'institutional racism' (MacPherson, 1999), theories of 'social closure' (Parkin, 1979, p. 44) and 'cultural capital' and how institutional racism and social and cultural capital can be utilised as strategies of exclusion and inclusion from some professional positions and privileges.

More so, this chapter presents an analysis of how markers of difference such as, race, class and gender are articulated in theory and practice, particularly, within the profession of medicine in Canada and Ireland and how the articulation of these differences serves as an axis upon which exclusion from practice, in some cases, from the most prestigious and desirable occupational positions, revolves.

Racism as a concept is important for understanding the experiences if IMGs. Thus, an analysis of the role 'race' plays in producing variegated positions within medicine as a profession in Ireland and Canada is conducted. Particular attention is paid, not just to forms of overt biological racism, but to covert racism, which can either be institutional or informal and can be based on or intersect with religion, language, culture, nationalism and citizenship (Gilroy, 2000: 34). As a result of the medical

profession's self-regulation, it is wise to examine practices within it through the lenses of these modern forms of racism.

The multiple challenges of being a female IMG is also taken into consideration. As a result, the role of gender within the profession of medicine and how it impacts on the experiences of female IMGs is examined.

The Profession

What are professions?

In as much as there is no consensus on the definition of professions by sociologists, an attempt is made to define professions in this chapter by synthesizing the various descriptions and definitions given to professions by theorists who have endeavored to render one. Most existing definitions of professions tend toward describing the features and functions of professions. Among sociologists who have attempted to define professions are Max Weber, Emile Durkheim, Talcott Parsons and Bernard Barber. Max Weber did not exclusively mention the word profession in his works. Rather, using his 'ideal type' (Weber, 1948, p. 90) model of explaining a phenomenon, he employed the word, a 'calling' or 'vocation'. According to Giddens (1993, pg. 288), 'an ideal type as an abstract description constructed by accentuating certain features of real cases to pinpoint their most essential characteristics'. For example, explaining bureaucracy, Weber constructed an ideal type bureaucracy with following characteristics:

1. A clear-cut hierarchy
2. Written rules that govern the conduct of officials
3. Officials are full-time and waged
4. The life of the officials outside is separated from the life within the organization
5. Material resources with which officials operate are not owned by them

In my attempt in this study to describe a profession, like Carter (2003), I use Weber's Ideal type model in identifying characteristics of a profession which are:

1. Autonomy. Professions are largely autonomous.
2. Possession of special knowledge: Members are expected to possess a special knowledge that makes them competent in performing their professional duties.
3. Existent of an independent body that monitors the entry of new members.

4. This professional body solely controls the means of acquiring skills and qualifications required to access the profession.
5. There is the existence of a clearly defined hierarchy and power.
6. Members are encouraged to specialise and become autonomous in the performance of their role.
7. Motives of members for joining the profession are perceived as altruistic.
8. Existence of clients to utilize the expertise of the professional.

Besides Weber, functionalists such as Emile Durkheim, Talcot Parsons and Bernard Barber have attempted, taking into consideration the functions of the profession, to describe what they perceive a profession to be. Durkheim (1957) as quoted in Grabb (1984) posited that professions contribute to the smooth running of the institutions of modern societies. He maintains that the disintegration of the traditional moral order initiated by capitalism can only be salvaged by the formation of moral communities based upon occupational membership (pp. 98-99).

Furthering the functionalist's perspective of the profession is Dietrich Rueschemeyer. Rueschemeyer (1964, p. 4) defines the profession as 'service or community oriented occupation applying a systematic body of knowledge to problems which are highly relevant to the central values of the society'. Similarly, for Parsons (1939), modern industrial societies owe their survival, to a reasonable extent, to the smooth functioning of the profession (Parsons, 1939). This is because, professions are not just distinctive features of modern capitalist societies (Parsons, 1939), but according to Johnson (1972), they are a stabilising force against the excesses of capitalist-induced individualism and state collectivism. Modern industrial capitalist societies, according to these functionalists, are believed to promote egoism and to demote community interests. Therefore, professionalism, when not motivated by personal interest or profit (Parsons, 1939), represents an important alternative to the rational egoism of capitalism (Turner, 1995) and a counteracting force against self-serving tendencies of individuals within capitalist societies. For Parsons, the professional is not thought of as engaged in the pursuit of personal profit, but in performing services to patients or clients, or to impersonal values, like the advancement of science. Thus, professionals are distinguished by some functionalists as dedicated to public service rather than being concerned only with their own economic position and status. Prior to Parsons, advocating this line of argument was Tawney (1921), as cited by Johnson (1972). In his campaign for the enlargement of professions in England, Tawney claimed that in the 'acquisitive society', where individualism had won over collectivism, or community interest (Johnson, 1972), professionalism was the major force imbued with the ability to

diffuse the individualistic excesses of capitalist societies. According to Turner (2007), the medical profession would appear to be an excellent example of such an altruistic vocation.

Conversely, in contrast to the description of professions rendered by the functionalists are conceptualisations by sociologists such as Everette Hughes (1963) and Eliot Freidson (1989). Hughes (1963) articulates the profession is an occupation in which certain people profess to be skilled. According to him, profession originally meant the act or fact of professing which later developed into:

> An occupation which one professes to be skilled in and to follow. A vocation in which professed knowledge of some branch of learning is used in its application to the affairs of others, or in the practice of an art based upon it. Applied specifically to the three learned professions of divinity, law and medicine; also, the military profession (Hughes, 1963, p. 3).

Going by this definition, the acquisition and application of specific skills, plays a key role in the process of professionalisation. This acquisition of specific skills translates into a kind of formal educational qualification requirements for those seeking to enter professions and the acquisition of these skills is marked by a ceremonial rite of passage (Carter, 2003). Besides skill requirements, long duration of training is required to acquire unique knowledge that will help solve the problems of clients. Hence, professionals are sometimes distinguished as being remarkable by the special kind of education, knowledge and skills that their members possess. Consequently, Hughes (1963) emphasising the material and symbolic benefits accrued from the monopolisation of occupations, based upon a license to practice, argued that the profession is more self-interested than pursuing the collective good. This perspective on the profession is supported by Friedson (1970, 1989). Friedson argues that the process of professionalisation emphasises the possession of monopolistic power of the medical profession. This power is manifested in its ability to deskill and subordinate related occupations such as pharmacy, dentistry and nursing. The essence of this is to create a basis for prestige because the profession is characterised by the power and high prestige it has in a society. In fact, it is more clearly defined by the power, prestige and value that society confers upon it.

Having gained an insight into what an ideal type profession is, a critical examination of the profession of medicine reveals that medicine is an ideal profession. It is clearly defined by power, prestige and value that have been conferred on it by different societies. This is evident in the self-regulatory nature of the medical associations and the monopolies medical associations enjoy over doctors' training and licensing. For example, the medical professional associations and training bodies in many countries of the world control the specific professional spheres, amounting to what Illich (2002, p. 8) calls 'medical colonisation'. Medical colonisation can be described as the increasing domination of medicine in defining and treatment of illnesses and disorders not

previously identified as such. The various medical councils set the rules to determine who gets registered, and the training bodies determine who gets onto specialist training schemes and which posts are designated as training posts. In Canada, like most technologically advanced countries in the world, the rules for registration of doctors are determined and set by the provincial Medical Councils in collaboration with the Federal Medical Council. Training and certification are the responsibility of training colleges.

Theory of the Profession, its Critiques and Medicine

From the above discussions, it is deducible that medicine in both Canada and Ireland are occupations which have successfully acquired the features of an ideal type profession such as the possession of autonomous professional bodies which monitor both new and existing members and recruit and train new members. These occupations in both countries also include amidst other features, membership based on the acquisition of theoretical knowledge and special skills. Increasingly, the profession has come under attack from sociologists and social scientists who perceive it as an institution of formal social control. The profession has been accused of being an instrument of social control. Professional social control is conceptualised in several ways, including professional control of colleagues (Freidson, 1975), control of the 'micropolitics' of professional - patient interaction, as in medicine, religion and law (Waitzkin and Stoeckle, 1976) and the acceptance of perspectives of professionals as the dominant definition of a particular phenomenon. The medical profession specifically, has been accused of being an institution of social control (see Parsons, 1964; Friedson, 1970; Zola, 1971). It is argued that medicine tries (knowingly or unknowingly) to secure conformity to social norms by specifically using medical means to minimize, eliminate, or normalise deviant behaviour (Conrad and Schneider, 2010). More so, Zola (1971) maintained that the medical profession is an institution of social control because of its increasing ability to 'medicalise' much of daily living by making medicine and associated labels 'healthy' and 'ill' significant to an ever-growing part of human existence. This line of argument was reinforced by Illich (2001, p. 46) when he claimed that, medicine 'is exercised by full-time specialists who control large populations by means of bureaucratic institutions' because it 'defines what is standard, proper, or desirable' (p. 45). Consequently, the medical profession enjoys certain institutional power that allows it to control larger part of the population socially.

Additionally, the profession has been criticised for its ability to create relationships of social and economic dependence and ironically, relationships of social distance. In this sense, social distance refers to when dependence on the skills of others erodes the common ground shared around experience and knowledge (Johnson, 1972, pp. 42-43). Besides creating social distance, it is argued that 'autonomy', one of the most expressive features of professions, has become not only unfashionable, but also socially counterproductive (Light 1988; Light and Levine 1988; Wolinsky

1988). Autonomy in a profession, according to Freidson (1988, p. 369), refers to officially organised independence aimed at not just freedom from competition or regulation of other workers, but freedom to regulate and dominate other occupations. Another significant aspect of autonomy enjoyed by a profession is its ability to educate and regulate itself. That is, it provides education and training to its members and regulates its own work. As Freidson concludes, the essence of autonomy in the profession is 'the opportunity to develop a protected insularity without peer among occupations lacking the same privileges' (p. 369).

Presently, it is argued that the independent and self-regulatory status of most professions may not only produce social distance, but also give rise to new forms of exploitations such as social control of entry routes into the professions.

Another critique of the profession suggests that professions have more to do with economic dominance and protection than with acting in the public interest (Friedson 1970). In fact, Johnson (1972, p. 45) claims, professions are not occupations, but a 'means to control occupations'. It was also suggested that professionalisation may be equated with the process of developing and maintaining closure around an occupation to maintain the self-interests of members which could include salary, status and power, as well as the monopoly protection of the occupational jurisdiction (Larson, 1977; Abbott, 1988). Larson (1977), conscious of how medicine commodified diagnostics and management of illnesses and disorders as medical conditions, concluded that the medical profession specifically, is an extension, rather than a counter, to the capitalist class whose interest is that of individual and not the collective.

Hierarchies, professional occupations and associated social conditions

One of the distinctive characteristics of the profession within contemporary labour market structures is the presence of a clearly defined hierarchy with benefits such as power, prestige and privilege being directly proportional to the hierarchical positions of members. These professional hierarchies in advanced modern societies can be linked to the division of labour of modern capitalist economic systems. Division of labour is a highly complex system of labour organisation which divides work into different numbers of occupations in which people specialise (Giddens, 1993). The end of the division of labour is not only specialisation, where workers become specialised specific areas of the production process, but also includes the ranking of 'worthy' and more 'unworthy' jobs (Veblen, 1994' p. 5).

This division of labour in advanced capitalist societies has resulted in training and certification of members of a profession in various aspects of goods and services production. For example, in the health provision sector, different fields of endeavour have emerged with specialised training, such as nursing, dentistry, pharmacy, radiology, physiotherapy and medicine. Within the field of medicine as

a specific profession, fields of specialisation such as gynecology, cardiology, occupational medicine, medical microbiology and neonatology have emerged as occupations that require specific training and certification.

For many medical practitioners, the job of a consultant is regarded as the hallmark of the medical profession because a consultant is responsible for managing his or her team. He or she is also responsible for standards of care given to all patients by doctors in their team. Hence, this position commands a lot of prestige and benefits, making it more socially and economically rewarding, than the position of a non-consultant hospital doctor. Therefore, the privileges and benefits attached to the position of a consultant may serve as a motivation for the dominant social groups to monopolise this prestigious position by minimising access to it.

Social closure, exclusion and the profession of medicine

The study of the profession is interconnected with the concept of social closure. This is because it is argued that members of the profession try to achieve a professional market monopoly and collective social mobility (Macdonald, 1985, p. 541) by setting rules for entry and rules to control those already within. Witz (1990), writing about the gendered politics of occupational closure, argues that:

> Professional projects are projects of occupational closure and a model of occupational closure strategies is needed, which captures both the varieties of strategies that characterise these projects and the gendered dimensions of these strategies (p. 675).

As a result of the tendency of the profession to develop exclusionary labour market strategies through the monopolisation of provision of particular skills and expert services, this study aims to find out, as mentioned earlier, whether the medical professions in Ireland and Canada were developed, amongst other reasons, to maintain social closure around medical occupations in order to maintain the self-interests of members. To do this, this section aims at examining the concepts of social closure and strategies of professional and occupational closure in use, for the purposes of exclusion and inclusion within the medical profession.

What is social closure?

Social closure, originally conceptualised by Weber (1968, p. 342) and further developed by Parkin (1974, p. 44) is defined as 'the process by which social collectives seek to maximize rewards by restricting access to resources and opportunities to a limited circle of eligible'. According to Weber, the society should be perceived as individuals pursuing their interests. This individual pursuance of interests leads to the emergence of 'collectively conscious groups, who are bearers of ideas that legitimate the pursuit of their interests' (MacDonald, 1995, p. 26). For members of these social groups to further their interests, they attempt to exclude others from their group and usurp the privileges of other groups. According to Weber, social or physical group attributes such as race,

language, social origin and religion may be utilized for the purposes of exclusion. For him, unlike the aristocratic domination (Parkin, 1974) that seeks to transfer status to lineal descendants, exclusion based on social closure ensures continuity through the nomination of successors. Besides Weber, Larson (1977) argues that for occupations to secure a monopoly over particular standardised skills, 'registration and licensure' appear as the modern sources of professional prestige. Therefore, a profession uses registration and licensing as a tactic to monopolise access to the prestigious occupational positions within it. More so, Berlant (1975) offered an important additional angle to professions and their exclusionary practices. For Berlant, professions and the state work together, in that the state legitimises exclusionary professional practices through licensure and registration of professions. By so doing, according to him, the state legitimises exclusion (P. 128).

Frank Parkin's (1979) analysis of social closure emphasises the legality of credentials as a strategy of exclusion. For him, the aim of a profession is to establish 'a legal monopoly' over the provision of certain services via licensure by the state. Consequently, for him, those who hold a legal monopoly of professional services and those who own or control productive capital can be regarded as dominant.

Based on these concepts, professional closure within the medical profession could occur when dominant social groups restrict access of other social groups into medical professional practice and to the more desirable and prestigious positions within the profession, on the basis of difference and otherness.

Other concepts which can be utilized for inclusionary or exclusionary reasons identified include credentialism, sponsorship and patronage.

Credentialism

Credentialism in this study is critically examined in-term of state support for credentials being used to reproduce *status quo*. Credentialism as a theoretical concept is described by Carter (2003) as the 'strategy of social closure which imposes educational requirements upon candidates before they can be considered for certain jobs' (p. 66). Credentialism is an essential feature of the profession because it is sometimes utilised to restrict access to prestigious and respected occupational positions. This strategy makes academic or educational qualifications and training a prerequisite for candidates to be appointed into certain positions. Therefore, to work as an accountant, it is necessary to have accounting qualifications. The more prestigious and desirable the job is, the more the qualification required. As argued by Parkin (1998), 'there is a universal tendency among professionals to raise the minimum standards of entry as increasing numbers of potential candidates attain the formerly scarce qualifications' (p. 130). Subsequently, according to Parkin, credentials are based on the tests designed to measure certain class-related qualities and attributes (p. 132). This,

therefore, increases tendency for domination of particular professions or occupational positions within professions by particular social groups such as racial, ethnic, gender, religious or cultural groups.

Something worth noting about credentialism as a strategy of social closure and inclusion is the legitimation of credentialism by governments in most technologically advanced Western societies. This is in stark contradiction to the core principles of capitalism and the advocacy for the autonomy of the market, championed by governments of these Western nations. Another significant aspect of credentialism is its neutral appearance. Educational, vocational and professional requirements are believed to be fair and objective measures of the ability of an individual that in no way have any relationship to that individual's social identity. However, research (Coker, 2001; Birchird, 2001, Carter et al., 1999; Payne, 1998) reveals that country of qualification and membership of particular racial, ethnic or social groups are, in some cases, regarded as an indication of competence or incompetence.

As mentioned earlier, credentialism stands out as an effective device for protecting the learned professions from the hazards of the marketplace. Not merely does it serve the convenient purpose of monitoring and controlling access into specific professions and occupations; it also effectively disguises all but the most extreme variations in the level of ability of professional members, thereby shielding the least competent from occupational disadvantage.

Sponsorship and Patronage

As a theoretical concept, sponsorship and patronage can be demonstrated in many forms, such as informal mentoring in the form of offering advice; encouragement to apply for certain positions as well as informal and formal recommendations. In some extreme cases, sponsorships of junior professionals by senior professionals or promotions are legitimised. Utilisation of sponsorship as a strategy for professional closure occurs when candidates for certain jobs become successful, not on objective merit but, because of their connection with a particular sponsor who is particularly powerful and influential within the profession.

A significant aspect of this strategy for closure is the self-perpetuating forms of mobility within it. Research has revealed that to access certain occupational positions, newcomers must share the same social identities as incumbent members. For example, Carter (2003), writing on the experiences of minority doctors in the medical profession in the UK, argues that '[w]hite, middle-class males continue to dominate because they select others to succeed them who share their social background' (p. 73). If this is so, it makes access and progression for members of subordinated groups into certain professions and some occupational niches in those professions extremely problematic.

Another significant aspect of sponsorship and patronage is the inability of members of the dominated groups to challenge it. This is because of the assumption that any form of challenge mounted will likely result in the end of career progression for the person instituting the challenge because of the powerful structure of the profession.

Social and informal networks

In the explanation of social inequality, Pierre Bourdieu (1984), who employed the concept of social capital, argues that durable social networks serve as a basis for inclusion and exclusion and are a source of inequality within societies. Bourdieu defines social capital as 'the sum of the resources, actual or virtual, that accrue to an individual or a group by possessing a durable network of institutionalized relationships of mutual acquaintance and recognition' (Bourdieu and Wacquant 1992: 119). Therefore, belonging or non-belonging or a perception of belonging or not belonging to certain social and informal networks, can serve as a basis for inclusion or exclusion into some occupational niches.

One aspect of social network that is tantamount to power is information available to members of certain social network. As the saying goes, 'knoweledge is power', access to specific information about career opportunities, pathways, etc. can benefits individuals with access to such network because informal social networks increase one's access to information. Having key information on a post/opportunity can result to accelerated career progression. As argued by Feldman and Ng (2007) in their paper, Careers: Mobility, Embeddedness, and Success, access to restricted information is related to objective career success. Objective career success includes promotions, pay rises, professional honours, etc. (Seibert, Kraimer, and Liden, 2001). Moreover, Hackman and Oldham (1980) and Spreitzer (1996) argue that because information and resources are bases of social power within an organisation, greater access to information empowers employees and enhances individual employee's work performance. For example, information about available opportunities within an organisation empowers employees with such information to utilise such opportunities if he or she chooses. More so, knowledge is regarded as power. Therefore, knowledge, acquired through information amounts to power in the hands of an employee who can access the information. Hence, employees with access to information are perceived to be more powerful or influential within an organisation (Brass and Burkhardt, 1993). As argued by Ferris and Judge (1991) and stated in Seibert, Kraimer and Liden (2001), these sorts of perceptions can allow 'individuals to be able to secure valuable organisational rewards independent of her or his actual performance' (p. 221). Furthermore, having access to information about funding, available courses, career opportunities, etc. can increase the feeling of integration, psychological empowerment (Spreitzer, 1996), control and competence at work (Gist and Mitchell, 1992).

Thus, social and informal networks can serve as an important form of social closure because who one knows can take precedence over what one knows when it comes to hiring or promotion. In most cases where informal networks are utilised as a strategy for inclusion, recommendations from members carry significant weight. This hiring via informal networks can be exclusionary because it provides room for personal judgments about individual candidates. These judgments sometimes about potential candidates can be racist or sexist or ethnocentric and impressionistic (Carter, 2003, p. 74).

Other concepts utilized in this study to understand the experiences of IMGs are career sponsorship and patronage. Career sponsorship is described as the provision by a mentor to a mentee, favourable and timely exposure to opportunities to engage in challenging assignments, career advice and coaching that may lead to career advancement (Kram, 1985; Noe, 1988). In this study, a mentor refers to a more experienced doctor willing to expend his or her time and expertise to guide the professional development of another less experienced doctor. This is done via coaching, guiding, tutoring, facilitation, counselling and trusted advice. The mentee is a junior doctor who wants to develop professionally and is willing to learn from a more experienced doctor by seeking his or her trusted and valuable advice. According to Kram (1985) and Noe (1988) career sponsorship is one of the primary responsibilities of a mentor to a mentee. Therefore, in the context of this study, career sponsorship refers to the provision by a mentor to a mentee, favourable and timely exposure to opportunities to engage in challenging assignments, career advice and coaching that may lead to career advancement.

Patronage, according to Boissevain (1966) is 'founded on the reciprocal relations between patrons and clients. By patron, Boissevain refers to a person who uses his influence to assist and protect any other person, who then becomes his client,' and in return provides certain services for his patron' ' (1966, p. 18).

Otherness and Difference

To understand professional exclusion within modern industrial capitalist societies, the understanding of the notions of otherness and difference and how this difference is socially constructed is crucial. In this work, drawing on Albert Memmi's description of difference in his work: *Racism* (2000), I define difference as the categorisation of individuals and groups into distinct groups based on markers of difference such as gender, race, nationality, religion and age within a society. Memmi (2000) argues that the first form of racism consists of stressing a difference between the accuser and his/her victim (p. 171). As stated by him, 'by emphasizing the difference, the racist aims to intensify or cause the exclusion, the separation by which the victim is placed outside the community of even outside humanity' (p. 171). Usually, in the case of racism, according to Memmi, the racist bases their

action on biological or cultural difference. Therefore, difference involves identifying insiders and outsiders because of different markers of difference such as race, gender, religion, etc.

As for otherness, this study draws on the work of Zygmaunt Bauman (1991). Zygmunt Bauman argues that the main method by which societies establish identity categories is through the notion of otherness. He argues that identities are set up as dichotomies, such as: woman is the other of man, animal is the other of human, the stranger is the other of native, abnormality the other of norm, deviation the other of law-abiding, illness the other of health, insanity, the other of reason, lay public the other of the expert, foreigner the other of state subject, enemy the other of friend (Bauman 1991, p. 8). For professional closure to be successful, there must be differentiation and 'othering' based on social markers of difference. Social groups are differentiated based on social identities such as gender, age nationality, religion, sexual origin and ethnicity. This act of differentiating and 'othering' is regarded as the axis upon which social exclusion rotates because of the social connotations attached to these groupings.

In other words, the act of social exclusion or the monopolisation of certain privileges and positions by dominant social groups can hardly be successful except in circumstances where insiders and outsiders are identified. This differentiation is made based on singling out or making up physical, social and cultural characteristics for exclusion. This infers that social exclusion is based on the indictment of the 'other' as 'different' and the exploitation of this difference, albeit imaginary or real, as the basis and the legitimacy for the 'others'' exclusion (Memmi, 2000). Das Gupta (2009) in her discussion of racism in the nursing profession in Canada claims that 'difference is often built based on sheer imagination or the desire to draw a protective barrier against people who appear to be physically different from oneself' (p. 17).

Consequently, within professions, physical markers of difference such as race, gender, age, academic qualification or even academic institutions are useful tools for the execution of inclusion of exclusion.

To gain an in-depth understanding of the central research questions, this study proceeds by examining how markers of difference are produced and sustained to disadvantage minority groups within professions. Specific attention is paid to the concept of intersectionality. Intersectionality of race, class and gender can develop into a kind of identity formation. Although, it is important to note that in this study, intersectionality is used not as identities, but as ideas which can guide us in our process of examining access and progression processes within the system because no one lens is enough to look at the process within the system. Thus, the intersection of race especially, in its modern form, with class and gender is applied in my analysis of this work.

To gain a broad understanding of intersectionality as a concept, I present a brief thought on it here.

Intersectionality as a Theory

Intersectionality theory argues that social constructions of gender and race and its systematic relation to the dynamics of the labor market generate inequality. For example, to understand the experience of Black women in the labour market, it is imperative that we do not just strive to understand the experience of women and Black people, but through the intersectionality. Intersectioanlity argues that experiences of black people in the world of work reflects racialised gender and gendered racialisation to create an experience (Browne and Misra, 2003, p. 490). It is because of this reason that weber (2001) argues that race and gender intersect as "social systems" that "operate at all times and in all places," (p. 4). According to her:

> Race, class, gender, and sexuality are interrelated systems at the macro-institutional level-they are created, maintained, and transformed simultaneously and in relation to one another. Therefore, they cannot be understood independently of one another. (Weber 2001, p. 104).

A few sociologists have an opposing view of how intersectionality operates. For example, Kilbourne et al. (1994) argues that gender and race represent distinct stratification systems that do not always inter-relate. For theorists with this outlook, gender and race are independent systems of stratification which create unique experiences depending on its combination.

In this study, the perspective of Kilbourne et al. (1994) is adopted because I believe race, class and gender are socially constructed independent categories, fluid, historical, inter-dependent, produced, reproduced and reinforced to perpetuate inequality. Given their complex and independent nature, although not necessarily unrelated, the outcomes of these systems create unique experiences of disadvantage depending on the combination of gender, class and race.

Within intersectionality, all the three categories merit attention because of firstly, the historical antecedent of injustice, marginalisation and oppression experienced by members of these groups. Secondly, the tendencies of modern political, economic and socio-cultural establishments to oppress and marginalise members of these groups make them worthy of attention. In the next section, I conceptualised and fully discussed these concepts.

Additionally, this section also examines the concept of internalised oppression. It also scrutinised how the ‘othering’ of differences combined with other strategies of social closure such as credentialism, patronage and sponsorship, help us understand processes that produce inclusion or exclusion of IMGs from positions of privilege, power and prestige within the medical professional fields in Ireland and Canada.

Race and Racism

Race as a Concept and an Ideology

Theorising 'race[20]' and 'race' thinking, Goldberg (1990), describes the notion of 'race' as a fundamental process of 'conceptualising and organising social worlds composed of persons whose differences allow for arranging them into groups that come to be called 'races' (p: 61)'. However, the idea of 'race' as an ideology and discourse has been a contested concept since its emergence. 'Race' has never been the object of consensus because of the fluidity of meanings attached to it and the fact that the origin and basis attached to racial difference have not remained constant. For example, speaking about the USA, Omi (2001) argues that the 'meaning of race in the United States has been and probably always will be fluid and subject to multiple determinations. Race cannot be seen simply as an objective fact, nor treated as an independent variable' (p: 244).

Nevertheless, in the development of European/Western political ideas, 'race' remains very important as an ideology. Racism remains a valid descriptor of injustice and oppression based on physical looks, cultural practices and national origins. 'Race' continues to be used as a marker of difference and the basis for inclusion or exclusion. Consequently, human beings are grouped into certain racial categories based on their physical looks, cultural practices and geographical locations for the purpose of, among other reasons, inclusion or exclusion.

Worth noting is the fact that the articulation of 'race' as a concept of differentiation and categorisation was invented by European explorers in the fifteenth and the sixteenth centuries (Omi and Winant, 1986). The European explorers invented it to conceptualise the differences encountered on discovering the racially distinct people of the new world. The information received from European travelers who encountered native inhabitants of Africa, the Americas and India were utilised by the enlightenment thinkers such as David Hume, Comte Buffon and Hegel to conceptualise and differentiate the native inhabitants of these regions into social categories (Garner, 2009). Subsequently, 'race' came to be utilised as the primary tool for differentiation and categorisation of human beings. Differentiation based on phenotype and geographical location were linked to intellectual ability and capacity for civilisation by these thinkers (Garner, 2009). During this epoch, physical appearance became a marker of cultural development and a pointer to the ability or inability to control and master one's environment (Eze, 1997). It is this enlightenment epoch that marked the rise of the idea of race as a categorising tool in Europe. Therefore, the civilised were considered to be the groups of human beings that were pale in complexion and dwelt in the 'temperate zones of Europe and America' (Garner, 2009, p. 15). It is based on this supposed racial differences and social connotations such as 'inferior', 'subject races' and 'subordinate people' (Said,

[20] 'race' in this study is used solely as a social construct. Hence, it is in inverted commas.

1994) attached to the phenotype as well as cultural practices of the people of the new world, that 'race' was based. Europeans, then used 'race' to justify capturing of Africans as slaves to be used as the beasts of burden in the Americas and Caribbean. Besides, the subsequent colonisation of Africa and other non-European/western colonies such as India and China were also based on race. It is this ideology of 'race' that is behind the dehumanisation, subjugation, oppression and, sometimes, extermination of the racially different 'others'.

From the 1850s there was a rise in scientific racism due to the construction of racial differences with impermeable boundaries. This was a scientifically-based construction and ascription of somatic physical features to groups of people leading to a hierarchical ordering of human beings, with 'whites', 'Europeans' or 'Caucasians' at the pinnacle of a hierarchy of humankind' (Fenton, 1999, p. 69). By arrogating intellectual superiority to the Europeans, the Europeans were presumed to enjoy economic, political and psychological advantages (Memmi, 2000). This categorisation further fuelled the feeling of superiority of Europeans over non-Europeans because of its scientific validation.

This science of 'race' and racist thinking was boosted by social Darwinism; a social theory associated with the work of Charles Darwin (1859), the '*Origin of Species'*. In this work, Darwin refuted the monogenic argument of human origin and offered his polygenic argument that the world is racially ordered. This argument led thinkers like Count de Gobineau (1915), to elaborate racist ideas about miscegenation or racial mixing which he said would lead to the decline of civilisation and the degradation and enervation of the Aryan 'race', which he considered to be the most superior of all the races. He asserted that blacks are marked by animal instinct, a lack of morality and emotional instability with the least intelligence (Giddens, 2010). It is this claim that the white 'race' possesses superior intelligence and morality that was behind the thinking of European colonial powers justifying their global civilizing mandate (Giddens, 2010).

'Race' vs Racism

From the late 1940s, 'race' as an ideology and concept became one of the most contested concepts in the fields of social science and sociology. This period saw the invalidation of social Darwinism by science and biological differentiation and categorisation of human beings into superior and inferior categories was condemned. Debates about the validity of 'race' as a social concept and its acceptable use as a sociological term also commenced. For example, Miles and Torres (1996) argue that since 'race' as a scientific concept has been proven invalid by biologists and geneticists (Montagu, 1951), it should become sociologically invalid as a concept. According to them, the continued use of 'race' as a concept, despite its rejection, further 'validates and perpetuates race thinking, because it continues to colour, if not pervade, contemporary cultural expression' (Goldberg, 1990, p. 86). Consequently, Miles and Torres insist on never employing 'race' as a

theoretical concept, but refer to 'the idea of race' in inverted commas.

On the other hand, other scholars such as Omi and Winant (1994, p. 1) disagree with Miles and Torres on the invalidity of 'race' as a theoretical concept. They argue that 'race' has been a profound determinant of one's political rights, one's location in the labour market, and indeed, one's sense of identity. Therefore, 'race' conflict and racism are perceived as primary determinants of social inequality (Omi and Winant, 1986). Castagna and Dei (2000) argue that although the concept of 'race' is always being reformulated in particular circumstances, to accommodate certain historical events and cultures, the reality of racism on the basis of phenotype cannot be denied. For them, ''race' exists materially, politically, socially and ideologically among the people. Therefore, it cannot be dismissed as a social construct only' (Das Gupta, 2009, p. 15). Hence, the concept of 'race' is still useful.

In this study, while subscribing to Miles and Torres' (1996) argument that even though 'race' as a concept is scientifically invalid, I agree with Omi and Winnant that differentiation, categorisation and inferiorisation or superiorisation of people on the basis of their outward physical characteristics such as skin colour, facial features and hair texture still interacts with the distribution of economic, political and social resources within modern societies. Therefore, while 'race' itself is a false construct racial categorisation may be a source of economic, political and social inclusion or exclusion. As a result, in this this study, the use of 'race' in inverted commas is adopted to acknowledge its sensitivity, but more as a really contested term that is embedded in cultural, social, legal and political structures.

Racism as a Concept and a Discourse

Racism is defined in diverse ways. These definitions range from the narrow to broad, from inclusive to exclusive and from simple to comprehensive. For example, racism is defined by UNESCO[21] as 'any theory which involves the claim that racial or ethnic groups are inherently superior or inferior, thus implying that some would be entitled to dominate or eliminate others, presumed to be inferior, or which bases value judgements on racial differentiation' (UNESCO, 1978: 61).

Consequently, for UNESCO, racism includes:

> racist ideologies, prejudiced attitudes, discriminatory behaviour, structural arrangements and institutionalized practices resulting in racial inequality, as well as the fallacious notion that discriminatory relations between groups, are morally and scientifically justifiable; it is reflected in discriminatory provisions in legislation or regulations and discriminatory practices, as well as in anti-social beliefs and acts; it hinders the development of its victims… (UNESCO, 1978: 62).

Memmi (2000) argues that racists make references to biological differences for the purposes of suppression and the establishment of certain privileges and advantages for themselves (Memmi,

[21] UNESCO- United Nations Educational, Scientific, and Cultural Organisation: an independent agency of the United Nations, established to promote international cooperation in science, art, and education

2000). He also argues that racism or subjugation not based on biological differences for the purposes of privileges and advantages is possible. Subsequently for him, racism is:

> a generalising definition and valuation of differences, whether real or imaginary, to the advantage of the one defining and deploying them (accuser), and to the detriment of the one subjected to that act of definition (victim), whose purpose is to justify (social or physical) hostility and assault (aggression) (p. 100).

According to Memmi, a racist is a person who discriminates against his or her victims based on biological or cultural difference. For him, racists do this to demonstrate the impossibility of including the victims in the community because they would be too biologically or culturally different, professionally or politically unskilled. This definition is supported by Miles (1989) who describes racism or 'racialism' as 'the process where meaning is attributed to somatic, cultural, religious and other bodily markers so that individuals are viewed and defined as being members of discrete 'races'' (Miles, 1989: 75). This process of categorisation is the representational process of defining the 'other'. Referring to the notion of difference and otherness as presented earlier, racism can refer to the process through which racism differentiates people who are phenotypically, racially and culturally different.

Examining all the presented definitions, it is obvious that racism involves the act of differentiating the 'other' based on their membership of a racial group. Members of differentiated racial group are ascribed with certain characteristics that are generalized. Hence, they are categorized into established, generalized stereotypes for denying them access to power and resources. Consequently, in this study, a description of racism as the act of ascribing negative connotations to certain groups of people, based on their bodily physical characteristics, cultural/religious practices and subsequent distribution of resources based on this negative differentiation, is useful. Additionally, older scientific or narrow sense racism is described here because it helps us understand the evolution of racism, although, our focus will be on new racism.

Old scientific racism, was described by Memmi (2000) as racism based on biological differences. As discussed earlier, this form of racism was the basis for the capture and transportation of around 10 to 20 million Africans from their native countries (Hatton and Williamson, 2005; Harris, 2002) across the Atlantic to labour as slaves in the Caribbean, Brazilian and the Americas plantations (Jackson and Weidman, 2006). Anti-Semitism and the Jews' holocaust by Hitler's Germany are directly related to old scientific racism. Furthermore, apartheid in South Africa and until the 1970s, racial segregation in the USA, are a consequence of old scientific racist thinking and ideology.

Subsequently, new forms of racism, which manifest in the form of cultural differentiation, is examined. More so, scrutiny is conducted on how cultural differentiation serves as the basis for the exclusion and marginalisation of the perceived culturally inferior groups from economic, social, political and sometimes, psychological benefits. A careful examination of how this practice endows

dominant European 'races' with spiritual, social, cultural and psychological superiority is carried out.

New Racism

New forms of racism, which is used as an analytical tool in this study emerged in Europe after WWII. Post-WWII is important because this period, in some European countries, witnessed the invalidation and condemnation of old scientific or biological racism by international organisations especially, UNESCO. This invalidation led to the withdrawal, in some countries, of the term 'race'. Despite this, the term, racism, is still very much embedded and prevalent in advanced western societies.

New forms of racism are a response to post-war immigration to Western Europe by former colonial subjects (Garner, 2004). They are rooted and grounded in differences in culture and religion (Stolcke, 1995) and started taking shape through the 1950s (Brown, 1999), becoming the dominant discourse in the second half of the 1970s in the UK and France, for example, (Garner, 2004. p. 169). The principal discourse of this mode of racism is the use of culture instead of biology (Stolcke, 1995). Examples of new racism are cultural racism, Islamophobia, institutional racism and racism against migrants. Cultural racism is the intersection of racism and culture. It refers to an act of inclusion and exclusion that emphasises the distinctiveness of cultural identity, traditions, and heritage among groups (Soysal I993). Cultural racism manifests itself in the racialisation of migrants, especially migrants of non-western origin who are perceived as posing a threat to national unity of 'host' societies because they are culturally different and ranked as inferior. An example of the invocation of the sentiment of culture against immigrants in the UK was Margaret Thatcher's popular statement of I978 in a television interview for the current affairs programme: *World in Action*. In this statement, Thatcher claimed that the British people are afraid that Britain might be swamped by people with a different culture. A more recent example is evident in the 'Breaking Point: the EU has failed us all', a poster by Nigel Farage, leader of the far-right UK Independence Party. This poster shows a vast queue of mostly non-white migrants and refugees stretching into the distance. Consequently, to protect Britain and the British 'way of life' from the threats posed by immigrants and their cultures, the message portrayed by the poster is that immigrants need to be contained and controlled.

Islamophobia can be defined as 'a single, unified and negative conception of an essentialised Islam, which is then considered incompatible with Euro-civilisation' (Semati, 2010, p. 256).

Institutional racism in this study, is defined in the context of the UK by Sir William Macpherson in his report in 1999 on the shortcomings in the police inquiry into the racist murder of the London teenager, Steven Lawrence, as:

> … the collective failure of an organisation to provide appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage

minority ethnic people (McPherson Report, 1999).

Internalised Oppression

Internalisation of oppression or what W.E.B Du Bois referred to as 'Double Consciousness' and described as the African-American psychological challenge of reconsidering an African heritage with a European upbringing in slavery and education. Du Bois (1989 [1903], p. 3) in describing how white domination impacts a 'double consciousness' on the Black American, stated that an African American is born into 'a world that yields him no true self-consciousness, but only lets him see himself through the revelation of the other world'.

More recently, Stuart Hall (1986) describes internalised racism as 'the 'subjection' of the victims of racism to the mystifications of the very racist ideology which imprison and define them' (Hall, 1986, p. 26). Internalised Oppression is described by Pheterson (1986) as:

> The incorporation and acceptance by individuals within an oppressed group of the prejudices against them within the dominant society. Internalized oppression is the mechanism within an oppressive system for perpetuating domination not only by external control, but also by building subservience into the minds of the oppressed groups. (p. 146)

These definitions describe a situation where members of oppressed or racialised groups as victims of oppression, are subjected to the mystifications of the very oppressive ideology that marginalises and oppresses them. Hence, they perceive it as fair and deserving of it. For example, victims of racism may blame themselves for being victims of racism and even sometimes, believe they deserve such treatment.

Gender Discrimination

As mentioned earlier, gender 'refers to the varied and complex arrangements between men and women, encompassing the organization of reproduction, the sexual divisions of labour and cultural definitions of femininity and masculinity' (Bradley, 1996, p. 205). The 'structure of social relations that centres on the reproductive arena, and the set of practices that bring reproductive distinctions between bodies into social processes' has also been referred to as gender (Connell, 2009, p.11). Therefore, gender involves attributing tasks, functions and roles to men and women based on bodily distinction and embedding this diffenentiation within social processes, relationships and interactions. It this way gender arrangements become socially constructed through existing and evolving structures. A notable aspect of gender discrimination is androcentrism. Androcentrism can be defined as the 'value system that views the male perspective as superior to the female perspective' (Newton and Zeitoun, 2003. p. 385). As a result, gender discrimination occurs when societal, organisational and institutional policies and practices that see male perspectives in workplaces as superior to females' and have the possibility of providing fewer opportunities for women than for men (Cleveland et al., 2005).

Within professions, I argued that women are systematically excluded from the most powerful and prestigious positions (Witz, 1990, 1992; Cassidy et al., 2002; Quinn, 2004; Russell et al., 2008) and that labour markets, apart from being racialised, are gendered (O'Connor, 2005). According to Witz (1992), strategies of social closure restrict women in the labour market because, 'women are typically hedged into low-paying and low status jobs with little autonomy, which invariably stand in a subordinate relation to male occupations' (Witz, 1992, p. 77). Even though researchers like Witz identified exclusionary (intra-occupational control) and demarcatory (inter-occupational control) practices against women, as a broad category, within professions, there were few references to the different experiences of women of ethnic minority background until recently (Kim, 2002).

Racialised gender identities have been claimed to be distinct sources of inequality for ethnic minority women as these women experience the double negative impacts of sexual and racial discrimination in the labour market. According to Nkomo (1988), because the status of ethnic minority women is evaluated negatively in two ways, they are positioned at the very bottom of occupational pyramids (Nkomo, 1988, p. 135).

It is also important to point out that very little is known about skilled female migrants who, more likely than their male counterparts, experience greater difficulties in gaining access to professions and occupations that are regulated and in some cases integrating into them (Kofman, 2012). Carter (2003, p. 79) writing on the experiences of Caribbean nurses within the NHS in the UK argues that closure was an integral part of the entire process of recruitment of nurses from the New Commonwealth. As a result, young women from the Caribbean were channelled into less prestigious parts of the nursing profession. Similarly, in an earlier study by Carter et al. (1999) on ethnicity and employment in higher in the UK, it was revealed that ethnic minority women are more generally positioned at lower grades than their 'white' counterparts (p. 23).

Additionally, recent research in the field of migration and labour market has revealed the double impact of gender and race on immigrant women's career opportunities. The 'double-bind' or 'double-whammy' theory views ethnic minority women as victims of a double whammy in employment (Kim, 2002, p. 403). For Kim, 'while sexism is harmful enough to ethnic minority women, it is the practice of this phenomenon within the context of racism that might differentiate the marginalisation experiences of ethnic minority women from those of white women' (Kim, 2002, p. 403). According to her, the gendered nature of professions has exposed migrant women to a position of disadvantage and vulnerability.

Also, the concept of 'glass ceiling' is employed to interpret the experiences of female IMGs. When discussing the lack of many women in managerial positions in the US *Fortune 500* companies, Nkomo and Cox (1996, 1989), Bell and Nkomo (1992) and Maume (1999) argued that the absence of

women was not as a result of women's intellectual or physical inability to study and practice medicine, but as a result of what feminists regard as the presence of glass ceiling in professions. Using the United States' Federal Glass Ceiling Commission (1995a: iii), the 'glass ceiling' can be defined as the 'unseen, yet unbreachable barrier that keeps minorities and women from rising to the upper rungs of the corporate ladder, regardless of their qualifications or achievements' (Federal Glass Ceiling Commission 1995b: iv). According to feminist writers, glass ceilings are put in place, mostly by men, to keep women away from prestigious and desirable career positions. In exceptional cases where women are allowed, they are only allowed to play subordinate roles to men (Witz, 1993; Das Gupta, 2009, 1996; Kim, 2004). An example of this was given by Stuart (1993) when she claimed that in the 19th century, women were largely perceived to be subservient to men and their roles were predominantly perceived as that of tending to their children. By the end of the 19th century, Kulys and Davis (1987) argue that when they were encouraged to enter the labour market, many were encouraged to take up the nursing profession where they became the doctors' (usually, male) helpers.

The theoretical insights gained so far allows me clearer understanding of how gender is constructed within the profession, and how this gender construction and roles sharing according to gender construction creates hierarchies within the profession. These hierarchies, within the medical profession, with males usually at the top, are sustained by policies and practices that clearly polarise the healthcare profession into doctors, usually males and nurses, who are usally supposed to assume the position of helping the male doctors.

Class

Social class, in a general sociological sense, according to Bradley (1996, p. 205) is used to designate differences based on wealth, income, occupation, status, group identification, level of consumption, and family background. Many sociologists rendered different definitions and descriptions of social class. Prominent amongst them are Karl Marx and Marx Weber. In this study, class is understood from the perspective of Max Weber (1948). I must note here that even though I am drawing on insights from Weber's status and prestige ideas, the analysis is not really a class analysis in a more traditional way. Weberian concept of class is used to understand the notion of class as to be able to analyse its production and reproduction within the area of focus in this study.

The Weberian concept of class explains that economic positions of individuals are an important aspect of inequality. However, the ownership of the means of production is just one of the many bases for inequality because inequality has multi-dimensional sources which are class, status and party. According to Weber (1948), class position, one of the distinct dimensions of inequality was also determined by a person's skills and education, besides their relationships to the means of

production. Instances of this, according to Weber is when directors of large corporations control businesses they do not own. Weber argues that in conjunction with wealth, the amount of prestige and power one commands also determines one's social class. Therefore, for Weber, social class refers to a group of people with similar wealth, prestige and power (Weber, 1948).

In addition, the property-less class is defined by the kinds of services individual workers provide in the labour market. Subsequently, he categorised workers, based on the value of distinct kinds of labour and different wages as skilled, semi-skilled and unskilled. For him, even though, class is not the supreme factor in social stratification, it is a distinct aspect of inequality. Therefore, some distinct class groups may form closure around certain occupations or positions of privilege by erecting social boundaries to restrict access to valued resources. This is, therefore, the process of subordination within a hierarchy, in which a group closes off 'opportunities to another group of outsiders beneath it which it defines as inferior and ineligible' (Murphy, 1988: 8). This idea of Weber's on class broadens my understanding of how certain professions and occupational positions within a profession can be closed off or opened because of the prestige attached to it because of being classified as more or less skilled. In most cases, only people with a certain level of economic means can acquire such qualificatiions and skill.

Conclusion

Having examined, analysed and gained insight into the profession as a concept, the concepts of social closure, difference, otherness, race, class and gender, are used as tools to analyse and understand, experiences of IMGs in the medical professional field in Ireland and Canada. Attention is paid to the intersection of race, class and gender on the integration of IMGs and how they interact with the ability of IMGs to access and progression within the professions. The intersection of race, class and gender is perceived as playing a vital role in the ability of doctors to be included or excluded within the medical profession in Ireland and Canada because of the perceived roles of wowen within the profession which is surbordinate to that of male. Also, the emphasis laid on credentials, economic cost of acquiring such credentials and cultural and social group the owner of credentials is perceived to belong to determine the ability of a doctor to access and progress within the medical profession.

It examines and analyses how every day experiences of IMGs are shaped by the concepts of difference and otherness. This study also uses these concept as a lens through which processes and practices within the medical profession in Ireland and Canada is interpreted.

Chapter Three

Interpretative Sociology as a Methodology and Professional Integration of International Medical Graduates in Ireland and Canada

Introduction

The research design for this study is exploratory and interpretive and data is analysed through qualitative methods. Like all valid research, this study is based on some underlying philosophical assumptions about what constitutes and how do we develop original knowledge. It is the successful identification, review and understanding of these assumptions that lead a researcher's ability to find appropriate framework for their study. Therefore, this chapter presents and discusses the research methodologies used in this study, which includes data gathering and analysis techniques, and all strategies and instruments used. Furthermore, it also explains the different processes involved in the study, the critiques of the chosen methodology and how these methodological shortcomings are dealt with. It also includes an exploration of what informed the study and the way the study might have been influenced by my own positionality.

A key work that is the basis for this Ph.D. study and which is in some cases referred to is my MA thesis. This thesis titled: *Employment Equality and Workplace Inclusion, a Myth or a Reality: An Post a Case Study,* to begin with, studied employment equality practices of An Post in relation to recruitment, retention and promotion of ethnic minority employees. An Post was selected because of its role as a semi-state national organisation with over ten thousand employees and a commitment to adopt and implement equal employment opportunity legislation in Ireland. To this end, the study bench-marked the findings against employment equality practices of the Royal Mail in the UK. Outcomes reveal that:

Institutional, rather than direct or overt discrimination is responsible for the exclusion of ethnic minority employees from the more privileged occupational grades within the organisation.

Besides institutional racism, the importance of social and cultural capital was revealed. Social capital was defined by Coleman (1990) and quoted by Seibert et al (2001, p. 220) as, 'any aspect of social structure that creates value and facilitates the actions of the individuals within that social structure'. Social capital theorists have identified and argued that social networking is crucial for the achievement of career goals and advancing in one's career (Seibert et al., 2001). This MA study unearthed how access to social networks of white Irish (especially male) employees of the organisation, facilitate access to information, resources and career sponsorship, which in turn, positively influence their career outcomes. Contrastingly, the lack of access to this level of resources, by many ethnic minority employees negatively impact the outcome of their career.

It is the outcome of this research, married with my identity as a Nigerian migrant, living in Ireland at the peak of the Celtic Tiger, and my experience of working as a Mail Operative with An Post that sparked an interest in me. This interest ignited the desire to find out if the kinds of institutional practices that disadvantage particular social groups is limited to only mail sorting floor of An Post, or, is it extended to highly-skilled professions such as medicine? The profession of medicine was chosen because it requires a specialised skill. Besides, presently, 35% of the total numbers of registered medical doctors in Ireland and 50% of the junior doctors in Irish hospitals are International Medical Graduates (Medical Council, 2014).

It is important to note at this junction that I am not in any way, suggesting that unskilled and semi-skilled workers deserve to be treated differently from skilled workers. I am only trying to find out if the kinds of practices and strategies of inclusion/exclusion that prevail on the mail sorting floor also prevail in the specialist professional sphere of hospital wards.

In addition, the outcome of the MA thesis could not be generalised to the experiences of the wider body of ethnic minority employees in Ireland, which is varied in culture, occupations and resident statuses, depending on the type of visa acquired to enter Ireland. It is, however, indicative of practices prevalent within workplaces in Ireland. A significant feature of the employment positions of ethnic minorities in An Post is their over-representation in non-managerial positions, despite many of them possessing third level degrees from their native countries and a few of them from Irish institutions (Kolawole, 2009).

Consequently, this doctoral research takes the MA further by exploring and benchmarking the experiences of IMGs of non-EU/Western origin within the Irish medical professional field in relation to access and progression within the medical profession in Ireland and Canada.

Interpretivist Research Paradigm

Broadly speaking, a research paradigm is a viewpoint which shapes ideas and actions. It is composed of certain philosophical assumptions that guide and direct thinking and action in research (Mertens 2005, p. 7). According to Fraser (2004, p. 59), paradigm is described as a 'set of beliefs about the way in which particular problems exist and a set of agreements on how such problems can be investigated.' It is this believe that made Olsen, Lodwick, and Dunlop (1992) opine that a paradigm means a pattern, structure and framework or system of scientific and academic ideas, values and assumptions (p. 16). Looking at this definition, I will say that a research paradigm tells us what reality is like and the basic elements it contains. It asks the ontological question, what do we know and epistemological question, how did we know what we claim to know?

These ontological and epistemological questions form the basis of a researcher's worldview. Worldviews can be either objective or subjective/constructive. Thus, a researcher engages in

research using either objective or subjective worldviews depending on their ontological and epistemological assumptions about the subject of research. In the last few decades, different paradigms of research were identified. One of them is interpretivism which is the paradigm used in this research. Interpretivism as a research approach tries to understand phenomenon from the perspective of an individual. It also tries to investigate interaction among individuals and the historical and cultural contexts which people inhabit (Creswell, 2009, p. 8). This approach lays emphasis on an individual case. Therefore, it aims at understanding realities from from subjective experiences of individuals.

Research Methodology

The inductive and descriptive nature of an interpretive research paradigm makes it heavily reliant on qualitative research methods to investigate social phenomena. In other words, the type of research methodology to be utilised depends on the nature of the phenomenon to be studied. According to Morgan and Smircich (1980), the suitability of the research method derives from the nature of the social phenomenon to be explored. Therefore, the subjectivity of experiences of the phenomena under investigation in this study, which include skilled migration, labour market participation of migrants, experiences of discrimination, exclusion and professional closure, data gathering techniques within the qualitative method of research are appropriate for gathering, analysis and validation of data.

Qualitative Methods of Research

Qualitative methods of research are methods used to study how people attempt to make sense of, or to interpret phenomena in terms of the meanings they bring to them (Denzin and Lincoln, 1994). According to Leininger (1985, p. 5), 'qualitative research refers to the methods and techniques of observing, documenting, analysing and interpreting attributes, patterns, characteristics and meanings of specific, contextual and gestalt features of a phenomenon.' Within these methods, the researcher often goes to the site of the interviewee to conduct the research (Creswell, 2003) and researchers also engage research interviewees in the process of data gathering. Through techniques such as interviews and focus group discussions, interviewees become part of the research process. As a result, qualitative methods of research increase a researcher's ability to generate data and construct well rounded and balanced views of interviewees.

Data gathering methods

Research Population and Research Interviewees

In as much as the overall aim of this study is to examine inclusionary and exclusionary processes and practices utilized by dominant groups within the medical profession in Ireland and Canada, focusing

on an aspect of citizenship, place of initial medical training, racism, social closure and institutional practices of discrimination in both countries, I interviewed three principal groups:

1. IMGs currently practicing medicine in Ireland and Canada
2. A smaller group of IMGs who have previously practiced in Ireland, but are now practicing in Canada
3. Representatives of employer and professional organisations.

The reason for interviewing members of the first two groups was to explore their experiences of access to medical practice and progression within medical practice in Ireland and Canada. The reason for the interviews with the employer and the professional organizations' group was to explore factors that guide formulation of policies for access and progression into medical profession and how these policies are implemented in both countries

Research Interviewees

Interviewing IMGs in Ireland and Canada

Possible interviewees in Ireland and Canada for this research were initially recruited purposively. Purposive sampling techniques refers to a sampling technique that involves the selection of interviewees in a research 'based on a specific purpose rather than randomly' (Tashakkori and Teddlie, 2003a, p. 713). Interviewees were successfully selected through identification of gate-keepers, snowballing and trawling of internet sites.

For IMGs, I must note here that I could not get access to the national database of doctors in Ireland and Canada. Also, the sensitive nature of the data generated during this study made recruiting interviewees for interviews, at the initial stage, in Ireland, extremely difficult. Sensitive data are defined by the Data Protection Commissioner of Ireland in the Data Protection Acts as:

> any personal data as to:
> (a) The racial or ethnic origin, the political opinions or the religious or philosophical beliefs of the data subject
> (b) Whether the data subject is a member of a trade union
> (c) The physical or mental health or condition or sexual life of the data subject,
> (d) The commission or alleged commission of any offence by the data subject, or
> (e) Any proceedings for an offence committed or alleged to have been committed by the data subject, the disposal of such proceedings or the sentence of any court in such proceedings
> (www.dataprotection.ie/docs/General/1237.htm).

The initial response of potential interviewees in Ireland, was that of mistrust and fear. It was obvious that many IMGs did not trust my intention and were afraid of discussing such sensitive issue with me. Some interviewees felt there were significant risks attached to their participation in the research. So, at the initial stage, there was reluctance on the part of some interviewees. This

brought up the issue of protection. This means I had to make sure interviewees were free to speak about their experiences without fear that their comment would carry any negative sanctions against them. As stated by Brannen (1988), when interviewees in a research are likely to reveal information that is delicate, steps must be taken to protect them from those negative sanctions that may result from their participation in such research. To ensure that IMGs participated and spoke freely about their professional integration experiences, I offered assurance of protection to interviewees. This was done by letting them know, in the purpose of research document emailed prior to meetings or handed out before commencement of interviews, that as interviewees any information they divulged during the interview would be written in a way that could never be traced back to them (see Appendix XI). Assurances were given too that data from interviews would be anonymized, even if it meant some transcripts would then not be included in the final draft, because of the highly individual and sensitive nature of the biographical accounts rendered.

Subsequently, to establish access in Ireland, I initially formulated my strategy around getting to identifying and contacting key gatekeepers within the groups of IMG and employers and professional organisations. Internet searches produced the names and contact addresses of migrant groups in Ireland. I approached the Overseas Medics of Ireland, the Association of Nigerian Professionals in Ireland and the Sudanese Community of Ireland. I did this by sending emails, making phone calls and, in some cases, sending registered letter by post to identify gatekeepers within these groups. Eventually, I identified interviewees who could influence participation of other others because of their positions within these organisations. For example, within the Overseas Medics of Ireland, I established a rapport with an IMG who has been practicing medicine in Ireland for nearly three decades and who was prominent within the group. An arrangement was made with him for an interview, a date was set up, and an interview was successfully conducted with him in March 2012. It was during this interview that I discussed the problems I encountered in the process of recruiting other interviewees. Having practiced medicine in Ireland for an extended period, being a prominent IMG, and having good relationships with many IMGs, he was in an advantageous position to recommend me to members of his organisation. Hence, he promised to send them emails, introducing me, explaining what I was doing and indicating that I was sincerely interested in the welfare of IMGs and I was not an agent of the HSE. He also copied me on those emails. The result of that email was phenomenal. Some of his contacts responded instantly that they were willing to meet with me. If I described the transformation that took place, it can be likened to what Carter (2004, p. 350) describes as a halo effect conferred on a researcher by a key gatekeeper whose intervention gave credibility among interviewees that was previously lacking.

Besides purposively approaching these associations, I snowballed by requesting that interviewees

from these associations, if willing, refer their friends and colleagues to me. Snowballing is not in disagreement with purposive sampling, because sometimes snowball sampling, can follow purposive sampling (Brown 2005). Subsequently, further interviewees were then identified through snowballing. The interviewees in Canada who previously practiced in Ireland were selected through snowballing. Out of the 33 interviewees in Ireland, 18 were selected through this sampling technique.

In the case of Canada, techniques to identify interviewees were similar to those employed in Ireland. Key gatekeepers were also identified and contacted via academic institutions and researchers who had previously conducted research on this topic in Canada and groups such as Association of International Medical Graduates (AIMG) in Alberta, The Association of International Physicians and Surgeons of Canada in Toronto, Yoruba Cultural Association in Toronto and an online forum for Nigerians living in Canada called: *Nigerian-Canadian Forum*, whose members reside across Canada. These key informants were either emailed or telephoned and between September 2011 and October 2012. Nine purposively selected interviewees were subsequently interviewed via Voice over Internet Protocol (VoIP) applications such as Skype.

Besides purposive selection of research interviewees, like in Ireland, further interviewees were then identified through snowballing. When I conducted an interview with an interviewee, I asked for referral to the interviewee's colleagues who might be interested in the study. Through this sampling strategy, 12 interviewees were selected and interviewed. Altogether, 24 interviews were conducted with and IMGs across five cities and representatives of IMGs' employers in Canada.

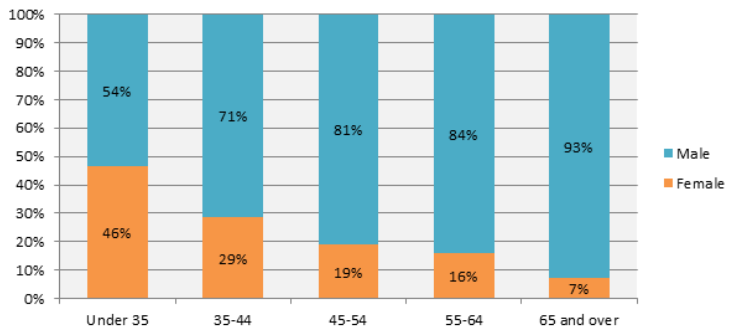
Table 10: Breakdown of Total Number of IMGs Interviewed according to Nationality and Gender

	Total Number of Interviews	
	Canada	Ireland
Rep of Employers	3	6
Female IMGs	8	7
Male IMGs	13	20
Nationality Breakdown of IMGs Interviewed		
India	6	3
Libya	2	2
Pakistan	4	7
Sudan	2	6
South Africa	2	2
Nigeria	3	5
Egypt	0	1
Malaysia	0	1
Jamaica	1	0
T&T	1	0
Total	21	27

This study also strove to make sure the gender of interviewees agrees with the gender distribution of IMGs in medicine in Ireland and Canada. Table 7 on the next page presents Gender breakdown of IMGs in Ireland indicating that participation of male and female IMGs in Ireland and Canada is consistent with the gender representation of IMGs within medicine in both countries.

The Table below shows gender representation of IMGs in Ireland.

Chart 1: Gender Breakdown of IMGs in Ireland as at May 2015



The Table and Chart above reveals that female IMGs make up only 25% of the total number of IMGs in Ireland despite increased feminisation of the physician workforce in Ireland. For example, the percentage of female doctors registered on the medical register in 2015 is 41% of the total number of doctors registered on the register. The breakdown of this figure shows that 62% of 25 to 34-year-old Irish graduates are female. In stark contrast to female doctors who are over 65 years old, female doctors now make up 53% of Irish graduated doctors aged 35 to 44 (MCI, 2015).

The factors responsible for the under-representation of female IMGs in both Ireland and Canada is

explored further in Chapter 9.

Table 11: Residents Cities of IMGs Interviewed in Ireland and Canada

Canada	Ireland
Toronto	Dublin
Ottawa	Cork
Calgary	Wexford
Montreal	Limerick
Vancouver	Letterkenny
	Cavan
	Tralee
	Naas

These cities are not the only cities where there are IMGs in Ireland and Canada. However, they are cities with substantial numbers of IMGs and ones where I was able to access the IMG groups.

The specialties of IMGs who participated is presented in Table 9 on the next page.

Table 12: Specialties of IMGs who participated in Ireland and Canada

Specialty	Pathology	Surgery	Gynaecolc	Medical M	Geriatric M	Occupatio	Neonatolc	Psychiatry	Family Me	Internal Medicine
Numbers	2	20	5	2	2	1	1	6	7	2

Altogether, 48 IMGs were successfully interviewed in Ireland and Canada. Within the Irish cohort of IMGs, 6 are consultants (see table below) and the remaining 21 are Non-Consultant Hospital Doctors (NCHDs). Within the Canadian sample, the issue of consultants does not arise because, the type of hierarchy that exists in Ireland does not exist in Canada. The difference that exists in Canada is between a specialist doctor and a family doctor. All interviews were conducted between October 2011 and June 2014.

All interviewees in Ireland and Canada were selected on the basis that:

1. The interviewee's country of origin and training was outside of Western Europe, Canada, USA, Australia and New Zealand.

2. Their willingness to participate in the study.

Interviewing Employers and Representatives of Professional Organisations

I purposively selected the representatives of employers that participated in this study. In Canada, I contacted Health Canada via an email. In the email, I introduced myself and gave a brief outline of the purpose, objectives, rationale and methods of my research. Health Canada's official accepted to participate in the research and I was directed to persons with the responsibilities for IMGs. I was directed to the Director of Healthcare Programs and Policy. An interview was scheduled and conducted with the Director in his office on the 28th October 2011 in Ottawa. After the interview, the director then directed me to a Senior Policy Analyst and the manager in charge of Health

Canada's Internationally Educated Health Professionals Initiative. On the 4th November 2011, I met and interviewed the manager in charge of Internationally Educated Health Professionals Initiative of Health Canada. She then invited me to the Health Canada IEHPI Policy Roundtable, November 23, 2011. The objectives of the consultations were to provide input into key policy issues related to policy developments on language, communications and culture in the workplace as well as alternative career paths for IMGs.

In Ireland, I contacted the Human Resources Director of the Health Service Executive (HSE) in 2012. He referred me to the General Manager, who I interviewed in his office on 9th April 2013. The interview lasted nearly 2 hours. The general manager then set up a meeting with the HR Lead - HR Communications and Improvements. She then set up a meeting with 3 of her colleagues who work as Equality Officers in the HSE on the 18th April 2013 in the offices of the HSE at 63-64 Adelaide Road, Dublin 2. After this meeting, I was introduced to the Medical Manpower manager in one of the hospitals and I interviewed her on 19th September 2013.

What is common in accessing all interviewees, both in Ireland and Canada is the provision of informed consent form (see Appendix XII) that was signed by all interviewees in the study. The information in the informed consent form included:

1. An indication that the participation is voluntary.
2. The rights of interviewees to withdraw at any time during the interview if they so wish.
3. Assurance about interviewees' confidentiality and anonymity.
4. The signature of the interviewees

Ethical Concerns

As mentioned earlier, ethical issues involving confidentiality and anonymity that may have arisen because of engagement with interviewees were addressed to the extent that was possible for me. For example, assurance was given to interviewees that none of their names would be used in the write up of the thesis and any information that would give away their anonymity would not be included in the final thesis. Additionally, during the interviews with all interviewees, I promised that, before my binding and submission of the thesis, contact would be made with them to confirm the accuracy, relevance and authenticity of my interpretation of their accounts. In some cases, interview transcripts that would give away the identity of the interviewee because of the biographical material of the narrative would be completely left out of the thesis.

It is important to mention here that in the final presentation of data in this work, names of participants were changed and all names presented in this study are made up.

Data Collection

This section discusses methods and techniques utilised in the process of collecting data. Bearing in

mind the overall strategy of this research, data were gathered via both primary and secondary data sources. Interviews were conducted, and data and documents generated from existing literature and qualitative interviews made up the primary data sources. In this study, data generated from employers, professional and training bodies' websites are considered as secondary data.

Interviews were chosen as a method of data gathering because they form a valuable method of understanding other people and getting to know their views. As Janesick (1998: 12) argues, an 'interview is a meeting of two persons to exchange information and ideas through questions and responses, resulting in communication and joint construction of meaning about a particular subject.' Besides, interviews help in the construction of stories and narratives (Ribbens and Edwards, 1997). Since the aim of this study is to understand professional integration experiences of IMGs, it was appropriate to hear their stories so, as to document and present their experiences. As a result, semi-structured face-to-face, telephone and VoIP interviews were utilised as the main instruments through which primary data were collected. Semi-structured interview format was used because it gives interviewees opportunities to reflect and make sense of past experiences (Birch and Miller, 2000). Within this technique, there is great flexibility as questions that are not included in the guide may be asked. The interviews questions' guide is included in Appendix IX and X. This is because the emphasis is on what the interviewee's perspective in relation to explaining and understanding events, patterns, and forms of behaviour. Telephone and VoIP interviews were employed because of their cost-effectiveness when compared with face-face interviews, especially in a study that extends over a large geographical distance (Frey and Oishi, 1995).

Subsequently, in-depth, semi-structured interviews were conducted with a total of 46 IMGs in both Ireland and Canada. The main source of primary data was the interview recordings and transcripts from the interview and documents given to me by some interviewees. Face-to-face interviews were conducted with seven IMGs in Canada and nineteen IMGs in Ireland. Besides, telephone and Skype interviews were conducted with fourteen IMGs in Canada and six IMGs in Ireland. In Canada, IMGs geographical locations vary from Ontario and Quebec, through Alberta, Manitoba and Saskatchewan in the Prairies to Vancouver in western Canada. Below is the map of Canada. Additionally, three of the IMGs interviewed in Canada are IMGs presently practicing in Canada with previous experience of practicing in Ireland.

The table and map on the next page shows the type of interview conducted and numbers interviewed.

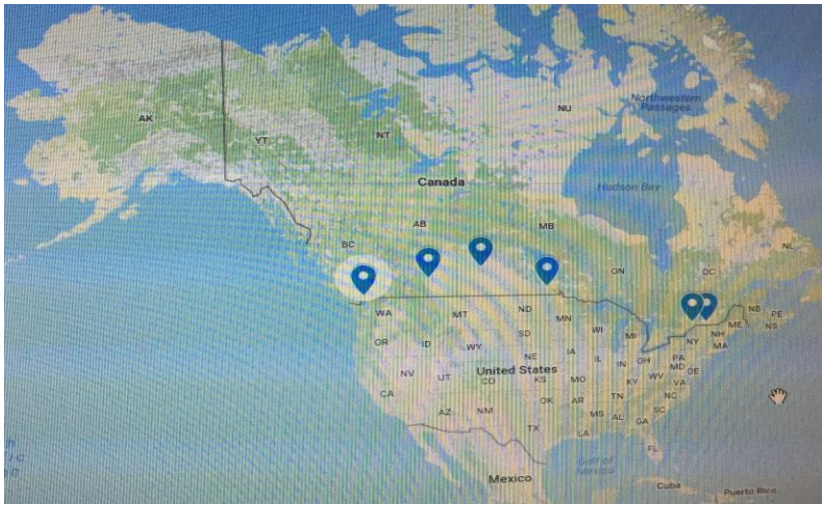
Table 13: Types of interview conducted and numbers interviewed

Type of interview	Canada	Ireland
Face-to-face	7	21
Telephone/Skype	14	6

Map 1: Ireland and places where interviews were conducted



Map 2: Canada and places where interviews were conducted



In Ireland, research interviewees' geographical locations were spread across Dublin, Wexford, Tralee, Letterkenny, Longford and Limerick (see map 1 above), although many of them perform medical functions in more than one hospital. For instance, a Consultant Pediatrics interviewed works in a city, but attends private clinics in another city.

My intention to take notes and record interviews were also made known to interviewees prior to scheduled interviews. Some of the interviewees agreed to have the interview recorded while the majority refused. The refusal, I believe, represents attempts to reduce a risk of negative sanctions associated with openly complaining about the medical profession's system of inclusion. Besides, they wanted to avoid anything that could be directly or indirectly traced back to them. As the few who agreed to have the interview recorded, I noticed the actual recording made them nervous. This was having a negative impact on the research environment and the responses were very short. In cases like this, I asked them if turning off the recorder would help them relax. Then, some of them asked me to turn it off. A few interviewees gained more confidence after turning off the recorder and I could then establish a good rapport with them.

The interview questions were, in some cases, open-ended questions and in other cases, they were themes to be explored (see interview questions is included in Appendix iii). Some of the themes are centered on processes and practices of access to professional practice; strategies of promotion used within the medical profession; attitudes of colleagues, consultants, other staff and clients and IMGs' coping strategies.

Besides conducting interviews with IMGs, face-to-face were also arranged and conducted with representatives of employers and professional, training and certification bodies in Ireland. All interviewees within this group did not agreed to use of a recorder during interviews. Email interviews were also conducted with representatives of a training body, the Royal College of Physicians and Surgeons, Ottawa, Canada.

Document Analysis

Besides interviews, documentary and policy analyses of data and policy documents from both primary and secondary sources were also conducted. Documentary and policy analyses were employed because of their ability to help elicit meaning, gain understanding, and develop empirical knowledge from both online and offline documents. As a result, country specific immigration policies, health policies and health professionals' recruitment policy documents were analysed. Besides, documents such as annual reports, statistics data, recruitment, retention and promotion and equality policy documents of the Medical Councils of Ireland and Canada and training bodies such as Royal College of Surgeons of Ireland, College of Family Physicians of Canada and the HSE were obtained for purposes of review. Newspaper articles on this topic or in more general, foreign doctors, in relation to Ireland and Canada were also accessed and analysed. More so, country-

specific studies on this topic in Ireland and Canada were also consulted.

There are some limitations to the usefulness of document analyses such as incomplete or missing document and data restriction to what already exists. Nevertheless, the benefits of document analysis, such as its cost-effectiveness, availability, and its lack of obstructiveness and reactivity far out-weigh its flaws.

Data Analysis

Data analysis is the process of reducing a large amount of data collected to a story and its interpretation (LeCompte and Schensul, 1999). It is a process of making sense of data. The analysis of data involves three key elements:

1. Organisation
2. Identification /categorisation
3. Validation and integration.

As a result, in this study, firstly, files were created for data collected. The data were organised in the order of date of interview and country of residence of interviewees. Subsequently, field notes were summarised and organised; recordings were transcribed, neatly organised, saved, and stored away in a safe place. After this, field notes and transcripts were read through, and initial codes were created. Secondly, transcripts and field notes were opened to reveal ideas and meanings embedded in them. Key narratives and materials that have contextual relevance in relation to the research were also identified. Subsequently, after several readings of the data, meanings within the stories were interpreted and structural descriptions of the experience of the phenomena were developed. Core categories were also selected and systematically related to other categories and key segments from documents were selected using methods of thematic and constant comparative analysis of documents and interviews. Thirdly, relationships were validated, and concepts brought together and integrated into categories which have explanatory power within the context of this research.

Researcher's Position and the problem of Reflexivity

When conducting research using the interpretive methods, the 'positionality' of the researcher *Vis-a- Vis* the researched can significantly influence access to informants and information (Herod, 1999). Positionality refers to the social location, subjective experiences and theoretical stance of the researcher; the interpersonal and institutional contexts of the research; and the effect on the research process (Mauthner and Doucet, 2003). In this study, I acknowledge my personal background as a male immigrant originally from Nigeria, who previously worked mostly in unskilled and semi-skilled sectors of the labour market in Ireland. In my experience as a job seeker and subsequently as an employee, I found out the crucial roles that markers of difference such as race,

gender, ethnicity, religion, etc. play within the paid work arena in Ireland. It is anecdotal in Ireland that most vacancies are filled by 'words of mouth and personal referrals.' This word of mouth method of filling vacancies, disadvantages migrants who may not have built enough social networks within the Irish labour market to take advantage of such method of recruitment.

Consequently, to complete an objective research, I made clarifications of my assumptions and presuppositions I might have because of my experience as a first-generation migrant from Nigeria, an employee in a semi-skilled position within the Irish labour market and a researcher. There is no doubt that my identity as a non-medical practitioner researching the medical professional field was methodologically problematic. This is because of my lack of knowledge about operational processes and procedures of the medical profession, lack of adequate knowledge about gatekeepers, and the self-regulatory nature of the profession makes it almost impossible for 'medical outsider', like me, to access data relating to organizational data. Also, there is an assumption that my non-medical professional status will hinder my ability to form a good research rapport with interviewees. However, in this study, I argued that such an assumption may be misplaced. Firstly, interviewees who are IMG and I are socially matched around being non-EU/EEA migrants. This was advantageous to the study and as Maynard (2002) suggests, 'matching interviewee and interviewer has been one way of minimising exploitative power relations in qualitative research these are serious issues in terms of good research practice' (p. 36).

Secondly, I can claim that my position as an outsider brought innovation to the interview process. This is because, I asked questions that insiders might take for granted and was able to uncover some not-usually-questioned common sense justifications that may be taken for granted by a medical researcher. Besides, because of the symmetry between the interviewees and myself in the area of ethnic identity and experience of migration and integration, I was able to get the interviewees to talk more about their migratory and integration experiences, because we share the same structural position when it comes to migration and integration, albeit, in different professional fields, by virtue of our cultural identity.

Chapter Four

IMGs and the Medical Profession in Ireland and Canada: A Structure of Access, Progression and Outcome

Introduction

This chapter presents and discusses the origins and early development of medical professions in Ireland and Canada. The section also compares access routes to practice and pathways for progression for IMGs with local medical graduates in Ireland and Canada. A statistical breakdown of IMGs in Ireland and Canada according to division registration and specialty is also presented. The purpose of this chapter to try to understand the structure of medical training within Ireland and Canada, the access and outcome realities of IMGs and the role traditional professional structures and practices play in shaping access and progression experiences of IMGs in both countries. This analysis is carried out sequentially. The analysis and discussion on Ireland comes first and then, that of Canada.

Medical Education in Ireland

Brief History

Historically in Ireland, physicians used various methods to heal including use of herbs, sweat houses, secret herbal charms and medicated baths. In the Christian era, St Patrick[22] was popular amongst the carers for the sick in Ireland. Records show the establishment of hospitals, mostly in monasteries and majorly for leprosy, but in some cases for other illnesses as well. Besides, secular hospitals such as the Hospital of St John the Baptist (1188), The Steyne Hospital (1220) and Hospital of St Stephen (1344) were built.

This practice of medicine continued in Ireland even though the development of formal medical education was largely absent through the 12th and 13th centuries until the 17th and 18th centuries. Prior to mid-1700, formal training of physicians and surgeons was non-existent. What existed was apprenticeship. Prior to 1662, medical training in Ireland was largely uncontrolled and unregulated especially in rural areas. According to Wilkinson (2008), medical apprenticeship up until late 17th century Ireland was a form of arrangement between a medical practitioner (master) and a trainee, where for an agreed number of years, normally from five to seven, the master imparted his knowledge to the trainee. The training did not follow any structure and no examination were taken. The apprentice did not get enumerated during the period of apprenticeship. Rather, the apprentice

[22] Saint Patrick, also known as the "Apostle of Ireland", was a fifth-century Romano-British Christian missionary and bishop in Ireland.

was required to pay a fee to his master, who, in turn, provided him with lodging, usually in his own house, food and clothing (Wilkinson, 2008. p. 160).

It was the 17th century that brought the establishment of a formal medical education, practice and regulation. Significantly, in 1654, 'the College of Physicians of Dublin' was founded in Trinity College by Dr John Stearne, a Professor of Medicine in the college. The college started as 'The Fraternity of Physicians of Trinity Hall', but was granted a Royal charter in 1667. The first professor of medicine was appointed in 1662 and the first medical degree graduate was conferred in 1674 (O'Brien, 1984, p. 57). In 1784, the Royal College of Surgeons in Ireland was also founded. The Charter that founded the Royal college of Surgeons gave the College power over surgical practice and training.

The development of medical education became formalised in Ireland in the 18th century by the collaboration between the College of Physicians of Ireland and Trinity College. This collaboration resulted in the formal establishment of the School of Medicine and School of Anatomy in Trinity College on the 15th August 1711 with four lecturers appointed (O'Brien, 1984). Candidates admitted into Trinity College to study medicine at that time first took a 'degree of Bachelor in Arts and then proceed to study for the degree of Bachelor in Physics as medicine was known then' (O'Brien, 1984: 78). The only place to obtain a medical degree in Ireland during this time was Trinity College. According to Farmer (2004: 19), there was little professional structure at this point in the history of medicine in Ireland. Nevertheless, it must be noted that hierarchy still existed. Then, Physicians were regarded to be at the top of the professional hierarchy, followed by surgeons and then apothecaries (modern day pharmacists). Physicians were regarded as the ones who were experts in diagnosing illnesses, while, surgeons and apothecaries marked specialisations in the treatment of illnesses (Farmer, 2004).

Another significant aspect of medical training in Ireland prior to and in the 1800s was the emphasis on clinical rather than laboratory training. It is significant to note that by the end of 1800s, there was a complete shift from medical apprenticeship to formal and structured medical education and training via the Royal colleges and Hospitals. Furthermore, the Medical Registration Act of 1858 established a medical register for both Great Britain and Ireland and a general Medical Council was inaugurated subsequently in 1927, to oversee medical education and professional practice in Ireland (Barrington, 1987). It is also noteworthy that 1901 census was the first to include the count of women doctors, which was put at five although the first set of women doctors were admitted as a licentiate in 1877.

Another notable feature of the structure of access to medical profession practice in Ireland during this time was the importance of family ties and religious affiliation. As Farmer (2004. p. 113) argues, 'in appointing doctors to the country dispensary jobs, professional qualifications were ignored and

political opinions, religious beliefs and local influence were the only questions considered'. In 1901, it was recorded that in Dublin, only two out of nine popular medical doctors were Catholics. The importance of family connections was evident in the medical dynasties that were produced. A few of such dynasties are 'O'Cassidys, O'Callaghans, Dunleavys and O'Maras' (O'Brien, 1984. p. 56). As for intra-occupational hierarchy within medicine in Ireland, by 1926, the consultants emerged as the most important personalities in the hierarchy of professional medicine and hospitals were transformed into highly specialised places to study and cure diseases.

This development continued into the 19th century especially, with the introduction of Anesthesia, vaccination and 'new bedside clinical training for the English-speaking world' (Farmer, 2004, p. 80). The establishment of the Catholic Medical University in Dublin and medical education faculties in Queen's Colleges in Belfast, Cork and Galway also contributed to the development of medical education in Ireland. More so, specialist studies such as the study of the eye and ear were introduced and medical instrumentations such as stethoscope, syringe, endoscope and hypodermic were developed in this era. In the middle of this century, the 'general practitioner' category was formed. This category comprised of men with qualifications in surgery, apothecary and sometime midwifery (O'Brien, 1984).

In the 20th century, the quest to finding lasting solutions to diarrhea, typhoid fever and tuberculosis spurred significant progression of medical education in Ireland. This era saw the introduction of the X-Ray machine and texts to help medical students who, unlike previous students, went through no apprenticeship period.

This form of medical education and practice with the royal colleges and hospitals as central and important continues until today, even though the health system has evolved over time. Another feature of the Irish medical profession that may continue to this time is the ability of certain social groups to reproduce themselves and reinforce their privileged positions. For example, initially, women were prevented from entering medical profession until nearly the 1900s. There was no record of a female graduate from the Royal College of Surgeons in Ireland until 1893 when Emily Winifred Dickson[23] became the first fellow of the Royal College (RCSI, 2012). Also, when it comes to progression within medicine in Ireland, social class and family connections are still regarded as powerful factors (Corrigan, Shield and Redmond, 2007) and women still experience negative career outcomes when compared with their male counterparts (Cannon, 2003).

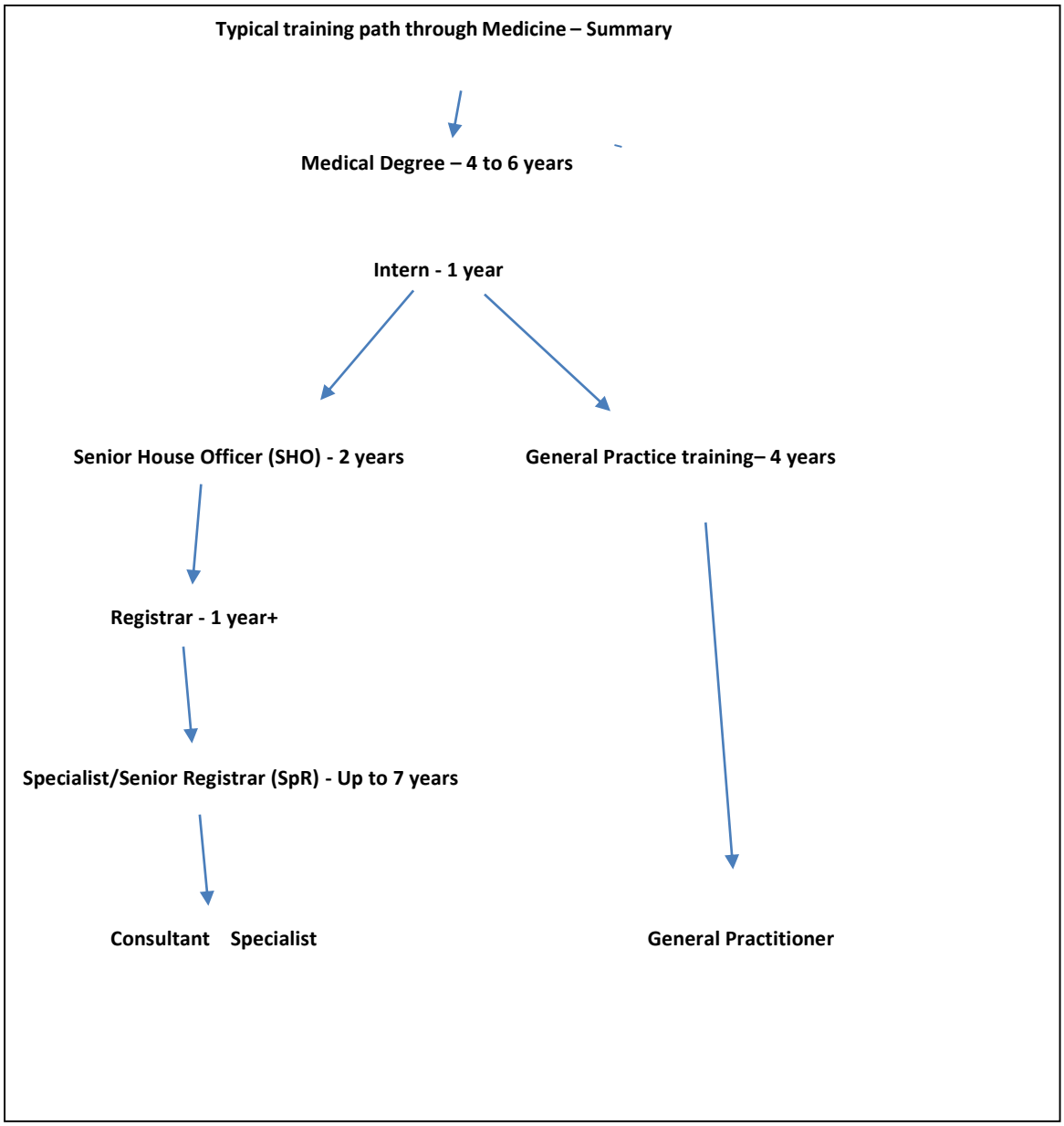
[23] Emily Winifred Dickson obtained the Licence of the Royal College of Surgeons in Ireland & Royal College of Physicians of Ireland in 1891 and graduated from the Royal University of Ireland in 1893 with the degrees of MB, BCh, BAO. She was elected the first female Fellow of RCSI in 1893 (https://www.rcsi.ie/index.jsp?p=164&n=1206&a=2116).

Current Medical education, Career Structures and Pathways in the Medical Profession in Ireland

This sub-section discusses medical training pathways in Ireland. Firstly, it, presents a diagram that represents the pathway. This is followed by discussions and detailing of the pathway.

The diagram below gives a representation of the medical training pathway from undergraduate medical student to a specialist in Ireland.

Figure 1: Structure/Pathway of Medical Training in Ireland



Source: National Audit of SHOs and Registrars Report (2008)

Extrapolating from the diagram above, we can deduce that there is a clear pathway for the progression of any individual who aspires to be a consultant in Ireland. This pathway follows a progression from undergraduate training within Medical Schools to postgraduate training with one

of the postgraduate training bodies. For the sake of simplicity in this thesis, the entire process is divided into two: undergraduate medical and postgraduate medical training. It is important to understand that, according to the HSE (2008), the training pathway from beginning to end, takes a minimum of 13 – 15 years.

Undergraduate Medical Training

Undergraduate medical education or training in Ireland is located within and controlled by academic institutions and the Medical Council of Ireland. There are six medical schools in Ireland. These schools are in University College Cork (UCC), University College Dublin (UCD), National University of Ireland, Galway (NUIG), and the Royal College of Surgeons in Ireland (RCSI), Trinity College Dublin (TCD), and University of Limerick (UL). The total number of students in these medical schools is around 850 per year (Medical Council, 2014). Depending on the access route taken by the student to acquire a medical degree, undergraduate degree programmes may take 6 years. Most of the final two years of undergraduate medical training are spent in hospitals. Upon graduation, the new doctor has an option to temporarily register in the Internship Division of the Irish Medical Council, to complete their one-year internship in a designated Irish hospital under consultant supervision. This Intern year is structured so that interns gain experience of a range of medical specialties. It is thought that this exposure will assist them in deciding on the area of medicine in which they want to specialise. On successful completion of the internship, the doctor is issued with a Certificate of Experience and if he/she so wishes, can apply for full registration with the IMC and then proceed to a specialist training.

It is important to note there are some overseas internships that are recognised by the Medical Council as equivalent to an Irish internship and granted the equivalent of an Irish Certificate of Experience. Overseas Internships are internship training undertaken outside of Ireland, including outside the EU states. Presently, overseas internships recognised as having the equivalent of an Irish Certificate of Experience are internships from Australia, New Zealand, South Africa, Pakistan (Internships commenced from January 2009), Sudan and Malaysia.

Presently, according to the *Progress Report on Medical Education, Training and Practice in Ireland 2008-2013* (Medical Council, 2014), there are three routes to acquiring undergraduate medical training in Ireland:

1. European Community applicants must achieve a minimum academic standard in the Leaving Certificate Examination[24] or its equivalent – including meeting any specific entry

[24] The Leaving Certificate Examinations which is commonly referred to as the Leaving Cert is the final examination in the Irish secondary school system.

requirements required by the individual medical school, e.g. passes in science subjects – and pass the Health Professions Admissions Test (HPAT) measuring candidates' logical reasoning, problem solving skills, non-verbal reasoning, and interpersonal skills (p. 14).

2. Non-European Community applicants must obtain the necessary standard in an equivalent to the Leaving Certificate, and additionally may be interviewed as part of the process (p. 14).
3. Graduate entry medical programme entrants must obtain a minimum of an Upper Second Class honours degree (2.1) in a primary degree - in any subject – and reach a threshold score on the Graduate Australian Medical School Admission Test (GAMSAT) or Medical College Admission Test (MCAT). Non-European Community applicants may also be interviewed (p. 14).

Postgraduate Medical Training

Postgraduate medical education, following an internship, is provided by the postgraduate medical training bodies and is usually funded by the Health Service Executive (HSE) (Department of Health, 2014). These bodies are recognised and accredited by the Medical Council to provide postgraduate medical training within Ireland. They are also responsible to the Medical Council for the structure of medical training programmes they deliver. Presently, Ireland has thirteen postgraduate training bodies. These bodies have combined responsibility of delivering specialist training programmes in fifty-two recognised medical specialties (Medical Council, 2014, p. 43).

Postgraduate medical education and training in Ireland is divided into two parts: General Professional/Basic Specialist Training (GPT/BST) and Higher Medical Training (HMT). All doctors undergoing postgraduate training must be registered on the Trainee Specialist Division of the register of the Medical Council. This division is 'specifically for medical practitioners who practice in individually numbered, identifiable postgraduate medical training posts, which are recognised by the Medical Council for training, while they are completing all or part of their medical specialist training in Ireland' (Medical Council, 2012, p. 5).

The BST part of the postgraduate training is a stage which lasts at least two years. BST provides doctors with foundation training in those competencies best suited to prepare them for the second stage of training – Higher Specialist Training (HST). During this period, the doctors receive general training and rotate across a range of specialties in Senior House Officer (SHO) or Registrar's posts. This training allows the doctor to gain a wide range of experience prior to deciding on a definite future choice of career. At the successful completion of this stage, a certificate of completion of GPT/BST is issued. The certification is required for the doctor to progress to an appointment to any of the higher specialist training programmes. The number of BST training posts funded by the HSE and filled by the postgraduate medical training bodies for the 2013-2014 period was 1,627

(Department of Health, 2014).

Presently, there are ten BST programmes in Ireland. These trainings are in anesthesia, ophthalmology, psychiatry, histopathology, general practice, emergency medicine, general internal medicine (and its subspecialties), surgery, obstetrics and gynecology and pediatrics including neonatology.

Higher specialist training (HST) usually lasts the period of 3-6 years, depending on the specialty and subspecialty. HST is the final stage of training and doctors essentially compete to get a place on a HST programme in their preferred specialty. It is important to note that appointment to this scheme is highly competitive. This HST is designed to bring a doctor's knowledge and skills up to the standard required for registration on the Specialist Division of the Medical Council's register and subsequent independent, specialist practice. During this period, a doctor is employed as a Specialist Registrar (SpR) or in the case of psychiatry, a Senior Registrar (SR). Upon successful completion of HST, a Certificate of Satisfactory Completion of Specialist Training (CSCST) is awarded to the doctor. Then the doctor is eligible to apply to the Medical Council for specialist registration. Another point worth noting is that during the period of HST, doctors may obtain other qualifications such as becoming a Fellow or Member of the relevant College. Doctors who choose to pursue research careers may carry out research at home or abroad and publish academic papers to have PhDs, Mch, etc.

BST and HST programmes represent a continuum of training. Some of the training bodies have moved, or are moving, to a continuous or 'run-through' model of training with a single selection point. Trainee doctors compete for access to proceed to BST for hospital-based training schemes or directly to specialist training in the case of general practice. It is also worth noting that in the case of training to become a general practitioner (GP), according to the HSE (2014), after the completion of internship, a doctor is eligible to apply for GP training programmes. Presently, there are twelve GP training programmes distributed geographically throughout the country. Unlike the other specialist trainings, there is currently a single programme of training of duration of four years in this specialty, with no separate BST or HST stages. The first two years are usually spent in hospital settings, and the last two in a supervised GP training programme at GP Registrar level. To enter the register of the Irish College of General Practitioners (ICGP), a certificate of satisfactory completion of training combined with Membership of the ICGP (through examination) is required. The accredited training body for general practice (GP) in Ireland is the ICGP.

Another important aspect of medical education in Ireland is the role of the Health Service Executive. The HSE has a series of statutory responsibilities regarding medical education and training under the Medical Practitioners Act 2007. These include:

The promotion and development of medical education and training in collaboration with the Medical Council and postgraduate training bodies.

Medical workforce planning which includes the assessment annually of the number of Intern and specialist training posts required and the number of non-training Non-Consultant Hospital Doctor' posts required.

Advising the Minister for Health on all matters relating to the development and coordination of medical education and training. In this context, in recent years the HSE has introduced service level agreements with the training bodies to fund Intern training, Basic Specialist Training (BST), Higher Specialist Training (HST), and a range of scholarship and other training opportunities (Medical Practitioners Act 2007, Part 10 (86)).

It is the responsibility of the training bodies to select trainees onto both BST and HST Programmes. The training bodies are also responsible for the training, assessment, progression and eventual certifying as eligible for admission to the Specialist Division of the Medical Council's register of trainee doctors.

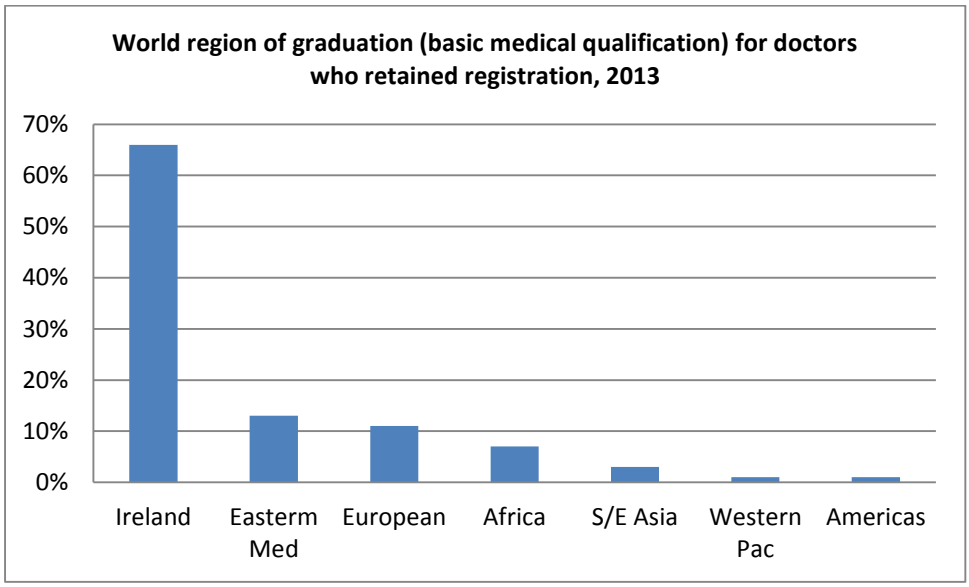
Access and Pathway for Progression for IMGs in Ireland

The following table and charts show the number of and trends relating to IMGs in Ireland between 2000 and 2015. It is important to note once again that until 2012, statistics in Ireland classify all doctors trained outside of Ireland foreign-trained. However, since 2013, the following categories were made: Qualified in Ireland, EU Citizen qualified in EU/EEA, Non-EU Citizen qualified in EU/EEA and Qualified outside EU/ EEA.

Table 14: Numbers of foreign doctors registered with the Medical Council of Ireland from 2000-2015

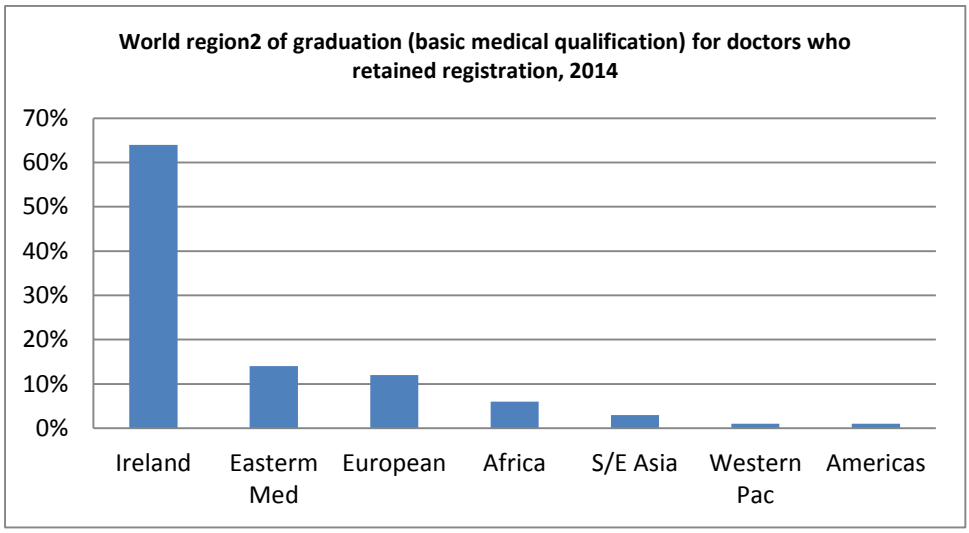
Year	International Medical Graduates	Foreign-Trained doctors (%) of all registrations
2000	1,746	13.0
2001	2,128	15.2
2002	2,753	18.4
2003	3,097	20.0
2004	3,542	22.3
2005	4,257	25.3
2006	4,558	28.1
2007	5,435	31.8
2008	6,110	34.1
2009	6,569	36.3
2010	6,274	33.4
2011	6,724	35.8
2012	6,325	34.8
2013	5,558	34.3 (23% are non-EU/EEA)
2014	5,947	35.7 ((23% are non-EU/EEA))
2015	7,954	39.0 (29% are non-EU/EEA)

Chart 2: World Region of doctors registered with MCI in 2013



Source: www.medicalcouncil.ie

Chart 3: World Region of doctors registered with MCI in 2014



Source: www.medicalcouncil.ie

Looking at the charts above, it is evident that IMGs form a significant part of the medical workforce in Ireland. Thus, it is important that we understand the access routes and career pathways available to them. Therefore, a careful analysis of their medical career pathways in Ireland is analysed. Consequently, the general processes of access and progression constructed for professional medical careers in Ireland are presented step-by-step in this subsection. Then, this is benchmarked against those processes put in place for the IMGs to access and progress within medicine in Ireland.

Access Route for IMGs into medical practice in Ireland

One point that is worthy of mention before the analysis of the pathway is presented is the difference between the pathway for access and progression within medical practice in Ireland between Irish graduates of medicine and IMGs. As mentioned in the HSE's *National SHOs and Registrars Audit Report* (2008), IMGs generally enter the Irish healthcare system at the SHO and Registrar level and do not work in Intern posts in Ireland.

An IMG who wishes to practice in Ireland, must first pass or be exempted from the PRES examinations, register in a division of the Medical Council's register, as discussed in Chapter Two and then, he or she must seek employment directly from hospitals. The IMG must apply to the HSE and the hospital management where there are vacancies for doctors. Even though there are specified training routes to accessing medical practice in Ireland, when it comes to medical positions, there exists two types of posts that doctors can apply to: Service Posts and Training Posts.

Service posts are posts without the recognition of clinical practice and experience acquired while the doctor is occupying it (HSE, 2014). Doctors employed in these posts are employed for service purposes only. Clinical experience is not certified and posts do not offer any opportunity for professional or postgraduate training. The posts are designated as Senior House Officer or Registrar (Department of Health, 2014). Presently, 1,895 IMGs as compared with 637 Irish doctors are occupying service posts in Ireland. This means IMGs constitutes 74.8% of junior doctors in service posts in Ireland (Medical Council, 2015, p. 44).

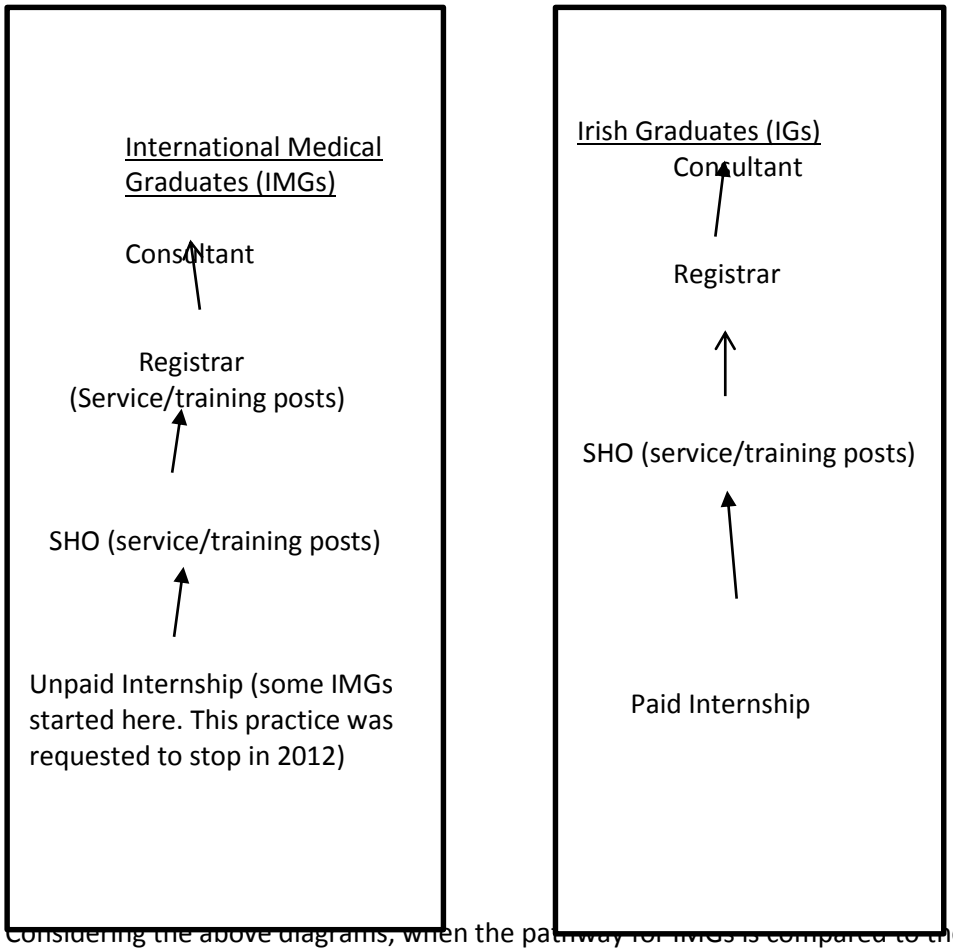
Clinical experiences gained by doctors occupying training posts are recognised and certificated. This basically means doctors who are employed in training posts are undertaking postgraduate medical training in recognised training posts unlike a doctor who is not occupying a training post, whose clinical experience, practicing in that post is not recognised. It is noteworthy that 417 IMGs (7%) compared to 1,525 (14%) Irish doctors were in specialist training as at 2014 (Medical Council, 2015. p. 44) and by 2015, there are 1,589 Irish doctors and 397 IMGs in specialist training (Medical Council, 2016. p. 46).

In relation to access routes for IMGs in Ireland, an initiative worth mentioning is the International Medical Graduate (IMG) Training Initiative. This training initiative was adopted by the HSE and The Forum of Irish Postgraduate Medical Training Bodies (the thirteen postgraduate training schools) on 15 January 2014. It operates separately from the National Domestic Specialist Training Programmes in Ireland and it differs in structure, purpose, objective, duration and learning outcomes. However, it provides one possible route for overseas doctors wishing to undergo structured postgraduate medical training within the public health service in Ireland. The IMG Training Initiative allows postgraduate medical trainees who qualified outside of Ireland to undertake a 24month period of active training in clinical services in Ireland after which they are expected to return to their country

of origin. The purpose of the IMG Training Initiative is to enable overseas trainees to gain access to clinical experiences and training that they cannot get in their own country, with a view to enhancing and improving the individual's medical training and learning and, in the medium to long term, health services in their own countries. The Initiative is aimed primarily at doctors from countries with less developed health sectors than Ireland, and is not intended to encourage the settlement of those doctors in Ireland.

Having presented the access routes available to IMGs in Ireland, it is imperative to gain an insight into their career pathways. The diagram in the next page (Figure 3) represents career pathways for IMGs within the medical profession in Ireland and compared with pathways for Irish graduates.

Figure 2: Pathway for access and progression of IMGs in Ireland



Considering the above diagrams, when the pathway for IMGs is compared to the pathway for Irish graduates, a slight difference is noticed. As mentioned earlier, IMGs, unlike their Irish counterparts, do not commence their career as paid interns. In the case of Irish graduate of medicine, the intern year commences after the completion of an undergraduate degree in medicine in one of the medical schools. This intern year offers a doctor a full-time, paid job in a clinical setting and the successful completion of it allows the doctor to fully register with the Medical Council. Internships are usually

done in a teaching/university hospital affiliated to the relevant medical school. IMGs, unlike Irish graduates, do not officially participate in an intern year in Ireland to start practicing. There is however, a widespread practice in Ireland until 2012, to informally require of IMGs who are here, but who have no explicit, documented permission to work in Ireland, to participate in unpaid internships (*Irish Times*, 2002, 27th May). This is done via the requirement of experience of Irish medical practice in some cases and references from existing consultants practicing in Irish hospitals in others. To satisfy these requirements, for instance to gain Irish experience, some IMGS are compelled to take up supernumerary posts within hospitals to gain experience and get references required to secure employment. It is worth noting that as far back as 2002, supernumerary positions were controversial. In 2002, an IMG from Malaysia, Dr Eng, was awarded €36,000 after he sued St James Hospital, Dublin for working as an unpaid intern for 9 months (Sheehy, 2002, 11th January). In 2012, the then Human Resource Director of the Health Service Executive, Mr Barry O'Brien, requested that the practice that allows clinical observerships for IMGs who do not have explicit, documented permission to work in the State, be stopped (Mudiwa, 2012, 13th December).

Career progression of IMGs, unlike their Irish counterparts, is problematic because it depends on the country of training. The Medical Practitioners Act 2007 disallows doctors with medical qualifications outside of Australia, New Zealand, Malaysia, Sudan, and South Africa (with an internship after 2006) and Pakistan (with an internship after 2008) from entering training posts within the medical profession in Ireland. This means that depending on where an IMG trained, his or her progression can be straight forward or complicated. Hence, IMGs from outside of those five countries mentioned may be employed as junior doctors to fill service posts, but then have no prospect of career progression. This presents a glass ceiling for them at the registrar grade. This segregation along country of training, is one of the barriers identified confronting IMGs from outside the EU and the five countries mentioned in the Act.

It is important to acknowledge the transformation within medical training in relation to specialist training in Ireland ushered in by the Medical Practitioners Act 2007. As mentioned earlier, this Act confers responsibility for medical education and training on the HSE. As a result, the Medical Education and Training Unit (MET) of the HSE was established in 2007. The role of this unit is to ensure that the legislative responsibilities of the HSE in medical education and training are met appropriately. In carrying out this responsibility, the HSE commissioned *The National Audit of SHO and Registrar posts* in 2007. This audit, which was successfully completed in 2008, resulted in Ireland, for the first time, having a comprehensive national database of SHO and Registrar posts in all relevant specialties. Besides, it identified a few key issues in relation to postgraduate medical trainings. According to the report (HSE, 2008, p. 2), such issues include:

The registration status of doctors with an approved postgraduate training body.
The structured progression of doctors through the postgraduate training pathway.
The current and future role of the registrar grade as a training post.
The future management of stand–alone training posts and the number of posts not accredited for training.

One of the recommendations contained in the report was that a working group, comprised of representatives from the HSE, the Medical Council, the Postgraduate Training Bodies, the Department of Health and Children and the Postgraduate Medical and Dental Board, should be established to develop plans and strategies to address the issues and challenges identified in the report. The challenges include the existence of NCHD posts with limited training potential within the hospital system and a poor training environment. According to Shannon (2010) as cited in Humpheries et al. (2014), this poor training environment embodies heavy workloads, poor pay and working conditions, inability of doctors to can achieve a better work–life balance and lack of mentorship. Subsequently, the working group was established and the outcome of the working group was the signing of memoranda of understanding by the HSE with the Medical Council and the Forum of Irish Postgraduate Medical Training. These memoranda of understanding made the HSE, the Medical Council and training bodies, stakeholders in the recruitment and training of doctors. The Medical Council regulates doctors and accredits training; training bodies identify training posts and train doctors and the HSE fund recruitment and training of doctors. As a result, some demographic groups within medicine in Ireland, such as women and IMGs have recorded considerable gains in terms of specialist training and becoming consultants. According to the *Medical Workforce Report 2014, '*58.3% of doctors registered in the Trainee Specialist division were women in 2013/2014. Among doctors aged less than 35 years who graduated from an Irish medical school, 69.6% registered in the Specialist Division were women' (p. 52). Furthermore, 'among Hospital Consultants aged under 35 years and who graduated from an Irish medical school 64.3% were women' (p. 52). Besides women, IMGs have also gained a little also. A few of them could secure some of the recognised training positions and eventually, became consultants. Therefore, there is a slight increase in the numbers of IMGs who are consultants presently, when compared with the period before 2007.

The pathway for progression for IMGs in Ireland

Going back to the aim of the research, which is to find out if IMGs are integrating into Ireland's medical profession, it is appropriate to examine the pathway for progression created by the profession of medicine in Ireland for the purpose of facilitating professional integration of IMGs. Therefore, as discussed in Chapter Two, IMGs wishing to practice in Ireland, after sitting and passing

the Pre-registration Examination set by the Medical Council, can register in any of the following four of the five divisions of the register of the Medical Council: General, Trainee Specialist, Specialist and Supervised. The fifth division is the Visiting EEA Registration. The table on Table 2 shows the distribution of IMGs across the four division of the Medical Council register in 2014.

Table 15: Irish Graduates and IMGs and their division on MCI register 2014

Division	Graduates of Irish medical schools		Graduates of a medical school outside Ireland	
	N		N	
General Registration	3248	30.6	3521	**63.4**
Specialist Registration	5928	55.8	1570	**28.2**
Supervised Registration	0	0.0	7	**0.1**
Trainee Specialist Registration	**1448**	**13.6**	**460**	**8.3**

Source: Medical Workforce Report 2014 (www.medicalcouncil.ie)

The table above reveals Irish graduates and IMGs in Ireland and their division in the Medical Council register as at June 2014. The table reveals that 63.4% of doctors registered in the general division are IMGs compared with 30.6% Irish graduates. This means the number of Irish graduates registered in the specialist division is nearly four times of number of IMGs registered in the same division. This is similar the statistics available on the trainee specialist division.

Now that the divisions of registrations of IMGs in Ireland are known, to find out if IMGs are integrating into the whole spectrum of medical practice in Ireland, the roles they play and their areas of responsibilities must also be examined. The next two tables reveal the roles of IMGs and their areas of responsibilities within medicine in Ireland.

Table 16: Country of qualification and role doctors in Ireland in 2014

Role	**Graduates of Irish medical schools**		**Graduates of a medical school outside Ireland**		**%of role graduating outside Ireland**
	N	%	N	%	%
Community Health Doctor	168	1.7	26	0.5	**13.4**
General practitioner	3422	34.0	900	16.9	**20.8**
Healthcare related management and admin	43	0.4	17	0.3	**28.3**
Hospital Consultant	2807	27.9	1227	23.0	**30.4**
Non-consultant hospital doctor, in training	2250	22.4	1155	21.7	**33.9**
Non-consultant hospital doctor, not in	527	5.2	1505	28.2	**74.1**
Other	269	2.7	87	1.6	**24.4**
Other Consultant or Specialist	442	4.4	396	7.4	**47.3**
Public Health Doctor	**133**	**1.3**	**18**	**0.3**	**11.9**

Source: Medical Workforce Report 2014 (www.medicalcouncil.ie)

Table 17: Area of Practice and Proportion of IMGs in Ireland in 2014

Area of Practice Area of practice	% of IMGs outside Ireland
Anesthesia	**48.4**
Emergency Medicine	**50.4**
General Practice	**20.2**
Medicine	**35.3**
Obstetrics & Gynecology	**55.2**
Occupational Medicine	**27.9**
Ophthalmology	**27.7**
Pediatrics	**42.7**
Pathology	**29.7**
Psychiatry	**38.2**
Public Health Medicine	**9.7**
Radiology	**32.3**
Sports & Exercise Medicine	**23.1**
Surgery	**51.2**

*Specialties where the proportion of international medical graduates is greater than average are highlighted
Source: Medical Workforce Intelligence Report 2014 (www.medicalcouncil.ie)

Looking closely at Table 16, it can be deduced that 74.1% of doctors who work as non-consultant hospital doctors and who were not in training, were IMGs compared with 5.2% Irish graduates. This shows an over-representation of IMGs in service posts, as mentioned earlier. The question this raises is why are IMGs over-represented in positions that do not offer progression, but under-represented in those that offer progression? Table 17 reveals that the proportion of IMGs in the medical professional sphere varies across areas of practice. Some areas of practice have a significant percentage of IMGs practicing in them. Such areas are Obstetrics and Gynecology, Surgery and Emergency Medicine. However, it is worth mentioning that these specialties, according to the *Medical Workforce Report, 2014*, also have a higher than average proportion of 'Non-Consultant Hospital Doctors Not in Training' practicing in them (p. 41). Some specialties are claimed to be more prestigious than others (this is discussed in-depth in Chapter 7). For example, only 17.2% of doctors working in Emergency Medicine were specialists. This probably explains the high representation of IMGs in them.

Conclusion

In conclusion, from the diagrams and explanations made, it is evident that IMGs, who form 34.3% of the total number of registered doctors in Ireland, are over-represented in positions that have no career prospects attached to them. It can be argued that the first barrier to professional integration of IMGs into the medical workforce in Ireland is the schism of medical posts into: service posts and training posts. Also, the institutional constraints placed on IMGs from outside of Australia, New Zealand, Malaysia, Sudan, and South Africa (with internships after 2006) and Pakistan (with

internships after 2008) in relation to access to training posts is enormous. The access to training posts has been revealed to be limited by the country of training of an IMG. This limitation is legitimised by the Medical Practitioners Act of 2007. As discussed earlier, the increase funding of posts and training by the HSE has increased the number of specialist training positions available for doctors. This has, in turn, resulted to increased numbers of IMGs availing of specialist training in Ireland. However, many of these doctors cannot avail of these opportunities they trained outside the catchment areas or because they had their internships earlier than the specified years in their countries of training. For example, IMGs from South Africa with internships after 2006 and from Pakistan, with internships after 2008 are disallowed from applying to training posts. What this means is that many IMGs who come to Ireland are confined to the service posts. This confinement ultimately impedes their professional integration into the medical profession in Ireland.

Medical Education in Canada

This section presents and discusses medical education in Canada by looking briefly at the history of and present day medical education and practice; medical career structure and pathways for progression; access route for IMGs and present outcome for IMGs in Canada.

History of Medical Education in Canada

The history of medicine in Canada, as Canada, can be traced back to the First Nations' people who were the original inhabitants of Canada before the arrival of the white settlers (French and British) in the 1400s. The first nations or Aboriginals were skilled in blood-letting and cupping, setting bone fractures skillfully, carried out successful amputations and used herbs to cure diseases such as rheumatism, sore throats, constipation and diarrhea (Swan, 1968). Even though the Aboriginals in Canada are regarded as contributing nothing to modern medicine in Canada, they are known to have cared very well for themselves, produced good midwives, and utilised common sense, folklore and imagination to deliver medical care for themselves (Swan, 1968). Their medical knowledge was passed on not in a formal structured way, rather, it was usually passed down orally and through observation and initiation.

From the time of the arrival in Canada of white settlers in the 1400s, little is known about medical education and practice until the 1600s when in 1644 and 1648 hospitals were established in Quebec and Montreal. These hospitals were run by nuns who emigrated from France. Giving a general description of the medical practice in this period, Swan (1968) argues that 'besides the flourishing of quackery then within the medical profession, conditions were tough for medical practitioners because of the weather condition of most of Canada' (p. 48). Quackery in this context, according to Swan, meant doctors had a negligible knowledge of anatomy and basic sciences (p. 48). However, the issue of quackery was dealt with in 1750 when a regulation was passed against it. Quackery in

medicine can be referred to a situation where a so called medical practitioner, who does not have the understanding and expertise of medicine pretends to have it and displays it publicly. This practice was common during this period in Canada. This ordinance required medical practitioners to sit an examination in the presence of the King's Physician to qualify for medical practice. In 1790, after Quebec was incorporated into British North America, the British parliament passed a law imposing official accreditation of doctors prior to practice in Canada (Swan, 1968).

By the 19th century, the standard of medicine in Canada began to improve and in 1823, the first medical faculty was established in the then University of Montreal, now, McGill University. Thirty years later, a second medical faculty, the Toronto Medical School, was started in Toronto by a Dr John Rolfe. Towards the end of the 19th century, the development of specialisation began to appear. In 1912, the Canadian Medical Council was formed to set uniform standard medical education in the whole of Canada. Prior to this time, there was autonomy within provinces in relation to medical education and legislation and qualified doctors could only practice within the province of their qualification. To be able to practice in other provinces within the country, doctors had to pass the 'Dominion Councils' examination soon after graduation (Swan, 1968. p. 49). The 1912 standardisation of examinations for graduates of all medical schools in Canada brought with it the expectation that medical graduates could move freely from one province to another in anticipation that their credentials would be recognised and accepted.

In 1943, the Association of Faculties of Medicine of Canada (AFMC) was established to represent the faculties and oversee medical education and clinical care in Canada and by the year 1950, eleven medical faculties were established. Presently, there are seventeen medical faculties responsible for delivering undergraduate and postgraduate medical training in the ten provinces and three territories of Canada.

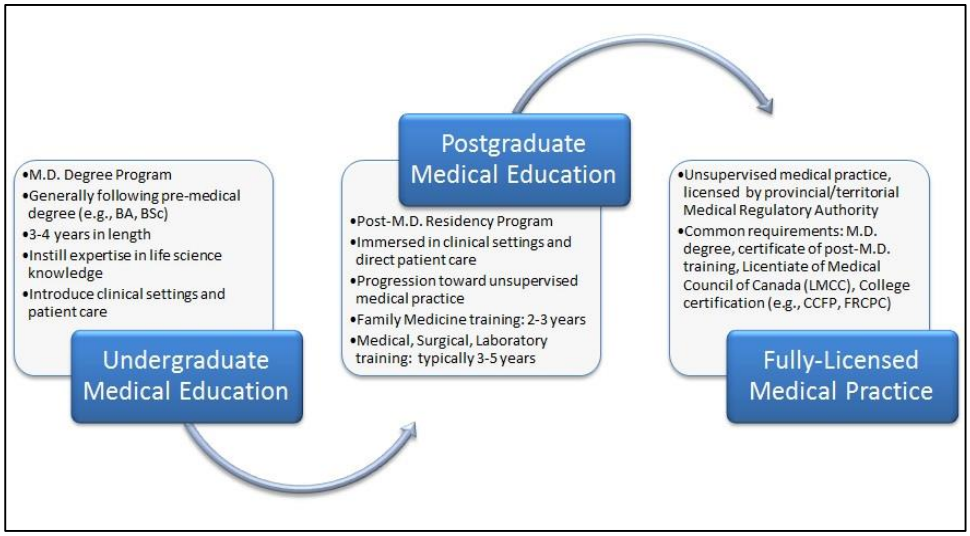
It is also important to note here that women were disadvantaged at the beginning of the development of the profession of medicine in Canada too. For example, no woman was admitted as a licentiate until 1877 when Dr Jenny Trout was licensed. This has paved the way for many women to access medicine and become successful practitioners in Canada.

Increasingly, many women are accessing the medical profession in Canada because of the new medical education and career pathway.

Current Medical Education, Career Structure and Pathway in the Canadian Medical Profession

The current medical education, career structure and pathways in Canada is represented by the diagram below.

Figure 3: A Diagram representing Medical Education in Canada



Source: http://www.caper.ca/en/post-graduate-medical-education

The diagram above represents a career pathway for anyone who wishes to become a medical specialist via studying and practicing in Canada. For anyone else, including a Canadian who studies abroad, the pathway is different. It is important to note that similar to Irish who studied outside the EU, Canadians who study medicine abroad are considered IMGs. Looking at the diagram above, it can be seen that medical education is divided into two stages: undergraduate and postgraduate medical education. Presently, as mentioned earlier, undergraduate and postgraduate medical education are provided exclusively by Canada's seventeen medical faculties. As we can see in the diagram, medical education in Canada starts with a three to four year programme at most universities. Medical students start, in most cases, after receiving a bachelor's degree in another field. However, a few medical schools in Canada do not require a bachelor's degree for entry into medical school. For example, Quebec's medical schools accept applicants after a two-year CEGEP[25] diploma. This is an equivalent of other Canadian provinces' grade 12, plus the first year of university. Most of the medical schools in Western Canada require at least 2 years of undergraduate university study, and majority of the medical schools in the province of Ontario require, at least 3 years university study before an application can be made to a medical school. Upon completion of undergraduate medical education, students are awarded the degree of medical doctor (MD). This is followed by a one-year compulsory paid internship. During this internship, doctors work under supervision in a hospital or clinic, gaining practical experience and increasingly having responsibility for the care of patients.

Besides the internship, there are various postgraduate specialist training programmes aimed at MDs and including the forty-four specialties recognised in Canada. It is also important to note that a few

[25] CEGEP means Collège d'enseignement général et professionel or College of General and vocation Education. There are 48 public and 13 private CEGEPS in Quebec.

medical faculties offer joint degree programmes in which interested medical students may simultaneously enroll in M.Sc. or Ph.D. programmes in related fields.

Post-graduate medical education usually referred to as Residency training, is the final stage of medical education, prior to College certification and practice as a fully-licensed physician. The aim of residency training is to perfect the MD graduate's skills for practice in a chosen specialty such as a family medicine, surgical, medical or laboratory. Canadian medical students usually enter the Canadian Resident Matching Service (CaRMS) in the spring of their final year in medical school. Students choose specialties and hospitals on a preferential scale and the hospitals do the same for the students. Each group's preferences are entered into a computerized matching system to determine placements for residency positions. 'Match Day' usually occurs a few months before graduation which in most cases is in March.

The length of post-graduate training differs with the specialty chosen. For example, Family Medicine is a two-year programme accredited by the College of Family Physicians of Canada (CFPC), and three-year programmes of residency training are available in various areas of practice, including Emergency Medicine, Maternal/Child, Care of the Elderly, Palliative Care or Sports Medicine. All other medical specialty residencies, usually of five years duration are accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC). Internal medicine and pediatrics are four-year programmes in which the final year can be used to complete a fellowship in General Internal Medicine or General Pediatrics, or can be used towards a longer fellowship (e.g., cardiology). Residencies in surgery sub-specialties such as cardiac surgery and neurosurgery, last six years. Sub-specialty fellowships are available after most residencies.

Unlike the provision of medical education in Ireland that is delivered by six medical schools at the undergraduate level and thirteen colleges at the postgraduate level, an important feature of the Canadian medical education is the role of medical faculties in providing both undergraduate and postgraduate medical education in Canada.

By and large, professional certification is usually the result of residency training for medical doctors in Canada. For example, on successful completion of Family Medicine training, residents sit the certifying examinations of the College of Family Physicians of Canada (CFPC). For residents who complete training in Medical, Surgical and Laboratory residency programnes, examinations of the Royal College of Physicians and Surgeons of Canada (RCPSC) are written. After passing these examinations and achieving certification, the doctor is ready for unsupervised, fully-licensed medical practice and a career supported by continuing professional development.

Access routes and progression pathways described above apply only to Canadian graduates of Medicine. So, it is important that insights are gained into the access routes and pathways to

progression available to the significant numbers of doctors in Canada who are IMGs. Therefore, the next subsection presents access routes and progression pathways for IMGs in Canada.

Access Routes for IMGs into medical practice in Canada

An IMG in Canada is defined by the Medical Council of Canada as a graduate of a medical school outside of Canada or the United States, with the exception of US schools of osteopathic medicine who are considered IMGs (Campell-Page et al. 2014). An IMG in Canada may be a Canadian or a non-Canadian who studied medicine outside of Canada.

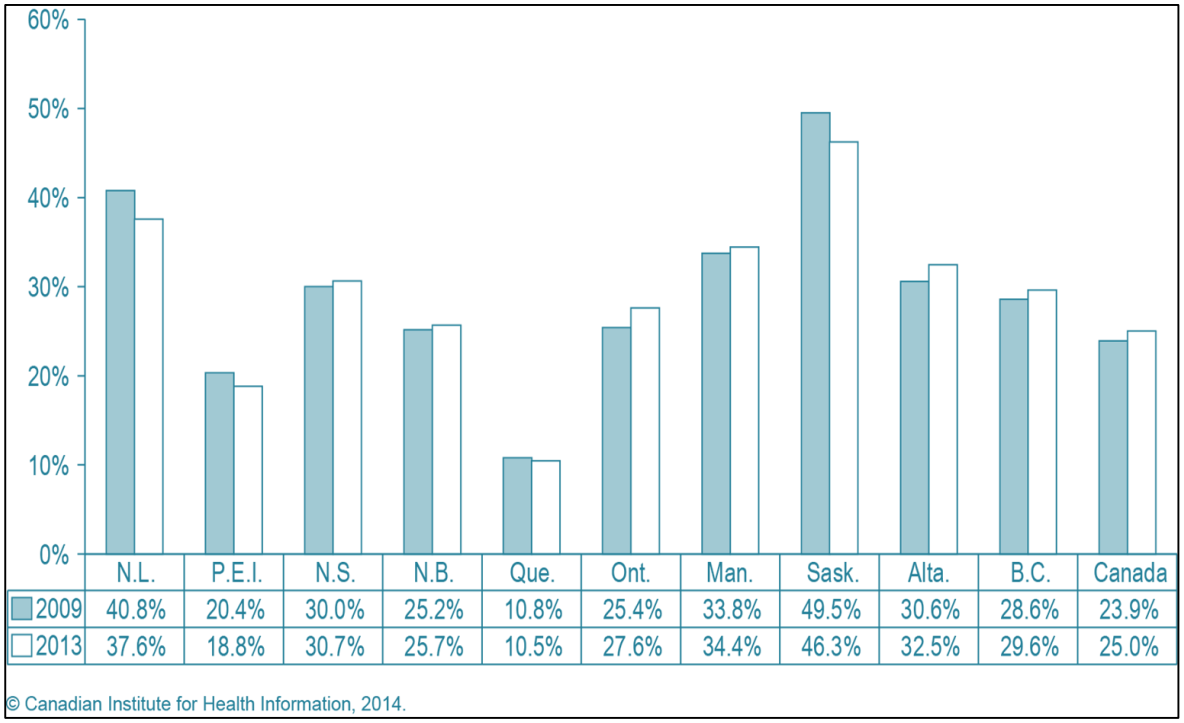
IMGs are an integral part of the medical workforce in Canada. In the early 2000s, IMGs made up 29% of the population of doctors in Canada, in 2012, IMGs made up 24.2% of Canadian medical doctors and in 2013, 24.8% (See Table in the next page).

Table 18: Numbers of IMGs registered practicing in Canada from 2002-2013

Year	Number of IMGs in Canada	IMG % of all registration
2002	13,407	29.0
2003	13,286	29.0
2004	13,452	29.0
2005	13,715	29.0
2006	13,680	29.0
2007	14,051	29.0
2008	15,100	30.2
2009	16,962	28.0
2010	16,632	24.0
2011	17,610	32.3
2012	18,592	24.2
2013	19,276	24.8
2014	18,048	24.1
2015	20,924	25.6
2016	17,853	22.2

Source: www.cihi.ca

Chart 4: Percentage of IMGs in the 10 provinces in Canada in 2009 compared with 2013

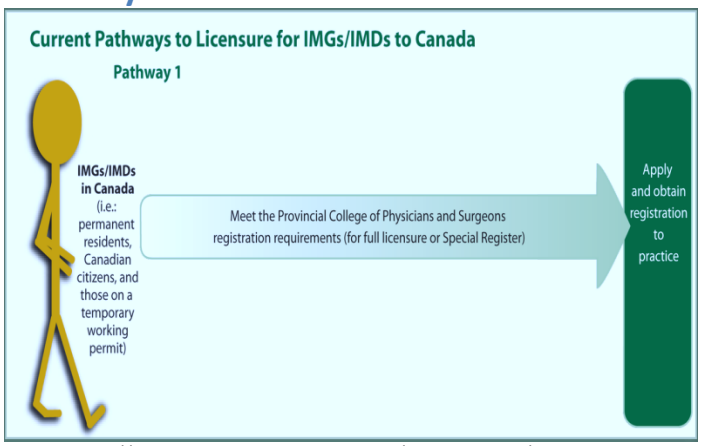


	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Canada
2009	40.8%	20.4%	30.0%	25.2%	10.8%	25.4%	33.8%	49.5%	30.6%	28.6%	23.9%
2013	37.6%	18.8%	30.7%	25.7%	10.5%	27.6%	34.4%	46.3%	32.5%	29.6%	25.0%

Source: www.cihi.ca

The chart above reveals a considerable number of IMGs in Canada. In some provinces such as New Foundland and Saskatchewan, IMGs constitute nearly half of doctors, while provinces such as Ontario and Alberta, had nearly 8,000 and 3,000 IMGs registered and practicing in 2013 respectively. Despite this, accessing medical practice for IMGs in Canada is very complex, confusing, time consuming and difficult. More so, the fact that IMGs migrate to Canada through different immigration schemes, access routes for IMGs to medical licensure and practice in Canada differs depending on the unique immigration situation of an individual IMG. Additionally, career pathways in medicine for IMGs in Canada also depend on the country of the IMG's medical degree and, then, destination province in Canada. It is worth mentioning here that for purposes of clarity, this study identifies two forms of licensure: provisional and full, and it broadly categorises medical professional pathways for an IMG in Canada into three categories:

Pathway 1



Source: http://communication4integration.ca/licensure-info/

This route is aimed at IMGs who meet the provisional College of Physicians and Surgeons of Canada's registration requirements for full licensure or specialist registration. These requirements include:

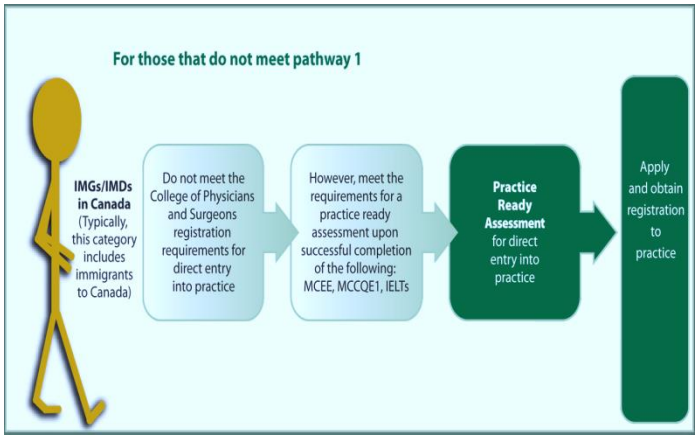
Canadian Citizenship, a permanent resident status or a valid work permit

One year of Canadian postgraduate training or medical practice.

Completion of Medical Council of Canada Qualifying Examinations (MCC QE) Parts 1 and 2.

Certification from the College of Family Physicians of Canada (CFPC) or the Royal College of Physicians and Surgeons of Canada (RCPSC).

Pathway Two



Source: http://communication4integration.ca/licensure-info/

This second pathway, as illustrated, is aimed at IMGs who do not fulfil the requirement for pathway 1, but who do meet the requirement for Practice Ready Assessment. IMGs in this category are usually IMGs who completed postgraduate residency training in a recognized jurisdiction. These jurisdictions are Australia, Ireland, New Zealand, Hong Kong, Singapore, South Africa, Switzerland, United Kingdom and the USA. For example, Certification in the College of Family Physicians of Canada (CCFP) may be granted to members who obtained their medical training in the USA, Australia, Ireland and the UK.

The Royal College of Physicians and Surgeons (RCPSC) recognises postgraduate medical training acquired in Australia, Ireland, New Zealand, Hong Kong, Singapore, South Africa, Switzerland, United Kingdom and the USA. IMGs who the College of Family Physicians of Canada or the Royal College of Physicians and Surgeons deem eligible can apply to the CPSO for a restricted license as far as they intend to write the exams necessary for an Independent Practice certificate. This restricted license enables the physician to practice in a chosen province under supervision for a number of years, depending on the province, while they complete the necessary exams. For example, in Ontario, IMGs with restricted license may practice under supervision for a maximum period of three years while they complete the necessary exams.

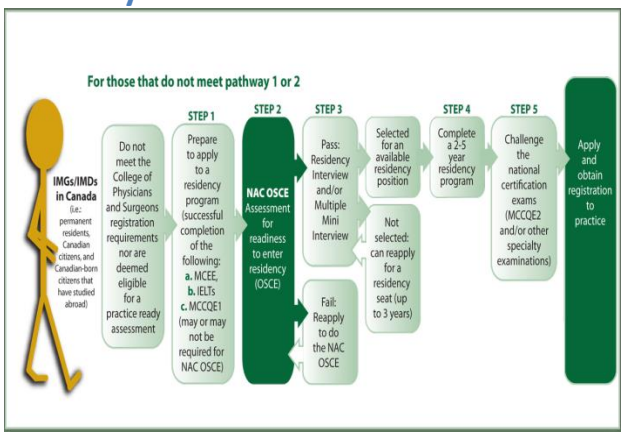
An IMG who falls within this category may take any of the routes specifically developed for and offered to IMGs by specific provinces or territories. These routes include:

Practice Ready Assessment (PRA) - This is a process administered through the Provincial Medical Regulatory Authorities. This route is for IMGs with specialist certification from their country of origin.

Jurisdiction Approved Training (JAT): This is intended for IMGs who completed their specialty training outside of Canada or the United States, but in an approved jurisdiction.

Individual Competency Route (ICR) – according to the Royal College of Physicians and Surgeons of Canada, ICR is for an IMG who enters Canadian residency but is deemed eligible for shortened residency due to competencies already achieved in an international jurisdiction. Therefore, this route is available to an IMG who has completed an undergraduate medical degree deemed acceptable by the Foundation for Advancement of International Medical Education and Research (FAIMER). FAIMER claims it promotes excellence in international health professions education through programmatic and research activities. It maintains a database of medical schools in the world, the *World Directory of Medical Schools*. This directory provides accurate, and comprehensive and latest information on each school (FAIMER, 2017).

Pathway Three



Source: http://communication4integration.ca/licensure-info/

This is the pathway available to many IMGs. This pathway is available for IMGs who cannot access practice via pathway one or two. Via this pathway, IMGs hoping to practice in Canada must first pass the Medical Council of Canada Evaluation Examination (MCCEE) to apply for residency positions through Canadian Resident Matching Service (CaRMS). Residency positions are highly competitive as openings for IMGs are few compared to the numbers of IMGs hoping to get residency. For instance, according to HealthForceOntario[26], an average of 1,500 IMGs applies through CaRMS each year for approximately 200 residency positions in Ontario. The competitiveness of these positions is further corroborated by Slade (2014). According to him, as of 2013, out of 9,225 applicants who were not born in Canada and who are not Canadian citizens, only 2,558 were found to be in postgraduate training. This left a shortfall of nearly 7,000 IMGs waiting to gain residency positions in Canada then (p. 10).

In addition to passing the MCCEE, provinces in Canada can also demand from IMGs further assessments such as the National Assessment Collaboration (NAC) examination to qualify for a residency position. According to the information available on the website of the Medical Council of Canada, the National Assessment Collaboration (NAC) examination assesses

'the readiness of an IMG for entrance into a Canadian residency program. It is a national, standardized examination that tests the knowledge, skills and attitudes essential for entrance into postgraduate training in Canada. Comprising a series of clinical stations, the NAC examination presents typical clinical scenarios. The examination may include, but is not limited to, problems in medicine, pediatrics, obstetrics, gynecology, psychiatry and surgery' ("The National Assessment Collaboration", 2015).

Unlike the MCCEE which can be taken outside of Canada, NAC can only be taken in Canada. Before candidates are eligible to sit the NAC examination, they must have sat and passed the MCCEE. In

[26] HealthForceOntario (HFO) was created in 2006 by the Ontario Government to ensure that Ontarians have access to the right number and mix of qualified health-care providers, when and where they are needed, now and in the future.

addition to these examinations, some provinces may require that candidates fulfil region-specific criteria to be eligible for specific provincially-funded training positions. Specific provincially-funded training positions are post-graduate training positions funded by provinces to attract doctors into specific specialties that are experiencing shortages of specialists in such provinces.

IMGs, apart from some USA graduates who may wish to apply for an exemption, can be required to pass the Medical Council of Canada Qualifying Examination (MCCQE) Part I and II. Candidates can choose to take a self-assessment exam to help them prepare for this multiple-choice component of the MCCQE Part I. This self-assessment is accessible over the Internet and can be done prior to arriving Canada. The difference between MCCEE and MCCQE is presented in Table 19 below:

Table 19: Difference between MCCEE and MCCQE

Difference between MCCEE and MCCQE part 1	
Uniquely Canadian content is not tested on the MCCEE (For example, questions dealing with Canadian legal issues in the practice of medicine are not included on the MCCEE.)	Included on the MCCQE Part I
Does not include a half-day session on clinical decision making	Includes a half-day session on clinical decision making
MCCEE is administered at many international test centers	MCCQE Part I can be taken only in Canada.
The MCCEE is a screening tool that allows candidates to assess their readiness to take the MCCQE Part I or pursue further medical education in Canada. For this reason, the pass requirement is less stringent for the MCCEE than for the MCCQE Part I.	

Besides the MCCEE, all provinces require a minimum of two years postgraduate training (residency) for licensure in Canada. The Licentiate is required for candidates to meet the Canadian Standard for full licensure, as defined through the Federation of Medical Regulatory Authorities of Canada (FMRAC)[27]. It is important to note that receiving the licentiate of Canada does not guarantee a licensure to fully practice in Canada. After receiving the licentiate of Canada, an IMG can now apply for restricted license and start practicing under the supervision of a specialist. At the same time, an

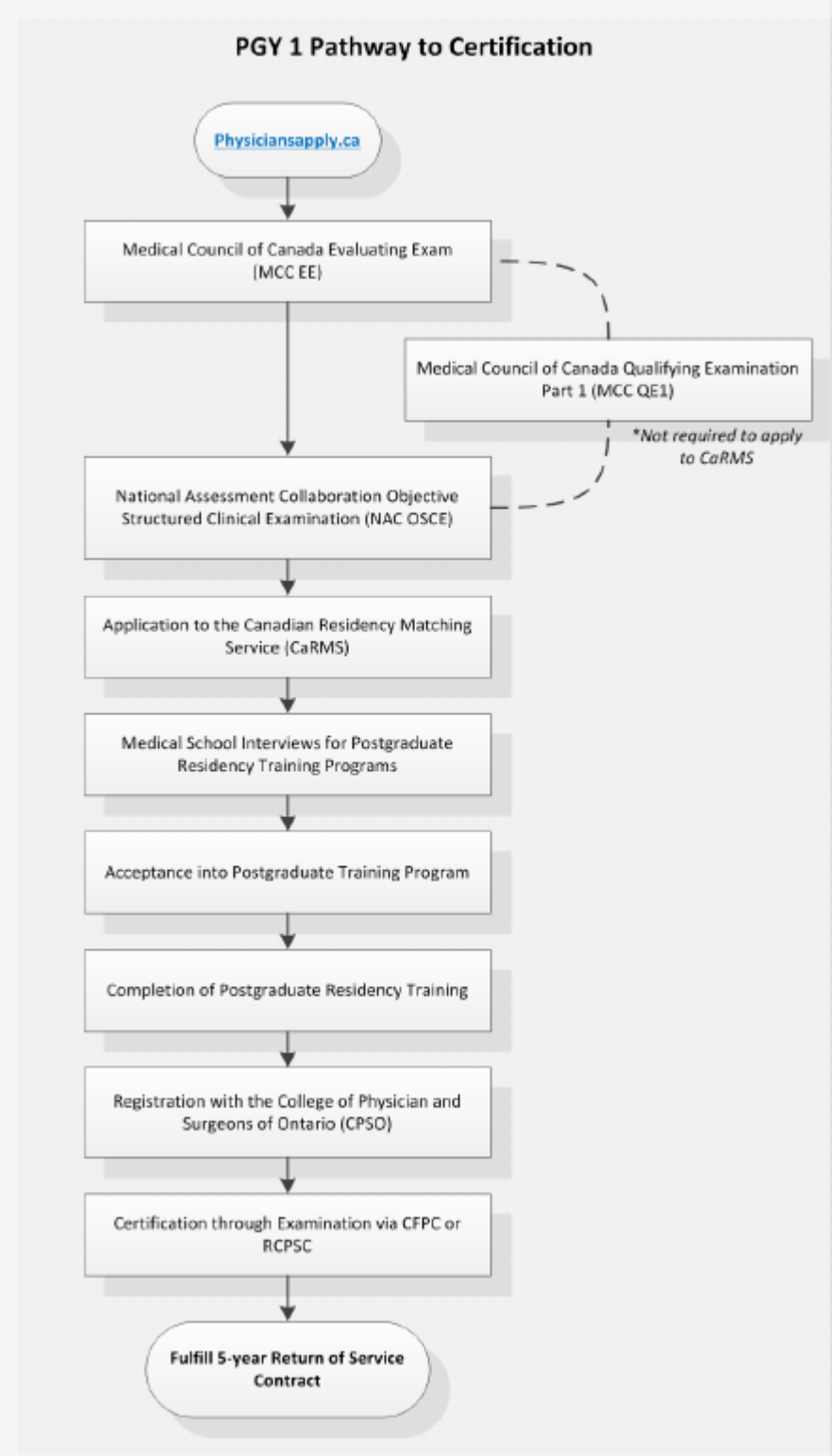
[27] FMRAC is the national organization and the privileged voice, both nationally and internationally, of the provincial and territorial medical regulatory authorities. It will consider, develop and share positions and policies on matters of common concern and interest. It will also develop and maintain services and benefits for its Members.

IMG can now work toward full licensure by attempting and passing MCCQE 1 and 2 and other specialty examinations. It is worth mentioning that these MCCQE are also required for graduates from Canadian faculties of medicine Candidates and it can only be sat for and written from within Canada. When an IMG passes the MCCQE Part II or the new Certification Examination in Family Medicine and have the required numbers of years of clinical experience, the IMG is now qualified to apply for a full licensure to practice medicine in Canada.

It is important to mention that in Canada, different provinces and territories have initiated 'Return for Service' programmes targeted at IMGs. Under this programmes, an IMG may agree to serve in an under-served area for a period ranging from 3-5 years depending on the jurisdiction, in return for full licensure in Canada.

It is also worth mentioning that registration processes may differ depending on the province or territory. For example, the diagram in Figure 4 describes the process to full licensure for IMGs in Ontario.

Figure 4: Pathway to certification in Ontario



Source: www.healthforceontario.ca/en/Home/Physicians/Training

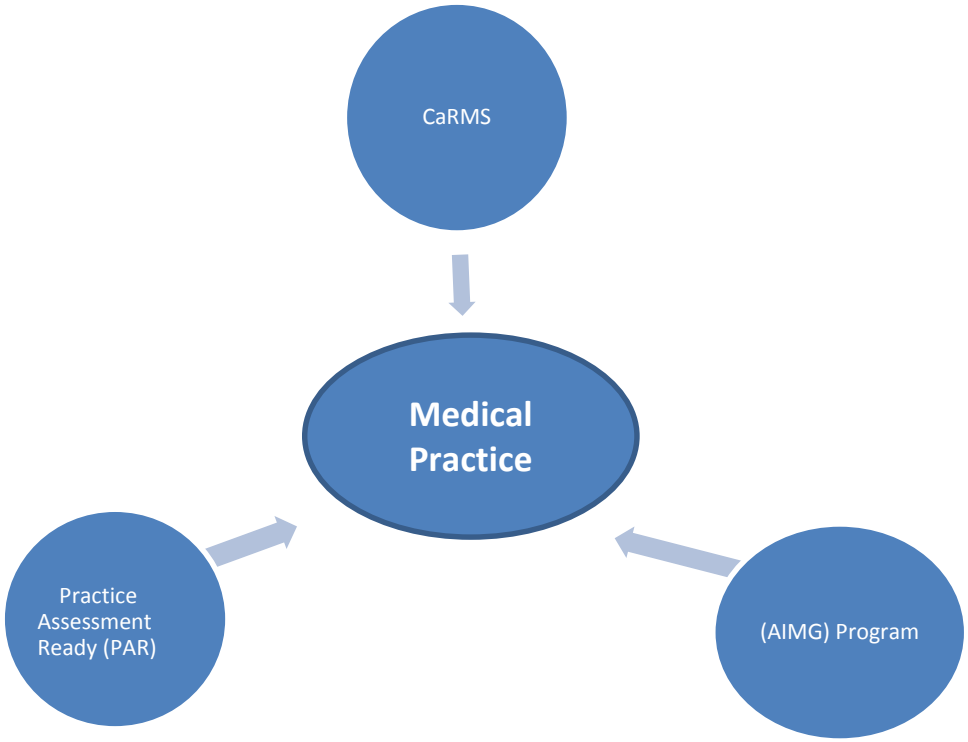
In Alberta, the following programmes are available to enable eligible IMGs obtain postgraduate training posts:

Canadian Resident Matching Service (CaRMS) - Works with the medical education community, medical schools, and students to coordinate postgraduate medical training throughout Canada.

Alberta International Medical Graduates (AIMG) Program - Provides IMGs with access to Alberta postgraduate residency training in Family Medicine or Specialty disciplines.

Royal College of Physicians and Surgeons of Canada Practice Ready Assessment Route – This is an alternative route for IMGs with who hold specialty certification from outside Canada and the USA to become eligible for the Royal College of Physicians and Surgeons of Canada specialty examinations. Such applicants must apply through their provincial medical regulatory authority.

Figure 5: Pathway to certification in Alberta



Besides the above-mentioned routes, there is also the Medical Practice Observation and Experience pathway. This pathway allows IMGs exposure to medical practice in Canada by observing a physician. The observation must be conducted according to the College's Medical Practice Observation and Experience advice. It is worth noting that the College does not maintain a list of physicians interested in supervising a medical practice observer and an IMG wishing to participate has the responsibility of identifying and applying to a doctor who is interested in offering observership.

It is important to point out here there is also an alternative career path for IMGs in Alberta, the

Alberta Clinical and Surgical Assistant Programs (ACSAP). The ACSAP programmes put candidates through a six-month assessment and evaluation period that, upon successful completion, leads to a full-time and permanent role as a Clinical/Surgical Assistants. These acute care coverage roles address clinical and/or surgical coverage shortages (Alberta Health Services, 2014). It is important to note that while an ACSAP programmes provides an IMG valuable work experience in acute care settings and may help applicants learn more about professional healthcare in Canada, it does not lead to independent licensure as a physician in Canada.

In British Columbia, IMGs are often registered in the provisional class as an interim step so that they engage in clinical practice under supervision. For them to become fully licensed, an IMG, registered in the provisional class must complete Canadian qualifying exams (MCCQEs) or, s/he may be eligible to participate in a comprehensive workplace assessment within a specified period. On the other hand, IMGs who are not eligible for full or provisional registration, but who wish to enter a postgraduate training programme in British Columbia, may apply to be registered as clinical trainees. This allows IMGs to obtain educational experience in Canada. This programme allows IMGs who are either Canadian citizens or permanent residents to obtain educational experience in Canada by observing and learning in a practical setting under another physician's direct supervision. It can only be for a maximum of three years and clinical trainees are not authorized to practice independently. It is also an unpaid position.

In British Columbia, IMGs are often registered in the provisional class as an interim step so that they engage in clinical practice under supervision. For them to become fully licensed, an IMG, registered in the provisional class must complete Canadian qualifying exams (MCCQEs) or, s/he may be eligible to participate in a comprehensive workplace assessment within a specified period. On the other hand, IMGs who are not eligible for full or provisional registration, but who wish to enter a postgraduate training program in British Columbia, may apply to be registered as clinical trainees. This allows IMGs to obtain educational experience in Canada and qualify them to be able to enter a postgraduate training program. Table 20 on the next page presents the different classes of registration available to IMGs in British Colombia.

Table 20: Class of registration for IMGs in British Columbia

Provisional	Permits a registrant to practice medicine with limits and conditions granted by the Registration Committee.
Assessment	Permits qualified and selected family physicians to participate in the Practice Ready Assessment – British Columbia (PRA-BC) program prior to being considered eligible for provisional registration.
Clinical Trainee	Permits a registrant to observe and learn in a practice setting under another physician's direct supervision to a maximum of three years. Registrants in this class are not eligible for independent practice.

Source: https://www.cpsbc.ca/for-physicians/registration-licensing/applying/imgs

Area of Practice and Proportion of IMGs in Canada

The areas of practice of IMGs vary from one specialty to another in Canada. Specialties in Canada can be broadly categorised into family medicine, clinical specialists, laboratory specialists, surgical specialists and medical scientists. Table 21 drawn from Physicians in Canada, 2016: Summary Report of the *Canadian Institute for Health Information* (CIHI) shows the general area of practice and the proportion of IMGs in Canada in from 2000-2015.

Table 21: Percentage of internationally trained physicians, by physician type, Canada, 2000 to 2015

Year	Family medicine internationally trained MDs	Specialist internationally trained MDs
2000	**22.3%**	**24.1%**
2001	22.6%	23.5%
2002	23.1%	22.9%
2003	23.5%	22.1%
2004	23.5%	21.8%
2005	24.0%	21.6%
2006	24.3%	21.2%
2007	24.6%	21.6%
2008	25.6%	21.5%
2009	26.2%	21.8%
2010	26.0%	22.7%
2011	26.7%	23.0%
2012	27.4%	22.8%
2013	28.0%	22.5%
2014	28.5%	22.5%
2015	28.5%	22.7%

Source: www.CIHI.CA

The above in the last page reveals that there has been a steady increase in the numbers of IMGs practicing as family doctors in the last 12 years up to 2015. For example, the percentage rose from 22.3% in 2000 to 28.5% in 2015. Compared to the percentage of IMGs practicing in other specialist areas, which seems to remain stable is significant. The table below presents national distribution of IMGs according to specialties in Canada in 2013, the latest data I could access as at the time of writing this thesis.

Table 22: National Distribution of IMGs in Canada according to Specialties 2013

Table 4.1 Physician graduates of foreign medical schools, by specialty and jurisdiction, 2015

Specialty	N.L.	P.E.I.	N.S.	N.B.	Que.	Ont.	Man.	Sask.	Alta.	B.C.	Y.T.	N.W.T.	Nun.	Canada
1.0 Famil	**251**	**15**	**370**	**151**	**815**	**4,693**	**650**	**766**	**2,072**	**1,958**	**17**	**6**	**0**	**11,764**
2.0 Medi	**171**	**21**	**310**	**209**	**868**	**3,225**	**191**	**306**	**1,039**	**1,022**	**1**	**0**	**0**	**7,363**
2.1 Clin	**154**	**19**	**284**	**175**	**778**	**2,937**	**163**	**280**	**912**	**937**	**1**	**0**	**0**	**6,640**
Interna	45	3	78	50	291	893	54	94	300	234	0	0	0	2,042
Medica	0	0	1	0	10	7	1	0	4	6	0	0	0	29
Derma	4	0	2	0	12	32	3	0	6	9	0	0	0	68
Neurol	7	0	8	7	28	84	5	10	45	33	0	0	0	227
Pediat	29	2	33	23	101	453	22	34	187	135	0	0	0	1,019
Physic	2	0	3	0	4	35	3	2	15	16	0	0	0	80
Psychi	30	6	75	48	160	732	27	55	181	282	1	0	0	1,597
Public	0	0	1	2	17	15	2	6	8	11	0	0	0	62
Emerg	0	0	2	4	3	29	0	8	3	8	0	0	0	57
Anesth	22	3	47	28	75	346	29	32	89	116	0	0	0	787
Nuclea	0	0	0	0	3	16	1	3	1	2	0	0	0	26
Diagno	12	3	27	9	58	230	6	28	64	63	0	0	0	500
Radiati	3	2	7	4	16	65	10	8	9	22	0	0	0	146
2.2 Labo	**17**	**2**	**26**	**34**	**90**	**288**	**28**	**26**	**127**	**85**	**0**	**0**	**0**	**723**
Medica	0	0	2	1	18	9	0	1	1	4	0	0	0	36
Medica	0	0	1	1	5	13	1	0	8	8	0	0	0	37
Genera	1	1	3	9	3	41	3	4	27	15	0	0	0	107
Neurop	0	0	2	0	1	8	0	1	4	2	0	0	0	18
Hemat	0	0	2	4	2	14	2	2	5	11	0	0	0	42
Anaton	16	1	16	19	61	203	22	18	82	45	0	0	0	483
3.0 Surgi	**42**	**7**	**66**	**57**	**269**	**758**	**64**	**95**	**184**	**241**	**1**	**1**	**0**	**1,785**
Genera	15	1	16	12	54	164	15	28	45	50	0	0	0	400
Cardia	0	0	3	0	12	23	1	1	9	7	0	0	0	56
Neuros	2	0	2	6	7	26	0	7	7	10	0	0	0	67
Obstet	11	3	14	16	76	215	21	27	52	71	1	1	0	508
Ophtha	6	1	8	3	30	74	9	8	26	32	0	0	0	197
Otolary	3	2	9	2	28	41	1	3	11	19	0	0	0	119
Orthop	3	0	6	7	31	133	10	14	22	34	0	0	0	260
Plastic	0	0	0	4	11	21	3	3	5	4	0	0	0	51
Urolog	2	0	7	4	17	49	3	4	7	10	0	0	0	103
Vascul	0	0	1	3	3	12	1	0	0	4	0	0	0	24
4.0 Medi	**0**	**0**	**0**	**0**	**0**	**5**	**2**	**1**	**2**	**2**	**0**	**0**	**0**	**12**
Total — A	**213**	**28**	**376**	**266**	**1,137**	**3,988**	**257**	**402**	**1,225**	**1,265**	**2**	**1**	**0**	**9,160**
Total —	**464**	**43**	**746**	**417**	**1,952**	**8,681**	**907**	**1,168**	**3,297**	**3,223**	**19**	**7**	**0**	**20,924**

Source: www.CIHI.CA

Extrapolating from the table above, there are more IMGs are practicing in Family Medicine (11,764)

than in all other specialist areas where there are 9,160 of them. In Ontario where there are 8,681 IMGs practicing, more than half, 4,693, are recorded as practicing in the Family Medicine specialty compared with 3,988 who are practicing in all other specialties. The most popular specialties for IMGs in medical specialties are Internal Medicine, Psychiatry, Pediatrics and Anesthesiology. Specialties such as Cardiac Surgery, Neurosurgery, Urology and Emergency Medicine have only a handful of IMGs practicing in them. This raises the question: why are IMGs over-represented in some specialties and under-represented in others?

Conclusion

This chapter presented a brief historical development of medical education and career pathways in Ireland and Canada. It discussed forms of medical education and career pathways in both countries and describes the various access routes to registration and practice. From the data presented, analysis and discussion, it can be deduced that IMGs are a very important part of the medical workforce of both Ireland and Canada. Particularly, the reliance of Ireland on international medical graduates is quite significant.

The chapter has also analyse medical education training and career structures in the two countries indicating the hierarchical origins of the professions in them and how these hierarchies were embedded in class and gender differentiations. It also presented how these hierarchies, presently, may facilitate social reproduction of status.

The Chapter went on to further reveal the many similarities and differences across both countries. They are dissimilar in that in Ireland, medicine as a profession records a longer history of formal medical education when compared with Canada. However, they are similar in that a hierarchy of hospitals exists in both countries. For example, in Ireland, the hierarchical ordering of training posts over service posts, and in Canada, urban center over rural area necessitated the invention of training and regulatory institutions to control access to training posts. This is akin to what Murphy (1988) refers to as social closure, that is 'the process of subordination within a hierarchy, in which a group closes off 'opportunities to another group of outsiders beneath it which it defines as inferior and ineligible' (p. 8). Another similarity is the gender differentiation, where policies that completely bar women from the profession were pursued by the professions in both Ireland and Canada until the late twentieth century. More so, the influence of class on access to medical profession and social reproduction of status within the profession that was a part of the profession previously in both Ireland and Canada were discussed. These practices are not new. Weber (1968) wrote of how social or physical group attributes such as race, language, social origin and religion may be utilized for the purpose exclusion. In this case, it may be that the gender, race and class of IMGs are used as the

basis to exclude them from positions at the top of the hierarchy.

Another striking similarity is in initial access requirement for IMGs in terms of writing pre-registration examination prior to registration. Clinical observership and acquiring Irish and Canadian experience are also features of the access routes to medical practice by IMGs in both countries. One can make sense of these features of both Ireland and Canada's medical profession through the lens of credentialism. Credentialism makes academic or educational qualifications and training a prerequisite for candidates to be appointed into certain positions. Even though, often, credentialism appears neutral, however, it serves the convenient purpose of monitoring and controlling access into some professions and occupations. Therefore, requirements such as writing pre-registration examination prior to registration, having to do clinical observership and acquiring Irish and Canadian experiences may be utilised to restrict access to medical practice by IMGs.

Another significant similarity in the Canadian and Irish process is the access route to practice after an IMG has acquired the Licentiate of Canada. The 'return-for service' or 'return for practice' access route compares favourably to the 'service post' route in Ireland. These routes in Canada, like Ireland, are becoming the most used access routes for IMGs to gain full licensure for independent practice. In Ireland, even though, services posts offer IMGs access to practice, it is largely perceived to be utilised to make IMGs remain in practice and to keep servicing the health service, rather than to assist them progress towards becoming an independent consultant.

Additionally, around similarity, it is revealed that the common areas of practice of doctors in both Ireland and Canada are quite similar, except for the general practice specialty. For example, there are equally a high proportion of IMGs practicing in Surgery, Anesthesiology, Emergency Medicine and Psychiatry in Ireland like that of Canada. There is a significant dissimilarity when it comes to the proportion of IMGs practicing as GPs in Canada (over 50% of IMGs) compared with about 14% of the total numbers of IMGs practicing in Ireland. This significant dissimilarity may suggest that the Family Medicine specialty may be closed off to IMGs in Ireland.

Finally, the overall picture emanating from this chapter is that the access routes and progression pathways for IMGs in both Ireland and Canada are quite arduous, sometime confusing and time consuming and can amount to disadvantage for IMGs in terms of access to practice and in the case of progression, exclusion from the prestigious and desirable medical positions and location of practice.

Chapter Five

Professional Cultures and Strategies of Exclusion and Inclusion within the Irish and Canadian Medical Profession

'Look my friend! The cultural practice of the medical training bodies, medical regulating body and medical profession in Ireland has made demi-gods out of a few lucky and older mainly male white doctors. These white males are the makers of the law within medicine in Ireland; they enforce the law and punish transgressors. As a result, they do whatever they like which results to inclusion for others that they see as 'their own' and exclusion for 'us' who to them, don't belong' (Dr S A)

Introduction

As discussed in Chapter Two, the above quote from one of the interviewees in this study explains that professional attributes and practices can be perceived as exclusionary or inclusionary depending on the groups involved. The profession also has a language, thought processes, styles of communication, customs, beliefs and practices that often characterise it. Some main characteristics of the profession are its autonomy, ability to self-regulate, and ability to create specialisations and hierarchies of positions based on these specialisations within the profession. It is argued that these features make a profession different from an occupation (Ritzer, 1975; Larson, 1978 and Jackson, 2010). These characteristics also impart the profession with special powers and privileges. For example, autonomy and the ability to self-regulate imbued the medical profession with the power to determine who is admitted into it, disciplined within it and dismissed from it. In short, the profession has the power to control what is happening within it and shield itself from external scrutiny. As a result, the medical professions in Ireland and Canada, one of the main traditional professions with attributes such as autonomy and self-regulation, have a tendency to develop inclusionary or exclusionary professional strategies through professional practices and cultures that monopolise the provision of particular skills and expert services such as medical diagnosis, advice and treatments. It also has the propensity to develop strategies of closure around specific prestigious and desirable occupational niches within the professions

In Chapter Three, it was argued that the profession is interconnected with the concept of social closure (Witz, 1990). This is because professions exercise professional market monopoly and collective social mobility (Macdonald, 1985, p.541), by setting rules for entry and rules to control members. They also have the power to create hierarchies and control registration and licensing. The reason for this as perceived by some interviewees may be to monopolise access to the more prestigious and desirable of the occupational hierarchies.

These closure strategies may include distinctions based on visible social and physical markers such as class, race and gender. As argued in Chapter 4, they may also be based on more covert and

institutional practices of distinction that appear neutral and benign, but which are still very powerful. Therefore, the questions then are:

What are the professional cultures in medicine that allow specific social groups to dominate and have the power to include/exclude others?

On what basis are these inclusions and exclusions founded and how are they produced, reproduced and sustained, over time, in Ireland and Canada's medical professions?

Building on the concepts discussed in Chapter 4, this chapter attempts to answer these questions by presenting and discussing the prevailing professional cultures within medicine in Ireland and Canada in relation to access to and progression. It presents an analysis of professional cultures, its mode of operation, and how professional cultures may serve as strategies of inclusion for the members of the insider group, and exclusion, for the members of the group identified as an outsider group. It does this by interpreting the narratives of interviewees using theories of the profession as the lens for analysis.

Professional Culture and Medicine in Ireland and Canada

Drawing on the definition and theories of the profession as presented in Chapter Two, Professional culture in this study is described as the sum total of ideas, customs, practices and social behaviour of a particular profession within the society. As a result, any examination of the professional culture of medicine must take into consideration the historical development, social organisation and professional practices of the medical profession in a particular societal context.

Presently, in Ireland and Canada, similar to other modern societies, there are peculiar professional features, customs and practices at the core of the medical profession which were largely absent from it until the 18th century. As discussed in Chapter Four, social organisation of medicine and its regulation or professionalisation did not take place respectively, until the late 18th and early 19th centuries when the Medical Registration Council was established in Ireland and the Canadian Medical Council, in Canada. It was this social organisation that mainstreamed regulation and uniform education within the medical profession and education in both countries.

The construction of such professional structures within medicine in Ireland and Canada, like other technologically advanced western societies, included the formation of certain practices as major characteristics. These practices, which are entrenched within the medical landscapes of both countries can be referred to as the culture of the medical profession in both countries. These professional and cultural practices include:

1. Processes of self-regulation and practice of professional autonomy.

2. Monopoly over medical knowledge and treatment.
3. Processes and practices involved in regulating and controlling entrance to the profession through the establishment of professional associations, uniform standards of education, licensing and setting of qualification examinations.
4. Creating specialisations.
5. The processes of creation and reinforcing occupational and positional hierarchies within the profession.
6. Monopoly over diagnosis and treatment of illnesses.

In practice, the afore-mentioned professional culture may turn out to be inclusive or exclusive, depending on how the dominant social groups within the profession conceptualise insiders and outsiders. For example, autonomy and the ability to self-regulate the profession, enjoyed by the medical profession in Ireland and Canada, are processes, stated by many interviewees, as strategies, used in producing and reproducing the dominant positions of middle-class white males in medicine in both countries. This is because, as mentioned in Chapter Three, white, middle-class and male doctors may restrict access of members of other social groups regarded as outsiders into the professions via closure strategies such as credentialism, sponsorship and patronage. This is possible because the dominant social group sets the criteria around who to allow in and they have the power to move the boundaries depending on who wants to come in. Moving the barrier can take the form of legislating against access and progression of a group or formulating policies that impede the inclusion of another group. An example of this in Ireland is the passing of the Medical Practitioners Act 2007 which prohibited many International Medical Graduates (IMGs) from accessing training posts vital to their career advancement, while at the same time, facilitating access and progression of Irish graduates and doctors to training posts.

In so many instances, the policies and practices appear bias-free and neutral, but the consequences of these professional practices on subordinate social groups are evident historically and currently. For example, as mentioned in Chapter 4, there was no record of a female graduate from the Royal College of Surgeons in Ireland until 1893 when Emily Winifred Dickson became the first fellow of the Royal College (RCSI, 2012). Likewise, in Canada, no woman was admitted as a licentiate until 1877 when Dr Jenny Trout was licensed. Similarly, in Ireland's medical sphere, up until lately, women were over-represented in the Non-Consultant Hospital Doctors category and under-represented in the Consultant grade (Cannon, 2003). The experiences of women within medicine in both countries may suggest the existence of a 'glass ceiling'.

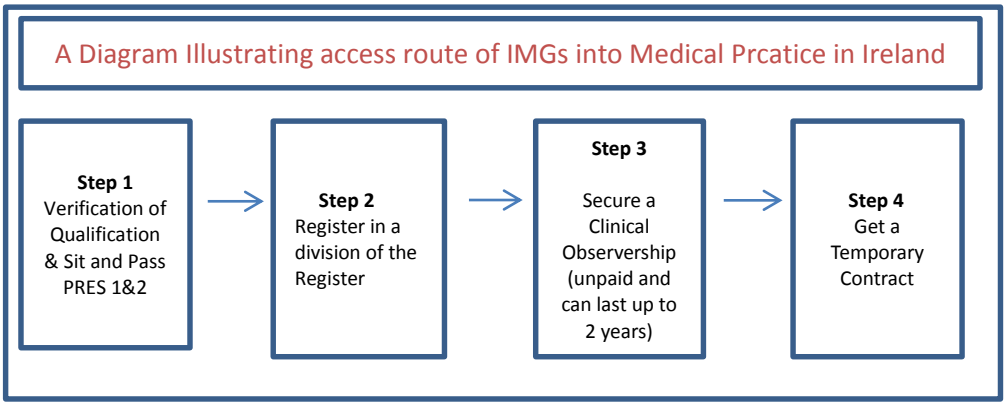
Professional Culture as Inclusion or Exclusion: Experiences of IMGs in Ireland and Canada

This section identifies and specifically discusses the processes and practices in the medical professions in Ireland and Canada in relation to access and progression of IMGs from the perspective of interviewees. It presents how IMGs who participated in the research make sense of their experiences of these processes and practices. It does this by, examining experiences of the medical professional processes and practices of admitting and integrating IMGs. Closure strategies such as credentialism, sponsorship and patronage, and the role played by race, class and gender, as outlined in chapter Three are utilised in analysing these experiences. This chapter is structured with the themes of 'access and progression'; 'specialisation' and 'hierarchisation' and 'autonomy and power'.

Ireland

Access and Progression

Identified in this study are some ways access and progression are blocked to IMGs. Such ways include lengthy registration processes, restrictive legislation that makes it impossible, regardless of an IMG's clinical experience and previous years of practice, to register in any other division of the register besides, the General Division. Additionally, a cultural practice of sponsorship and patronage within the profession were suggested as ways access to and progressions within the profession are blocked. As a result, access and progression within medicine in Ireland is discussed in light of these factors.



As discussed in Chapter Four, access to professional practice in Ireland for IMGs starts with verification of qualifications, writing and passing the Pre-Registration Examination System (PRES) of the Medical Council. This is then followed by the ability of a particular IMG to secure a position within the hospitals, but since it is difficult for many of them to secure a position, they take up supernumerary post. Supernumerary posts or clinical 'observership' posts' are doctors' positions filled by doctors who have already passed their Medical Council examination, but have yet to secure employment with any hospital. They do routine work in hospitals, but do not have an employment

contract nor are they remunerated. The purpose of these positions, as described by interviewees, is to facilitate an IMG who does not have any previous Irish medical care experience to gain such experience, for the purposes of eventually gaining employment as a doctor in Ireland. Hence, all but one interviewee participated in this scheme. Disappointingly, according to them, the scheme would have been worth it and life would have been easier if accessing employment post-supernumerary participation depended solely on their educational qualifications, personal abilities and medical competence, demonstrated when in a supernumerary post. According to all interviewees who are IMGs in Ireland, gaining employment depended not only on the three mentioned criteria, but also importantly, on the generosity of consultants who agree to work with IMGs and subsequently recommend them to hospital management for employment. An interviewee shared her experience with me and she has this to say:

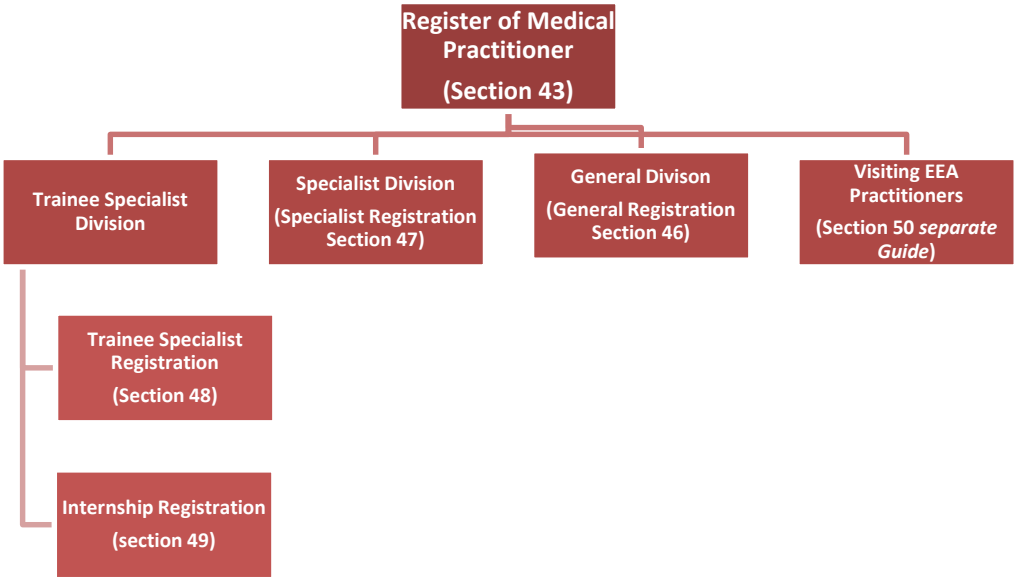
> Don't assume that passing the Medical Council exams qualifies you automatically for work. No, it doesn't. It just signifies you are now ***allowed*** to apply for job as a medical doctor in Ireland. What happens is after passing, you will now start to apply to hospitals with vacancies to work. In my case, I applied to nearly all the hospitals in Ireland to work with no success, for nearly 18 months after passing my exams. It was then someone told me to go and talk to a particular consultant, who within the IMG's circle, is regarded as sympathetic. I then went to him with my CV and he said the best he could do is for me to come and be an observer for 6 months. If he is satisfied after that, he will recommend me for a job. This was the opportunity I availed of and that was how I got into medical practice here in Ireland. (Dr Nasir. Author's emphasis).

Many interviewees in the study clearly stated that they thought most practices within the profession of medicine in Ireland and Canada are constructed on a culture that is historically inclusive of middle class white males and exclusive of ethnic minorities, women and working-class people. To maintain this *status quo* within the profession, evidence from this study suggests androcentric, racist and classist policies and practices. These policies and practices are based on identifying aspects of social identity such as class, gender, nationality, ethnicity, etc. to differentiate between social groups within the profession. For example, according to some interviewees in this study, women are regarded as not reliable with reference to job rotation since it is perceived that most women will, at one point in time or the other during their career, take maternity leave. Interaction with the profession and motherhood was identified as a barrier facing women as far back as the 1980s, when Kelly et al (1982), observing the 'Medical Graduates of the Seventies' noted that 'Irish female medical graduates with children had difficulty combining parental responsibilities with medical training to the point that one-third of them were not working' (p. 34). The marginalisation of women within medicine in Ireland can be likened to practices within medicine the UK in the 1990 where there were calls for women to be discriminated against. Moore (2002, p. 754) quoted the stark argument of a Dr Peter Holden, a member of the BMA's GP negotiating committee who advocated

positive discrimination *against* women in access to medical training by saying that 'you do not get 35-40 years of service from the females' for family reasons. Interviewees in this research commented on practices that exclude women from progressing into a position of consultant when compared with men. They believe that not adequately providing for maternity leave cover, and in not considering the family circumstances, roles and responsibilities of female doctors, in the implementation of rotation of trainee doctors around hospitals across the country, the Irish Medical Council effectively marginalises women. Rotation of trainee doctors around hospitals in the country on a tri-monthly or six-monthly basis has been claimed to specifically have a negative impact on female doctors with school age children (Cannon, 2003).

Additionally, the Medical Practitioners Act 2007 which disallows doctors with medical qualifications outside of Australia, New Zealand, Malaysia, Sudan, and South Africa (with an internship after 2006) and Pakistan (with an internship after 2008) from entering training posts within the medical profession in Ireland emerged as mitigating against the inclusion of many IMGs into the profession. As argued in Chapter Three, the state passes such legislation to legitimise exclusion. Berlant (1975) reasoned that professions and the state work together, in that the state legitimises exclusionary professional practices through licensure and registration of professions. By so doing, the state legitimises exclusion. Legitimisation of exclusion is how many interviewees make sense of the Medical Practitioners Act 2007. The legislation was argued by interviewees to be another method used by the dominant group within medicine in Ireland to exclude IMGs from progressing to become consultants. The Medical Practitioners Act 2007 became effective in 2009 and led to the establishment of a new Register of Medical Practitioners in 2009. This register replaced the old one and it comprises of four divisions, as mentioned in Chapter Four (see the diagram on next page).

Figure 6: Structure of the Register of Medical Practitioner



Source: http://www.medicalcouncil.ie/Registration/Guide-to-Registration.pdf (p. 6)

It is worth noting that in 2011, to particularly accommodate the over two hundred doctors recruited from India and Pakistan, the Supervised Division was added, increasing the numbers of divisions to five.

The Medical Practitioners Act 2007 effectively prevents foreign-trained doctors from registering in the Trainee Specialist Division by requiring them to either (1) pass or be exempt from the PRES examination, or (2) hold a 'Certificate of Experience' or its equivalent (See section 46 (b)(iv) of the Act). The Certificate of Experience confirms that the doctor in question has completed an internship, which is equivalent to one completed in Ireland in his or her country of training. As at the time of writing this thesis, for the Medical Council, through the Act, only doctors trained in Australia, New Zealand, Pakistan, Africa, Sudan and Malaysia's certificate of experience were considered comparable to the Irish certificate of experience, in terms of quality[28].

Many interviewees claimed the medical profession in Ireland was not structured in a way that facilitates access and progression for many IMGs. Many interviewees argued that, if Ireland had any other choice, they would have chosen not to recruit non-EEA trained doctors. This, they claim exhibits itself in how doctors from outside the West are treated within the profession. This is the way a doctor from Sudan conceptualised it:

… what IMGs don't know prior to arrival in Ireland is that the medical profession in Ireland was not structured to

[28] see Medical Council's *Certificates of Experience or Equivalent*. Available on https://www.medicalcouncil.ie/Information-for-Doctors/Certificates-of-Experience-or-Equivalent/).

accommodate IMGs, especially African IMGs (we are actually abhorred). It is just that the Irish don't have a choice. When they had a choice, they didn't employ us. They prefer to employ their kind or even the Eastern European even though, the majority of the Eastern European don't speak good English. Well, now that they have no choice than to employ outside of Europe, they are yet to put in place a structure that will enable us to progress. To them [Irish], we are not supposed to progress. We are just supposed to come and do the dirty medical jobs and when we are frustrated, we go away. In that way, we will not displace their children and will not get pension when we are old. We are meant to be temporary workers. (Dr Kamal)

Other strong practices that interviewees claimed to inhibit access to medicine in Ireland besides that of country of training are: the duality of medical posts into training and non-training posts and making recommendation from existing consultants. Clinical knowledge and experience are also considered to be important requirements to be admitted onto the specialist training posts and eventual appointment as a consultant. According to many interviewees, these practices legitimise and promote a culture of patronage. Eight out of ten interviewees stated that having a biological or a social connection with some existing 'powerful' consultants within the profession of medicine in Ireland is an added advantage. Where this connection is absent, they claim IMGs might be disadvantaged in terms of competing for access and progression within the profession. Some interviewees argued that because a personal recommendation is a significant requirement for access to and promotion within the profession, their observation of the position of consultants and the people who fill it, can be likened to 'like continues to produce like'. That is, white male doctors especially of Irish origin, trained in some colleges, and coming from specific families are more likely to get recommended by senior colleagues, who share the same social characteristics with them, than doctors with no father or grandfather or uncles, and a network of family and friends who are existing consultants. A doctor from Pakistan puts it this way:

… as an IMG, the process of becoming a consultant in Ireland is harder than the process for a camel to go through the eye of a needle! I tell you! It is the most frustrating thing in life. Except you get into a training post from the beginning, you're doomed to a life as a junior doctor in a service post. And how do you get into a training post when Darragh, Oisin and Dylan, the sons of the consultants are tipped for it. Since they started medical school, they have the knowledge they are going to get it when the time comes. Even when by stroke of luck, you get into a training post and you complete the training, the system does not guarantee you becoming a consultant. You have to be recommended by an existing consultant. In most cases, the mainstream Irish consultants have their own candidates. So, you are seldom considered. It is very sad because the system does not select base on merit, but who you know most of the time. As a result, these policies and practices of making IMGs jump through the loop is to frustrate them into working for 3-4 years and then move on from Ireland. Then a new IMG will be recruited from Pakistan or Sudan to go through the same frustrating process. (Dr Khalil)

Many interviewees argued that the structure of the medical profession in Ireland, the requirements for accessing training posts and the differentiation and 'othering' of IMGs on the basis of their nationalities or country of training in relation to access and progression, could be the basis for the

marginalisation of the majority of IMGs. However, a few IMGs disagree with this notion. A female IMG from Nigeria has a contrasting opinion to the opinions expressed by Dr Khalil. She said:

.. . well I do not believe the system is calculatedly loaded against any individual. It is a system created to absorb the best and the brightest. As a result, many individuals who cannot compete successfully are quick to blame their failure on gender or race or whatever. This is not true. The only explanation is they lack what it takes to compete. (Dr Doyin)

Dr Doyin's perspective is contrary to the perspectives of many other interviewees. Many of them criticised it when I raised it with them. They responded by saying such thinking is the direct result of buying into the very culture that disadvantages them. It was argued by many IMGs that after they painfully go through the system, they tend to, not just have experienced the power dynamics in the system, but they also internalised it. As a result, they believe their inability to progress is because of their inadequacies. Hence, they say: 'I am not good enough'. This perspective resonates with the writings of many race theorists who have written on the experiences of Black people and how the oppression experienced by them creates self-doubt and being self-critical in them.

Talking about self-doubt and self-criticism among some IMGs, some interviewees argue that the impact of their experiences of marginalisation within medicine in Ireland is that of feeling and believing that the present processes and practices of closure experienced by many of them is justifiable. Many interviewees claim the perspective of Dr Doyin can be produced by only the internalisation of exclusionary practices within the profession. They argue that it is the reality within their profession in Ireland that the dominant social group controls access to more respectable and prestigious positions within it by adopting policies that exclude members of specific social groups from such prestigious positions. In cases where members of these subordinate groups are allowed access, according to the interviewees, they are often restricted to service posts which do not have promotion built into them. Thus, borrowing Carter's (2003) depiction of the positions of ethnic minorities in the NHS in the UK, described as, 'at best, peripheral' (p. 5), many IMGs end up occupying positions within medicine that are marginal and not offer progression.

Also, there are IMGs who confirmed there is exclusion built in the system, but they are not perturbed by it because they are in Ireland purposely to use Ireland as a stepping stone to practice in places like Canada, Australia and the US. To these IMGs, they are not interested in whether there are opportunities for progression or not. All they wanted was to get European experience which will serve as vital when they move to places like the USA, Canada, etc. Acquiring European is important for IMGs becaue it allows them less difficult access to practice in for example, Canada, where with it, they may be exempted from going through residency all over again. European experience also qualifies an IMG to commence medical practice with a provisional licence in Canada. It must be

noted that there a many kind of provisional licence depending on the province.

Another interviewee mentioned his non-interest in progression because his family is young and requires a lot of time. So, he does not want any additional responsibility by taking on extra work or studying for another examination.

Experience of Specialisation and Hierarchisation

As mentioned in Chapter One, besides the structural aspects of the medical profession, there also exist hierarchies of hospitals, according to type: private or public, and specialist/teaching or non-specialist/teaching hospitals. Also, as mentioned, the range of services offered by specialist/teaching hospitals contributes towards professional prestige and privileges for its doctors than doctors practicing in rural hospitals that provide less services. As a result, many interviewees in this study argue that within the circles of doctors, hospital of primary assignment is important. Equipped with this knowledge, members of the dominant social group within the profession, continually pursue policies and engage in practices that can amount to the exclusion of groups deem as 'outsiders' from urban, specialist hospitals, while facilitating easy access to its own group, the 'insider'. One interviewee mentioned this:

> … the only reason why Ireland recruits IMGs is to fill the unfilled positions in the rural areas where the posts are mainly service posts and the Irish graduates are not interested in filling. They also want 'bodies' to work those long hours which their children will not do mostly. That is why you see that more than 50% of IMGs are working as Non-Consultant Hospital Doctors (NCHDs). If those positions are not there, I bet you, they will never employ IMGs. (Dr Mashad Q.)

Another practice within medicine in Ireland that disadvantages IMGs relates to a hierarchy of specialties. According to many interviewees in Ireland, the professional culture of specialisation and hierarchy of specialties, a prominent feature, not unique to medicine, but other professions such as academia and law (Hinze, 1999) promotes the exclusion and segregation of IMGs into specialties that are less prestigious. As Hinze (1999) argues, intra-occupational hierarchies exist and women, more often than men, find themselves on the lowest rungs of occupational hierarchies. According to her, in medicine, while paediatricians and psychiatrists vie for the bottom rungs of the ladder, surgeons are regarded as 'kings' (p. 217). In parallel to Hinze, few interviewees in this research, still rank surgical subs-specialties, such as cardiac surgery and thoracic surgery number one in the pyramid of specialties in Ireland. The general practice was ranked next to them. According to interviewees, both specialties, except in instances of tokenistic gestures to IMGs, remain largely the domain of 'white', male Irish doctors. Many interviewees consider general practice completely closed to most IMGs in Ireland.

According to the Medical-Workforce Intelligence Report 2016 of the Medical Council:

'The proportion of international graduates in the medical workforce varied across areas of practice; the leading areas of practice with high proportions of international medical graduates were Obstetrics and Gynaecology (58%), Emergency Medicine (56%) and Surgery (53%) (p. 42).

Table 23: Area of practice and percentage of IMGs in Ireland in 2015

Anaesthesia	50.7%
Emergency Medicine	55.9%
General Practice	19.8%
Medicine	40.8%
Obstetrics and Gynaecology	57.8%
Psychiatry	40.3%
Occupational Medicine	25.2%
Ophthalmology	33.5%
Paediatrics	47.4%
Pathology	31.2%
Public Health Medicine	9.8%
Radiology	34.1%
Sports and Exercise Medicine	32.5%
Surgery	52.9%

*Specialities where the proportion of international medical graduates is greater than average are highlighted.
Source: www.medicalcouncil.ie

Considering the claim of interviewees about general practice, a guesstimate from interviewees in Ireland puts the number of IMGs practicing as GPs at less than thirty doctors. Unfortunately, I could not retrieve an official data from the Irish College of General Practitioners on this. When I compared this guesstimate with the available data in the *Medical Workforce Intelligence Report 2016* by the Medical Council, which claims that 19.8% of the total number of IMGs registered with the Medical Council are GPs, I was told that the figure of the Medical Council comprises doctors largely from old and new EU member states. IMGs from outside these regions, they claimed, find it hard to become GPs in Ireland. A female Nigerian doctor related her frustration at accessing GP training in Ireland. She said:

… as a result of the money, prestige and flexibility involved in GP practice, the Irish doctors have closed it off completely to IMGs. They create all sorts of barriers to close it off to us. These barriers include intentionally failing us when we write the exam to get on the training. Can you imagine, I wrote the exam to become a GP five consecutive times, but failed those five times. It was after the fifth time and I was frustrated and depressed that one of my friends told me to go and write it in the UK which I did. Guess what? I passed the UK exam once. I have since started my GP training in the UK. Can you believe that? I just wasted five years in Ireland. I believe they knowingly fail you to keep you away from becoming a GP and to keep collecting your money. (Dr Banjo A.)

According to this interviewee, even though GP training in the UK is similar to GP training in Ireland, the one in the UK is far more accessible to IMGs. The fact that Dr Banjo could succeed so quickly in the UK system can be an indication that the barriers she faced here in Ireland were, indeed, structural ones.

In summary, in Ireland, all research interviewees thought that Irish medical profession and practice is two-tiered and many interviewees perceived the medical profession as presenting barriers to IMGs in progression to the position of consultant. Many interviewees believed that IMGs, in most cases, are allowed into areas within the profession that cannot be filled by Irish graduates, but are denied access to the most prestigious and desirable professional specialties and positions. This practice as described by the interviewees, can be conceptualised through Nigel Harris' (2002) justification for international migration. As mentioned earlier, he argues that immigration helps sustain economies of developed countries. According to him, immigrants facilitate native workers or their children, with steadily higher educational qualifications, to transfer to well-remunerated and cleaner jobs. He further claims that without the army of semi-skilled and unskilled labourers who are predominantly immigrants in industrialised countries, skilled workers would not last long. Even though IMGs are regarded as highly skilled, it is important to understand that in most cases, because there are barriers to accessing specialist training and becoming a consultant, they are compelled to take up positions, largely in rural hospitals, characterised by lack of training opportunities and no clear career pathways.

Autonomy and power

As discussed in Chapter Three, the medical profession enjoys a large degree of autonomy over its conduct and members. Through the social organisation of the medical profession, a characteristic common to professions in general, it could create autonomy for medical practitioners around self-regulation, control of who is accepted into the profession, who is rewarded or disciplined and how disciplinary action is carried out. In other words, the medical profession, by and large, has been able to organise itself in a way that it not only controls its own activities, it also protects itself from external scrutiny in relation to its activities. Thus, according to interviewees, dominant groups within medicine in Ireland and Canada sometimes utilise this unique feature of the profession to pursue policies that exclude subordinated groups such as the IMGs. This exclusion is possible because the profession has been described as a project of occupational closure (Witz, 1990). For example, a male Sudanese IMG has this to say about the autonomy of the Irish Medical Council in regulating doctors in Ireland:

> Policies you see the Medical Council pursue most of the time are the reflections of who the executive officers are. Firstly, I want you to look at the composition of the Council. It is predominantly white and male. Many of them still have this idea that medical practice is a dynastic business that must be handed down to their children. So, anyone outside their network is excluded. I remember when I was in RCSI and I complained about the preferential treatment given to Irish students, a professor told me they don't really need me here and if I am not happy with the system, I should go back to my country. You can see the display of disdain for IMGs by some consultants and nothing can be done because they make and enforce the rules. So, they enjoy absolute power and you remember 'absolute power corrupts absolutely'. (Dr B. K)

This idea of autonomy has been under severe criticism from critics of the medical profession. It is stated that the autonomy enjoyed by professions such as medicine, creates institutions of social control, relationships of social distance (Illich, 1976) and has become not only unfashionable, but also socially counterproductive (Wolinsky, 1988). More so, as argued in Chapter Three, the independent and self-regulatory status of a profession like medicine, may not only produce social distance, but may also give rise to new forms of exploitation and further need for social control of entry routes into the profession.

Some interviewees in this study heavily criticised the autonomy enjoyed by the medical profession in Ireland. It was argued by many interviewees that because medicine in Ireland is largely exempted from external scrutiny, it allows, in some instances, dominant social groups within it to utilise its independent and self-regulatory status to produce and sustain social control of access to, progression, and exploitation of IMGs within it. This opinion is synonymous with previous findings on this topic in Australia, the UK and USA where it was contended that the invention of medical regulatory bodies serves the purpose of keeping out doctors regarded as outsiders and maximising opportunities for insider doctors (Khan et al, 2014; McGrath et al., 2009; Douglas, 2008; Coombs and King, 2005; Moore and Rhodenbaugh, 2002).

At this point it is worth focusing on the power of the consultant, as a high-ranking position within the medical profession. According to a male interviewee, 'consultants have the power to make you or break you'. The way it happens in Ireland, as mentioned earlier, is as follows. To succeed in a competition for a consultant position, a candidate must, in addition to building up a portfolio of academic qualifications, clinical experience, research, and publications, be recommended by an existing consultant. Hence, the reference of an existing consultant forms a considerable part of the requirement for progressing to the position of consultant in Ireland. The conferring of such power on consultants perpetuates the culture of patronage and sponsorship (this is discussed in detail in chapter 7). It also reproduces power imbalances in favour of doctors with established connections to existing consultants against IMGs with no such connections.

Canada

Access and Progression

As discussed in Chapter Four, IMGs hoping to practice in Canada must navigate a highly complex system with paths to licensure and practice not clearly laid out in some instances. More so, because IMGs migrate to Canada through different immigration schemes, access routes to licensure and practice for them differs, depending on the unique immigration situation of individual IMGs. Nevertheless, as discussed, for an IMG aiming to practice in Canada, they must first pass the Medical Council of Canada Evaluation Examination (MCCEE) to be able to apply for post-graduate residency

positions. The MCCEE establishes the basic medical knowledge of an IMG. Residency positions are usually applied for through the Canadian Residents Matching Service (CaRMs). In addition to passing MCCEE, all provinces in Canada have the right to demand additional assessments such as the National Assessment Collaboration (NAC) examination to qualify for residency positions in their province. This assessment, which is only administered in Canada, is a verbal examination which comprises many clinical problem-solving knowledges that may include gynecology, medicine, obstetrics, pediatrics, surgery and psychiatry. As mentioned in Chapter Four, some provinces also may require that candidates fulfil region-specific criteria to be eligible for specific provincially funded training positions. For example, all IMGs applying for first and second iteration CaRMS positions in British Columbia are required to provide passing scores for both the Medical Council of Canada Evaluating Exam (MCCEE), and the National Assessment Collaboration (NAC) examination[29]. Furthermore, as already discussed in Chapter Four, IMGs, with the exceptions of some USA graduates, who may apply for an exemption, may be required to pass the Medical Council of Canada Qualifying Examination (MCCQE) Part I and II.

Like Ireland, the source of the medical degree of an IMG determines how easy it is for them to access medical licensure and eventual practice in Canada. Like Ireland, the medical qualifications of many IMGs are regarded as not up to standard[30]. However, in Canada, IMGs who lack such qualifications must complete a period of post–graduate residency training before becoming licensed to practice.

Another parallel between Ireland and Canada in relation to access of IMGs becoming licensed and qualified to practice in Canada is clinical observership. IMGs in Canada may apply for clinical observership positions, referred to as the Clinical Trainee License in Canada, just like IMGs in Ireland. In Canada, participation in clinical observership allows IMGs to do electives in Canada (as an M.D.) while they wait for a residency position through the Canadian Residency Matching Service (CaRMs). The Electives Program in medical training in Canada is an opportunity available to both local and international medical students for self-education in an area of the student's own interest. The aim of

[29] Summary of intake criteria for IMGs by province at: http://www.carms.ca/en/residency/r-1/eligibility-criteria/provincial-criteria/).

[30] According to information available on the website of Royal College of Surgeons and Physicians of Canada, there are 29 international jurisdictions that the Royal College has assessed and deemed as having met Royal College criteria. For the graduates of these particular jurisdictions, the College assesses their training to determine the extent to which they have successfully met and completed the Royal College training requirements. When the training is deemed comparable and acceptable, the IMGs are ruled eligible to take the Royal College certification examination. Success at the certification examination leads to Royal College certification. The list of approved international jurisdiction is available on http://www.royalcollege.ca/portal/page/portal/rc/common/documents/credentials/jurisdictions_e.html

these electives is to improve the ability of a student to function as a doctor. These electives do not, however, count as an IMG's core rotation. Core rotation is the period when medical students, during their final years of study, apply the classroom knowledge acquired earlier to clinical experience. During core rotation, there is a requirement for students to rotate through different medical specialties and treat patients under the supervision of fully qualified doctors. The purpose of hospital rotation is to allow students to gather experience through observing and practice. An IMG is required, similar to Canadian graduates, to have successfully passed through medical residency before he or she is allowed to practice in Canada. Medical residency is postgraduate medical training that gives doctors who have graduated from an accredited medical school and hold a medical degree (MD, DO, DPM, MBBS, MBChB) in-depth training within a specific branch of medicine. The difference between Canadian graduates and IMGs is that the first iteration or admission into residency has a stream for IMGs that is different for Canadian Graduates. There are designated positions for each stream and IMGs can only apply to a separate stream of positions from Canadian graduates in one or more disciplines. Another difference is that nearly all IMG's positions have a Return of Service (ROS) contract attached to them. For example, in the summary of intake criteria for IMGs in in Canada for 2015 by the Canadian Resident Matching Service (CaRMS), 'all IMG stream positions in first iteration have a return of service attached. Vacant positions in the IMG stream in the second iteration, except Family Medicine, are available only to IMGs and have a return of service attached' (Summary of intake, 2015). As stated in Chapter Four, ROS is part of a package of strategies designed to attract physicians to Canada's underserviced communities. The provincial Ministry of Health and Long-Term Care, through the Health Human Resources Policy Branch, provides training and assessment opportunities for physicians in exchange for an agreement to provide service in Ontario's underserviced communities.

In comparison to Ireland, there is dissimilarity on what is obtainable to an IMG after participating in a clinical observership. In Canada, observership is not succeeded by medical practice. Whereas, Ireland, after an observership, an IMG can choose to apply for a junior doctor position within any Irish hospital, once the IMG can secure a recommendation from a consultant. Clinical observership, in a way, allows IMGs to obtain recommendations from existing consultants to gain employment. Another significant contrast is in Canada, clinical observership can be arranged through the Province an IMG lives in, e.g. the College of Physicians and Surgeons of Alberta, if the IMG lives in Alberta. Contrastingly in Ireland, it is arranged individually, through personal contacts with, and friends or acquaintances of consultants.

Referring to the perception amongst IMGs in Canada on closure of access routes to medical licensure and practice for IMGs, it was noted there was a consensus on closure, but there was no consensus

on the reasons for the closure. All interviewees agree access to medical practice is made more difficult for IMGs compared to Canadian graduates. Although, some interviewees opined that the greatest problem is not the barriers to access, but lack of preparation by IMGs prior to migrating to Canada. Half of the interviewees thought access to medical practice by IMGs is consciously made difficult to exclude IMGs from practicing in Canada and to favour Canadian trained doctors. According to a male IMG of Indian origin:

> The hardest part of practicing in Canada is getting licensure. It took me 5 years to navigate around the system here. There are so many barriers to practicing here for IMGs. Foremost of the barriers is the non-recognition of my previous experience from Pakistan. IMGs are forced to write the expensive examinations and then you are made to join the queue. As at my time, nearly 7,000 IMGs waiting to get a residency spot. It is a hard one my friend. (Dr Abdul S.)

Evidence from this study, as represented by the opinion of the interviewee expressed in the quote above, suggests that the non-recognition of foreign medical qualification from countries outside of the twenty-nine accepted jurisdictions, as mentioned earlier, the limited numbers of residency positions for IMGs, especially in the first iteration of residency matching scheme, and the cost of writing the pre-registration examination, proved to be obstacles that make the process of licensure a protracted, costly and sometimes, unsurmountable one. Even though all the interviewees in Canada found a way through, they all acknowledge that there are thousands of IMGs who had not been able to go through the system successfully. For example, according to the information available on the CaRMs website, in 2008, 929 IMGs competed for 48 residency spots designated for IMGs in the various faculties of medicine in Canada. This leaves more than 95% of IMGs in the queue for that year alone. By 2015, the residency spots increased to 244, but so did the number of IMGs who competed for them, to 1,984 (Lofters et al., 2014).

Some other interviewees think that the present system of licensure in Canada is hierarchical and exclusionary. They perceived that the system is aimed, as much as it can, at restricting the access of IMGs to medical practice in Canada, especially to urban areas, by making it extremely difficult for non-Canadian, non-White doctors to practice in Canada. According to a interviewee:

> The Canadian medical entrance examinations (MCCQE) and other criteria required to be fulfilled by IMGs to become licensed in Canada were instituted to keep them out for as long as possible, devalue their skills and banish them to medical fields and positions that are unpopular amongst Canadians. Don't you think if they allow every IMG that comes into Canada to practice straight away, the profession will lose its value, command less respect and money and practitioners lose out? As a result, they must categorise IMGs and invent some artificial and neutral reasons why some categories cannot practice straight away even though the bases for those reasons are deeper than those artificial reasons given. (Dr Thembi F.)

Contrastingly, the other half of interviewees think the inability of IMGs to gain access to practice in

Canada is because of them not seeking adequate information prior to migrating to and settling in Canada. As stated by a male Nigerian doctor in Alberta, Canada:

> … I don't know where people get the idea that Canada excludes IMGs from! The failure of most IMGs to become licensed is due to their failure to seek accurate information and plan prior to migrating to Canada. I did my homework before coming to Canada so I wrote and pass all my exams before my arrival in Canada. Also, I already had a residency spot before packing my baggage and saying I am migrating to Canada. And since my arrival 10 years ago, I have never experienced any form of barrier. Life is not a bed of roses. People must be prepared to work hard and be patient. I have worked hard and now I have my own family practice here in Alberta. (Dr F. A)

The core argument of the above quote is reiterated many times in the 2011 Health Canada *Internationally Educated Health Professionals Initiative* Policy Roundtable in Ottawa. Factors recognised by many policy makers, service providers and other stake holders is the unavailability of information for incoming IMGs and many IMGs not availing of available information. Therefore, like Dr F. A, above, many interviewees in this research and the Policy Roundtable located the problem of securing residency positions and subsequent practice in Canada, on the failure of recruiting authorities to provide adequate information and on those IMGs to seek and access accurate information prior to migrating to Canada. Non-availability of sufficient information on the Canadian health system and medical career pathways has been identified by both researchers and policy makers as considerable barriers to the inclusion of international healthcare professionals in Canada (See Lofters et al., 2014; Bourgeault et al. 2010). Lack of insight about the Canadian health care system and career pathways were particularly identified by Lofters et al (2014) in their study of experiences of international medical graduates in Ontario, Canada. This finding agrees with the perception of some interviewees in this study, who came into Canada prior to 2010. These interviewees claim there was very little information online prior to 2010. They said the correct information could only be accessed from friends who worked in Canada, but if one had no existing social ties in Canada with inside knowledge of the workings of the medical profession, it was difficult to know which information was accurate. However, many of them now agree that there is enough information available online and that there are recruitment agents, who now supply information that paints the true picture. Furthermore, many IMGs now talk about their experiences and they make it public.

According to Lofters et al (2014), another 35% of their interviewees said lack of information about medical career pathways were big barriers to becoming licensed (p. 84). Besides, in 2011, I attended the *Inter-Provincial Policy Roundtable Forum* organised by the *Internationally Educated Health Professionals' Initiative* (IEHPI) unit of Health Canada. The unavailability to IMGs, prior to their arrival in Canada, of adequate, well-articulated information about the medical profession and its career

path in Canada, was identified by interviewees there as a barrier to the ability of IMGs to access medical practice in Canada.

Like the opinion of Dr Doyin on p. 131, an IMG from Nigeria disagrees with the notion that the licensure requirements in Canada is specifically aimed at excluding IMGs from certain countries. He reasons that licensure requirements in Canada are not specifically exclusionary of any race or ethnicity. Rather, he considers that the rigorous process and requirements are necessary to maintain a high standard of medical care delivered to the Canadian population. He argues:

… why do people complain about the medical licensing exams? Do they not want to be tested before being entrusted with precious Canadian lives? Look, the medical practice is a very delicate one with lives at stake. So, it must not just be opened to every Dick, Tom and Harry. Doctors must be made to defend their certificates. (Dr Frederick. O)

This perception was corroborated by another IMG from Pakistan:

… man, if you have a company, will you employ every one that presents his or her certificate without finding out they can do what they profess to know? I am from Pakistan and the fact that all these IMGs wave their qualifications at your face does not mean they can defend it. Remember, certificate is just a piece of paper. That piece of paper will not treat patients. Doctors do. So, if you say you are a doctor, you must be able to perform what you profess and must be able to do so in the context of medical practice obtainable not in Pakistan or India, but in Canada. (Dr Jabbar Y.)

However, other interviewees argued that even after IMGs have passed all the required examinations, which may be a testament to their knowledge and ability to practice medicine, they still find it extremely difficult to get residency posts. These interviewees thought that access-control measures are formulated to exclude IMGs of specific descents such as Africans, Asians and the Caribbeans.

Experience of Specialisation and Hierarchy

Like Ireland, in Canada, hierarchies of urban over rural also exist for doctors. It is worth noting that Canadian rural areas are experiencing declining population trends because of an ageing population, lower birth-rates and rural-urban migration of youths. As a result, in Canada, doctors prefer urban centres because most of the Canadian population reside in urban areas. Besides, the harsh weather condition in many areas, as well as a shortage of doctors in rural areas, mean that available doctors tend to be over-worked. These serve as discouraging factors for doctors (Simmard, 2009). Therefore, some interviewees believe in instances where IMGs access the profession, they are allowed access largely to practice in geographical areas that are unpopular with the Canadian graduates. For example, one interviewee has this to say:

… to practice medicine in Canada as an IMGs is almost an un-accomplishable task. The only way you can get around it is if you are willing to serve in an area that is under-served. These are areas where most Canadian medical graduates will never go to serve because of the unbearable climate which could be as bad as -30-40 degrees centigrade in some places and with

uneasy accessibility. These are the only positions that are opened to majority of IMGs for the first 5-7 years of their practice in Canada (Dr Nnamdi M.)

When the focus shiftes from access to progression, there was a near consensus (8 out of 10) that in post-licensure medicine in Canada, the field becomes a fair playing ground for both IMGs and Canadian medical graduates. Half of the interviewees believe as soon as you gain access to medical practice in Canada, nothing stops you from getting into any specialty. Many interviewees claim that they experienced no barrier when trying to access any specialty. The barriers to integration of IMGs into medicine in Canada, according to them, exist only at the access point. However, there was a mention by 4 interviewees that some specialties are more difficult to access than others. For example, 2 interviewees mentioned Psychiatry as an easier specialty for IMGs to access in Canada. They claim Psychiatry as a specialty in Canada is not as popular as Cardiac surgery. Hence, access to Psychiatry is a little relaxed. A interviewee from Nigeria with a private practice in Calgary, Alberta reinforced this point. He stated:

… the hardest part of an IMG's integration is the access part. As soon as you get yourself in the garden, you have equal opportunities like everyone else. You can eat of any fruit in the garden without the fear of being thrown out of it. For example, I migrated here 12 years ago and in that 12 years, I started practicing after four years. Now, I have my own practice that employs other 3 doctors, I lecture in the university here, I am an examiner and I sit on several committees in the college of family physicians and surgeons of Canada, Alberta branch. How can I achieve all this if there is segregation into specialties according to race or gender? I don't think so. (Dr Inyiam E)

Not all doctors share this position. They comment on the existence of a hierarchy of specialties and probable segregation of IMGs into less prestigious specialties within Canadian medicine. A female doctor of Indian origin has a differing opinion in relation to the ease with which it is to get into some specialties and how hard it is to get into others. She has this to say:

… you see in Canada, the easiest specialty you can progress in is Psychiatry. Majority of Canadian medical graduates believe it is not as prestigious as, say a Neurosurgeon. This is the reason you see so many IMGs in Psychiatry. It is because they have more opportunities in Psychiatry than any other medical specialties in Canada' (Dr B. A).

Extrapolating from the responses of interviewees and existing literature on factors that influence career choices among medical students globally, prestige was identified as one of the main factors that influences medical students in choosing their area of specialisation (Azizzadeh et a., 2002; Chang et al., 2006; Creed, Searle and Rogers, 2010; Norredami and Album, 2007; Glynn and Kerin, 2010). Searle and Rogers (2010) revealed in their research that prestige of medical specialty may affect the physician's choice of specialty not in just a part of the world, but everywhere in the world.

This practice of segmenting medical practice into desirable and less desirable specialties, posts and positions, as described by interviewees in both Canada and Ireland, can be interpreted through the

lens of Nigel Harris's (2002) justification for international migration. Harris (2002) argues that immigration is the lifeline of developed countries' economies because immigrants facilitated native workers and/or their children, with steadily higher educational qualifications, to transfer to well-remunerated and cleaner jobs. According to Harris (2002), without the army of semi-skilled and unskilled labourers who are predominantly immigrants in the industrialised countries, the skilled workers would not last for long. Applying this theory in the specific context of IMGs, it could be understood that even though IMGs are regarded as highly skilled, in most cases, they experience a degree of devaluation of their qualifications and previous clinical experiences, forcing them to, in most cases, to practice in less desirable positions and locations.

Autonomy and power

Again, as is expected within professions generally, the medical profession in Canada enjoys a large degree of autonomy over its conduct and members. Like Ireland, it is largely self-regulated. As stated in the Canadian Medical Association Policy Document on Medical Professionalism of 2005, in return for self-regulation, doctors are expected to hold each other accountable for their behaviour and for the outcomes they achieve on behalf of their patients' (p. 1). This aspect of the medical profession in Canada was acknowledged by some interviewees has not only allowing Canada to meet the unique healthcare needs of its citizens, but also, made Canada's health system, one of the best in the world. What I see here is that those IMGs have also bought into their own professional autonomy as a group.

Contrastingly, others considered that the system constitutes the positioning of power in the hands of the dominant demographic group within the profession. Hence, when executive members of the Medical Council of Canada or some medical faculties have some form of biases, interviewees considered that they tend to use the Council as an instrument to pursue their personal ideologies. For example, a male IMG from Libya has this to say about the autonomy of the Canadian Medical Council and Royal Colleges of Physicians and Surgeons in regulating doctors in Canada:

> It is quite sad that the Canadian Medical Council and the training colleges have such tremendous power in Canada. They determine what happens within the profession and because many of them prefer to maintain the prestige and wages attached to medical practice. They control the numbers of people becoming licensed. As a result, they put up various kinds of barriers to licensure of IMGs, especially from non-white, non-Christian countries. They do this, by working with the government in turning on and off at will, the tap of IMGs. When there is dire need, they relax the requirements and when they perceive there is no dire need, they close it up and make it onerous. (Dr Gaddafi L.)

This contention that the medical profession in Canada utilises the power and autonomy it enjoys as instruments of social closure against IMGs may have validity, considering that it enjoys monopolies over training deemed acceptable and the registration and licensing of new members. As a result,

evidence from the study suggests that it potentially restricts access of IMGs, who are considered as outsiders, to prestigious medical specialties and locations. According to Parkin (1974), basing his arguments on social closure as defined by Weber (1968), as discussed, groups may seek to maximise rewards by restricting access to resources and opportunities to a limited circle of eligible. For Parkin (1974), physical group attributes such as race, language, social origin and religion can be used for exclusionary purposes.

Conclusion

In conclusion, the findings in this study draw attention to the way professional processes and cultural practices of the medical profession may be utilised by dominant social groups to restrict access of IMGs to more prestigious and desirable occupational niches within the profession. The mechanisms identified by the experiences and opinions of interviewees include non-recognition of previous qualifications and experience, making the licensing process lengthy, inadequate provision of information on access and pathways to promotion within the profession, and via legislation, restricting IMGs to medical posts that come without career progression. The narratives of IMGs reveal that professional regulatory bodies in Ireland and Canada in certain circumstances, regulate and set uniform standards of education and training for doctors; such regulation presents barriers to access and progression of IMGs to the profession. In some cases, it appears that access to certain prestigious occupational positions are effectively denied to IMGs. Therefore, IMGs aiming to practice are only allowed access to the less prestigious occupational positions within the medical profession.

Another interpretation of the experiences of IMGs in relation to access and progression of IMGs within the medical profession in Ireland and Canada can be made through the argument of Nigel Harris (2002). Like the explanation mentioned earlier (p 142), he argues that immigration is the lifeline of developed countries economy because immigrants facilitate the native workers or their children, with steadily higher educational qualifications, to transfer to well-remunerated and cleaner jobs (Harris, 2002). According to Harris (2002), without the army of semi-skilled and unskilled labourers who are predominantly immigrants in the industrialised countries, the skilled workers would not last for long. This means without attracting and employing immigrant workers, who are often skilled into occupational positions that locals perceived as less desirable, there will be a big gap within occupations in industraliased societies. As a result, IMGs are recruited, in the case of Ireland, to fill positions and specialties that mainstream Irish doctors have vacated and cannot be filled by another Irish doctor. In the case of Canada, IMGs are granted access to practice in geographical locations that are less desirable to mainstream Canadian doctors. This is evident in the Return-for-Service programmes that IMGs are compelled, in most provinces, to enter, to become licensed for

practice in Canada.

Chapter Six

Social Closure a Strategy of Inclusion and Exclusion in the Irish and Canadian Medical Professions

Introduction

As discussed in Chapter Three, the profession is argued to be a project of occupational closure (Witz, 1990), and many professions such as medicine, utilise social closure to produce, reproduce and reinforce the exclusion of perceived outsiders from professional practices. In some cases, where they are allowed access, outsiders may be systematically segregated to occupational areas that are less desirable, prestigious and respectable. As discussed in Chapter Five, professional cultural practices such as hierarchizing specialties and autonomy in the medical professional fields in Ireland and Canada, that help control access to the profession, may amount to inclusion for specific doctors from the visible minority groups. Following on that, this chapter discusses the concept of social closure as initially conceptualised by Max Weber (1978) and later developed by Frank Parkin (1979), to analyse, understand and explain the experiences of IMGs in relation to access to and progression within the medical profession in Ireland and Canada. It does this by analysing the experiences of IMGs within medicine in both countries through the lens of social closure.

It looks at how social identities such as ethnicity, gender, class or country of medical graduation are utilised to differentiate 'insiders' from 'outsiders'.

It examines and discusses how access and promotional opportunities are granted or denied to social groups based on this differentiation within medicine in Ireland and Canada.

It does this by describing what social closure is and what occupational closure looks like in medicine in Ireland and Canada. This analysis is presented sequentially with the case of Ireland presented first and thereafter that of Canada.

Some Processes of Social Closure in the Medical Professions in Ireland and Canada

According to Frank Parkin and as discussed in Chapter Three, social closure has two clear implications. Firstly, successful social closure can be achieved by the ability of the dominant social group to restrict access to and to monopolise resources (Harrits, 2014). The dominant class, as described by Parkin, are those who hold the legal monopoly of professional services and those who own or control productive capital. Secondly, social closure is only obtainable via closure strategies and processes, where the dominant groups, as individuals or collective agents, actively seek power

and privilege. Thus, the profession of medicine, per Freidson (1970), is a particularly powerful example of how professions ideologically operate a form of social control to ensure market and service monopoly. As claimed by Freidson and applicable to the medical profession, this privileged status position of the profession is justified by the following three arguments:

1. As a result of the specialised skills involved in the medical profession, non-professional people lack the expertise to evaluate or regulate it.
2. Medical professionals are claimed to be responsible. Hence, they can be trusted to use personal discretion in the process of performing their specialist work without any form of supervision.
3. The medical profession can be trusted to self-regulate itself, and in cases of violations of professional and ethical standards, it can dispense judgements accordingly.

Subsequently, as claimed by Freidson (1970) and still relevant today in relation to the medical profession, the state-licensed control over recruitment, training and the regulation of the conduct of members enjoyed by the profession of medicine validates the claim that the medical profession is successful at shielding itself from external scrutiny.

The medical professions in Ireland and Canada enjoy professional autonomy over the recruitment and training of new members, and the regulation of the conduct of both old and new members. They also have clearly defined hierarchies and the ability to control access to professional medical practice of new members through the imposition of rigorous educational requirements. The processes international medical graduates (IMGs) are required to navigate for the purposes of registration and licensure were suggested by some interviewees in this study as a basis for professional non-integration of many international medical graduates in Ireland and Canada. These processes are analysed in the following discussion, based on the experiences of them within the medical profession in Ireland and Canada, by interviewees in this study. The analysis of Ireland is presented initially and is followed by that of the medical profession in Canada.

Processes of Social Closure within Medicine in Ireland

The medical profession in Ireland, like other professions, exhibits features of a profession as explicated above. These characteristics include a clearly defined hierarchy, the ability to control access to professional medical practice to new members through the requirement for educational credentials and professional autonomy. They are exhibited via specific processes and practices. These processes and practices include setting of educational qualifications for registration to practice by the Medical Council of Ireland (MCI); medical training provided by the six medical

schools[31] and thirteen postgraduate training bodies[32], courses accredited by the Medical Council; training posts identified by the Health Service Executive, accredited by the Medical Council and training provided by the training bodies and disciplinary actions, in cases of misconduct, provided by the Medical Council. Evidence from this study suggests that some of the above-mentioned features of the medical profession in Ireland can impede the professional integration experience of IMGs.

As a result, the perceptions of interviewees about how professional processes and practices can amount to exclusion are presented thematically according to the three features of the medical profession in Ireland. These features are monopoly over registration, restriction of access to training posts of some IMGs and the monopoly over the mechanism and process of discipline and punishment.

Control of Access to Medical Practice via Imposition of Rigorous Preregistration Requirements

As discussed in Chapter Five, the professional monopoly enjoyed by the Medical Council of Ireland over who gets registered to practice medicine is perceived by many interviewees in Ireland as a mechanism for social closure around the profession. According to 22 out of the 27 interviewees, the autonomy enjoyed by the Medical Council around regulating doctors in Ireland may appear objective. However, the possibility exists for the criteria to be manipulated to effectively exclude some IMGs from professional medical practice. According to a female interviewee of East Asian origin:

> You see, our problem (as IMGs) starts with the absence of any overseeing body to oversee the conduct of the Medical Council around registration. Moreover, the Council has succeeded in monopolising medical regulation in Ireland. The problem then is who are the people running the Medical Council? What are their ideologies in relation to IMGs from outside of Europe and the West at large? Are these IMGs regarded as having entitlements to practice here? From the attitude of many of these guys (in the Medical Council), I don't think we are seen as having the right to work here. The only problem is they could not get enough Europeans to work, so they needed workers from outside of Europe. But until a vacancy cannot be filled by an Irish candidate or European and Western candidates, the other IMGs are not considered. You know they say, 'absolute power corrupts absolutely'. I think absolute power to regulate the practice of medicine given to the Medical Council could sometime be used by the Medical Council to include the Irish graduates and other western

[31] National University of Ireland, Galway (NUI GALWAY); Royal College of Surgeons in Ireland (RCSI); Trinity College Dublin (TCD); University College Cork (UCC); University College Dublin (UCD) and University of Limerick Graduate Entry Medical School.

[32] College of Anaesthetists of Ireland; College of Psychiatrists of Ireland; Faculty of Occupational Medicine; Faculty of Paediatrics; Faculty of Pathology; Faculty of Public Health Medicine; Faculty of Radiologists; Faculty of Sports and Exercise Medicine; Institute of Obstetricians and Gynaecologists; Irish College of General Practitioners; Irish College of Ophthalmologists; Irish Committee for Higher Medical Training and Royal College of Surgeons in Ireland

European candidates over IMGs from Sudan, India or Nigeria. (Dr Kike D.)

This perception is supported by some other interviewees who claim that the fact that executive members of the Medical Council are predominantly, 'White' Irish doctors can negatively affect the integration experiences of IMGs. The basis of their apprehension, as mentioned earlier in this chapter, are that social identities such as ethnicity, gender, class or country of medical graduation can be used to differentiate 'insiders' from 'outsiders'. According to these interviewees, the non-representation of IMGs on the executive council and many committees of the Medical Council equal, exclusion. It is important to understand the autonomy the Medical Council enjoys as the medical regulatory body in Ireland. Even though, from 2012, its activities are reviewable by the Ombudsman under the Ombudsman (Amendment) Act 2012, it still enjoys a considerable autonomy. It is this autonomy that warrants asking, who are the decision makers? To answer this question, I visited the website of the Council. I found out the Council consists of 25 members, including both elected and appointed members. It also has a few committees, sub-committees and working groups which report to the Council. According to the information available on its website, the Council Members from 2013-2018 are predominantly White and Western European (see http://www.medicalcouncil.ie/About-Us/The-Medical-Council/Council-Members-2013-2018/). The same goes for many of the committees and sub-committees. Therefore, some interviewees question the diversity and equality intention of the Council. According to an interviewee:

How can our interest be represented when we are not part of the committee? If nearly 35% of the doctors working here are IMGs, why can't the Council and committee membership reflect this diversity? (Dr Doyin)

The issue raised by the quote above speaks to the claim by some interviewees that the medical profession in Ireland is exclusionary towards the IMGs. Moving a step forward, one interviewee actually questioned the process appointment to the executive committee of the Council. She asked:

Who appoints executive members of the Medical Council? What are the criteria for these appointments? I assume about thirty-five% of the doctors in Ireland are from abroad. On this note, I assume the executive council of the Medical Council to represent this diversity in its membership. And this is not the case as of now. Go and check out the annual report, you will see who the members are. They are mainly 'White' people. Why is there no non-white people appointed as executive council members? This raises the fundamental question of transparency, fairness and equity. Although, I am not saying these members are not fair, the question is, they may not be bringing a diversity of perspectives, especially, where it relates to IMGs, to the table. You know what I mean. (Dr Olisa, T. Y)

According to this interviewee, the issue of concern here is 'who regulates the regulator?' This interviewee draws attention to the mechanisms put in place to prevent abuse of power by executive council members of the Medical Council. The question here is how equity, transparency and fairness in the regulatory processes of the Medical Council is ensured when there is no representation of

35% of the doctors on the Council that controls and regulates the profession? It is important to understand that when equal representation is absent, the potential exists for members of the dominant social group to utilise professional regulatory processes of licensure for purposes of exclusion. As Weeden (2002) argues, 'licensure, which requires that individuals obtain permission from the state to identify themselves by an occupational title, and in many cases, practice a particular set of skills (e.g. counseling), can be utilised to control the supply of labour and enhance the market value of the occupation (p. 62). There is the perception of some interviewees that the rigorous registration criteria imposed on IMGs could be a conscientious effort by the Medical Council to exclude IMGs from the prestigious divisions of the register. Therefore, in as much as the Medical Council of Ireland enjoys autonomy and monopoly over the right to register new doctors, set standards and conditions of practice for existing physicians, and create rules for when and how members can exit or may be removed from the register, it can be argued that the processes of professionalisation within the medical profession in Ireland have the potential to become strategies of closure. Such processes can be used against IMGs from outside of Europe and the West. This practice is what Macdonald (1985) claims the profession uses to achieve a market monopoly. Macdonald (1985) argues that professions try to achieve a professional market monopoly and collective social mobility by setting rules for entry and rules to control those already in (p. 541).

Control of Access to Training Posts via State Legislation

As discussed in Chapter Three, one of the distinctive characteristics of a profession within contemporary labour market structures is the presence of a clearly defined hierarchy with benefits such as power, prestige and privilege being directly proportional to members' hierarchical positions. These professional hierarchies in modern advanced societies can be linked to the division of labour of modern capitalist economic systems. As also argued in Chapter Three, the division of labour is extremely complex dividing work into different numbers of occupations in which people specialise (Giddens, 1993). The result of this is not only specialisation, where workers become specialised in particular areas of the production process, but differentiation between 'worthy' and 'unworthy' jobs (Veblen, 1994).

This division of labour within medicine in Ireland, similar to most advanced capitalist societies, has resulted in the training and certifying of members in different aspects of medical practice. For example, fields of specialisation such as gynecology, cardiology, occupational medicine, medical microbiology and neonatology have emerged as occupations that require specific training and certification for practitioners to practice.

As argued in Chapter Five, one of the contradictions within the development of specialisations and

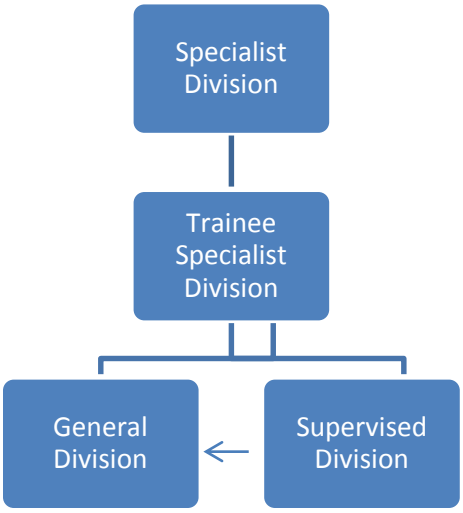
structural differentiation (Rueschemeyer, 1986) within professional occupations is the structure of inequality associated with hierarchies in these occupations, because of the varying degrees of prestige attached to different specialties within the same occupation (see Chapter Five). For example, claiming that varying degree of prestige is associated with different medical specialties, a 1991 Norwegian study that documented a prestige hierarchy for medical specialties found that neurosurgery, cardiology, thoracic surgery, and anesthesiology were ranked highest in prestige, while psychiatry, dermatology, general practice, and geriatrics ranked lowest. Another study in the United States describes a medical hierarchy, with surgery, rated as most popular and psychiatry, the least popular (Hinze, 1999). Like Hinze findings, within medicine in Ireland, according to many interviewees, medical specialties and posts do not carry with them equal prestige or status and this discrepancy in status aggregation for medical specialties has culminated in the demarcation between the 'desirable' and 'undesirable' medical posts.

For many medical practitioners in Ireland, as argued in Chapter Five, the job of a consultant is regarded as the hallmark of the medical profession because of the prestige and benefits attached to it. Hence, it is more socially and economically rewarding than that of a non-consultant hospital doctor. As a result of the privileges and benefits attached to the position of a consultant, many of the interviewees perceived that there may be a monopoly of access to this highly prestigious position, which is perceived to be controlled by the dominant social group. Interviewees identified the dominant social group as white, Irish and male. They claim this monopoly can be achieved through the restriction of access to it via official rules and the legislative provisions of the Medical Act (2007). As discussed earlier, the Medical Act (2007) disallows doctors with medical qualifications outside of Australia, New Zealand, Malaysia, Sudan, and South Africa (with an internship after 2006) and Pakistan (with an internship after 2008) from entering training posts within the medical profession in Ireland. What this means is that IMGs qualified from outside Ireland, EU and the countries mentioned, are only allowed to register in the General Division of the Medical Council, provided they pass the pre-registration examinations. The General Division is for doctors who do not practice in any training posts, or who have not been proposed for a post in the Supervised Division, and who have not completed recognised specialist medical training. The Supervised Division is a division of the medical register of the Medical Council specifically for doctors who are offered a post with the Health Service Executive (HSE) that has been approved as an individually numbered, identifiable post. Registration in the Supervised Division is for a maximum aggregate of two years after which the doctor can continue registration with the Medical Council by applying to transfer to either the General Division or the Trainee Specialist Division of the Medical Register. According to the *Medical Workforce Intelligence Report 2016* released by the Medical Council, 64.2% of IMGs are

registered in the general division of the register of the Medical Council.

The diagram below shows the divisions of the Medical Register and the structure of progression.

Figure 7: Medical Council of Ireland Divisions and Progression Pattern



In relation to training, evidence from this study suggests that restrictions, via the Medical Practitioner Act (2007) impedes the progression of IMGs, but facilitates the ability of members of the dominant group to monopolise access to the prestigious position of consultant. As a result, there is an over-representation of non-EEA/Western-trained doctors at junior doctor levels and an under-representation at management-consultant level. Some interviewees reasoned that, in as much as strategies of closure are embedded in the processes of professionalisation of medicine in Ireland, exclusion of members of the subordinate groups must be expected. As a interviewee clearly puts it:

> The claim by the Medical Council that it 'aims to protect the public by promoting and better ensuring high standards of professional conduct and professional education, training and competence among doctors' sounds noble and pious. Yes, but at the same time, in the process of doing this, access to prestigious posts within the medical field in Ireland is cordoned off to particular groups of doctors. Sadly, this exclusionary process is backed up by the 2007 Act. So, this act of discrimination is legalised by the Irish State. What a shame! (Dr Ikemba C.)

Another significant question that came up is, who selects the executive members of the training bodies. Why are the members made up mainly of White Irish doctors? Or why are members of other ethnic groups not represented? This uneasiness and critique is not out of place because when members of the executive council are members of the dominant social group, they may see themselves as the insiders and perceive others as outsiders who should be excluded. As a result, members of the dominant group may pursue policies and practices that will marginalise doctors regarded as outsiders. This perspective agrees with the arguments of closure theorists who argue that social closure explicates the process by which social groups try to maximize their privileges and

opportunities within a profession by restricting the access of members of other social groups, regarded as outsiders to the profession (see Weber, 1978; Parkin, 1979, Murphy, 1988). One crucial factor to note here is the role 'insiders' and 'outsiders' play in social closure. Outsiders need to be identified, to include insiders. Hence, according to Weber (1978), groups interested in reducing competition try to monopolise advantages and maximise their rewards by closing off opportunities to outsiders, they define as inferior or ineligible.

Still on membership of executive councils of training bodies, to find out if the suspicions of interviewees are valid, I conducted an online examination of the background of members of the executive council of the Medical Council and the training bodies. My search confirms the claims of interviewees such as that of Dr Olisa. As mentioned earlier, the Medical Council consists of twenty-five members including both elected and appointed members. The twenty-five members include twelve female and thirteen male members. All members are 'White' Europeans[33] (see Appendix I). Besides the Council Members, the membership of sub-committees such as the Audit, Strategy and Risk, Education, Training and Professional Development, Registration and Continuing Practice and Ethics and Professionalism, were also found to be predominantly 'White' European.

Similar to the Medical Council are the over-representation of White Irish/European/Western persons and the under-representation of non-Irish/European/Western people in the top management positions in the training institutes and faculties in Ireland. For example, as at the time of writing this thesis, the 38 Council Members of the Royal College of physicians of Ireland (RCPI), a college that houses six of the 13 postgraduate specialist training bodies, are all 'White' European[34] (see Appendix II). Also, in the College of Anesthetists of Ireland (see Appendix III), all but one of the 25 Council Members in 2015/2015 are 'White' Europeans[35]. The membership of the Board and Council of the Irish College of General Practitioners (see Appendix IV and V); Council of the Irish College of Ophthalmologists (see Appendix VI) and the Royal College of Surgeons of Ireland are revealed to be predominantly, in many cases, totally 'White' European (see Appendix VII).

The domination of the decision making and prestigious positions of medical regulatory and training bodies in Ireland by members of a particular social group is perceived by many interviewees in Ireland as contributing to exclusion and limiting their professional integration opportunities. This perception, as mentioned earlier, is supported by the arguments by Parkin (1979) and Murphy (1988).

[33] http://www.medicalcouncil.ie/About-Us/The-Medical-Council/Council-Members-2013-2018
[34] https://www.rcpi.ie/about-us/our-people/our-president-and-council/
[35] https://www.anaesthesia.ie/index.php/college-council

Further on the case of insider/ outsider within the medical professional field in Ireland, interviewees in the study argued that IMGs, especially of non-EU/Western origin, are perceived as outsiders by members of the dominant social group. Many interviewees claim they are regarded and treated as outsiders professionally within medicine in Ireland. One interviewee claims that:

No matter how long you spend here, you are never Irish and you'll never be regarded as an Irish. There is this distinction between the White Irish, European/Westerners and others. We, foreign doctors are the others. It is on the basis of this distinction that most times, appointments are made. What I noticed in my eight years of practice in Ireland is that as a foreign doctor, you are expected to wait for the last. I mean, you only get what the Irish doctors don't want. It is like the biblical parable of 'what belongs to the child is not fit for the dog'. It is a widespread practice that the White Irish are treated better than us. It is even legitimate. The practice is, if there is a position, the Irish are considered first. It is the law. So, we as outsiders, we get the crumbs or nothing at all. (Dr Ahmed S.)

I responded by asking specifically about the legislation that legitimised the practice of considering the Irish first for appointments. The interviewee responded by saying he could not mention it specifically, but they always say that Irish candidates are considered first. This argument that the Irish are always considered first was also expressed by another interviewee who said:

Within medicine in Ireland, it is a common knowledge amongst IMGs. In fact, some white Irish are compassionate, sometimes and they ask, why you chose to come to Ireland. They know they stand a better chance than us even though they are not necessarily better academically or clinically. The difference is they are white Irish. There is the EU law that says EU citizens must be considered before other nationalities first for employment. I believe this is the law that is used in every area of medical appointments. If we compete for training posts, the Irish get it first, followed by other EU nationalities. In fact, we joke amongst ourselves that is there is a vacancy and there is one Irish candidate and five or six IMGs. We say there is no vacancy because the Irish will get the job. And if there are two vacancies and one Irish applicant and ten IMGs, we joke that the ten IMGs are competing for one post because the Irish will automatically get one position. That is the extent to which the process of recruitments and appointments, managed majorly by White Irish, excludes IMGs. (Dr Doyin, A.)

The implication of these opinions is that the process of recruitment monopolised by a white Irish majority may be contributing to the over-representation of IMGs in the non-training, service post positions and their under-representation in the consultant positions. An example of where preference is given to Irish and EU citizens is the process of the RCSI's allocation of places on the Specialist Training Programme, 2015. An RCSI document that sets out the process to be applied to the recruitment and selection of new specialist trainees for their specialist programmes particularly stated that:

Available specialist training places will be allocated by the Royal College of Surgeons Ireland (RCSI) in the first instance to those candidates who at the time of application are citizens of Ireland or nationals of members another member state of the European Union (RCSI, 2015).

Such a process as this, which considers an Irish candidate before other candidates during

competition, can be perceived as contributing to the over-representation of IMGs in the Non-Consultant Hospital Doctors in the not-in-training category of hospital doctors in Ireland. As mentioned in Chapter Five, IMGs make up 74.1 percent of doctors working as non-consultant hospital doctors who were not in training (Medical Council, 2014). Besides, this process is a breach of European Union Directive 2003/109/EC[36] which states that as from January 2006, long-term residents will enjoy the benefit of Community preference. It is important to draw our attention to the exclusionary nature of a practice such as community preference. The European Union Council 'Community Preference'[37] directive gives preference to workers who are nationals of the Member States over workers who are nationals of third countries about access to Member States' labour markets. However, there is also the EU Directive 2003/109/EC mentioned above concerning the status of long-term residents. A long-term resident status is conferred on migrants who have resided legally in an EU country for five years. Member states were expected to comply with the Directive by 23rd January 2006. As we can see, the practice by RCSI clearly breaches this EU Directive. As a result, the preference given to Irish and EU citizens over IMGs who are long-term residents in Ireland, in relation to access to training positions with RCSI, can contribute to the marginalisation of IMGs within the medical profession in Ireland.

On the contrary, this claim of discrimination was refuted by one of the officials of the Health Service Executives (HSE) who participated in this study. He stated that the HSE is an equal opportunity employer that employs based on merit and not on nationality. According to her:

All the HSE is interested in is someone to do the job. The responsibility of the HSE if to be deliver quality healthcare in the most effective way to the people of Ireland. That is why we have gone out to recruit from everywhere really. We don't discriminate. As far as you are qualified to do the job and there is vacancy, yes, you get the job. (Ms Cloghessy. S)

To further buttress her point, this interviewee mentioned something significant about why she thinks IMGs may not get some positions. According to her:

As an official of the HSE, there are times you realise that IMGS present CVs that do not represent their strength. Yes, they have all these qualifications and experiences, but they must be able to present them on their CVs, so they can sell themselves very well. In some cases, they do not. (Cloghessy. S)

Summarily, critically looking at the arguments of interviewees above and some professional processes and practices within medicine in Ireland, it can be deduced that the medical profession's

[36] Directive 2003/109/EC stipulated that, as from January 2006 (Directive 2003/109/EC), long-term residents will enjoy the benefit of Community preference.

[37] Community preference means EU Member States will consider requests for admission to their territories for the purpose of employment only where vacancies in a Member State cannot be filled by national or Community manpower or by non-Community manpower locally resident on a permanent basis in that Member State and already forming part of that Member State's regular labour market.

pursuit of professionalisation and maintenance of professional standards in Ireland may, besides, maintaining a high standard of medical practice, amount to a tactical pursuit of social closure around certain positions and posts especially, in cases of highly prestigious, respected and desirable training posts and consultant positions. The evidence available suggests that the dominant social groups may seek to minimise access to these positions by instituting access control strategies that serve to include the eligible Irish graduates and exclude the ineligible IMGs. Further evidence suggests that IMGs are largely employed to fill shortages that cannot not be filled by local Irish graduates. The employment of members of ethnic minority groups is the last resort when all other avenues are exhausted. As argued by Larson (1977), previously excluded members of minority groups may be granted access to the professions only in times of a critical shortage of professionals. This is because professions have been using their power to restrict access to their privilege through controlling both the supply of professionals and the demand for their services. Therefore, in the case of Ireland, evidence from the study suggests that IMGs are used as reserve labour who are allowed access to professional practice conditionally when the demand for doctors exceeds the current supply of Irish graduates.

Narratives of the processes of selection of trainees into training posts and selection of consultants of 25 out of the 27 interviewees in ths study suggest that the present structure of the profession of medicine in Ireland may be developed, amongst other reasons, to maintain closure around certain medical occupations such as the position of consultants, to maintain the self-interests of members of the dominant social group and facilitate status group's reproduction. This confirms the supposition that the concept of professionalisation may be equated to the method of developing and maintaining closure around an occupation to keep the self-interests of members which may include salary, status and power as well as protection of the occupational jurisdiction (Abbott, 1988; Larson, 1977).

The claims of inability to access training posts by many interviewees in Ireland confirms Catherine Shanahan's (2014, 29th August) claim in the *Irish Times* that "when it comes junior doctors, most of the training posts essential for career enhancement are not held by international medical graduates".

This revelation echoes the findings of Barrett and McCarthy (2007) on the broader labour market in Ireland where the positions of migrants are found to be weak compared to their Irish counterparts. Furthermore, the experiences of the IMGs within medicine in Ireland are comparable to the experiences of migrants in Ireland who have been found to be less likely to secure higher level occupations. Migrant workers in Ireland are found out to be under-represented in managerial jobs

and over-represented in lower level jobs in Ireland (O'Connell and McGinnity, 2008).

Finally, the experiences of many interviewees reinforce previous reports on the experience of discrimination by IMGs within the Irish medical profession. One of those reports, a report in the *Sunday Times* of April 23rd, 2006 written by Dearbhail McDonald and Kate Butler, quoting a foreign doctor practicing in Ireland, Altaf Naqvi, wrote that the medical profession in Ireland is rife with cronyism and nepotism. They argued that foreign doctors, who staff more than half of all hospital jobs, claim they are blocked from consultant positions because Irish doctors 'look after their own'. Therefore, IMGs may not be able to experience full professional integration if processes and practices mentioned above are in place. In fact, those processes and practices may be utilised for the exclusion of IMGs from positions of power and prestige because of the ability of the dominant group to monopolise these professional processes.

Monopoly over Disciplinary process

Another feature of a professionalisation process that can be used as a strategy of inclusion or exclusion is the power conferred on professions to punish behaviour and practices that are deemed to violate professional and ethical codes of the medical profession, as prescribed by the Medical Council of Ireland. In Ireland, the Medical Council is responsible for maintaining discipline amongst doctors and it makes sure doctors conform to the code of ethics of the profession. It does this through the 'Fitness to Practice Committee'. The committee investigates complaints made by clients against a doctor and then institutes disciplinary procedures as appropriate. Inquiries are heard by a Fitness to Practice 'Panel' which is made up of three members: two non-medical people and one doctor.

According to the Medical Council, complaints can be made against doctors on the following grounds:

1. Professional Misconduct
2. Poor Professional Performance
3. A relevant medical disability
4. A failure to comply with one or more condition(s) attached to a doctor's registration
5. A failure to meet the terms given by the Medical Council or failure to take any action regarding context of a previous inquiry
6. Infringement of the Medical Practitioners Act 2007

7. A conviction in the State regarding an accusation of a wrongful offence or, if convicted outside the State, an offence that would be punishable in the Irish courts.

As soon as the Preliminary Proceedings Committee (PPC) perceives it has been supplied with adequate information, it decides what action to take. Then, if the PPC believes further action is warranted, it refers the complaint to the Fitness to Practice Committee. On the other hand, if it thinks further action is unwarranted, it does not refer the complaint to the Fitness to Practise Committee, but recommends that the Medical Council do any of the following:

1. Take no further action.
2. Refer the complaint to another body or authority or to the Medical Council's professional competence scheme.
3. Resolve the complaint via mediation or other informal methods.

In Ireland, Fitness to Practice hearings are conducted publicly, except in cases where there is a special request by a complainant, doctor or a witness to hold all, or part, of the inquiry in private, and the Fitness to Practice Committee is satisfied that it would be appropriate in the circumstances to do so (Medical Council, 2015). At the end of any hearing, the Medical Council decides to impose sanctions which can be:

1. Advice, admonishment and censuring doctor.
2. Fine up to €5,000.
3. Attachment of conditions to a doctor's registration.
4. Transfer a doctor's registration to another division of the register.
5. Suspend doctor for a specified period or striking off doctor from the medical register.
6. Prohibit doctor from applying for restoration to the register for a specified period.

Whatever the outcome is with the Fitness to Practice hearing, a respondent doctor can appeal the decision to the High Court. If no appeal is made against the Medical Council's decision, the Medical Council will apply to the High Court to confirm its decision. This means that the Medical Council's 'Fitness to Practice Committee' takes the role of the legal system in the first instance. The Council does not need confirmation from the High Court if the sanction does not include fines, transfer from one division to another, suspension or expulsion from the register of the doctor, but only if the doctor is advised, admonished or censured. By censoring, a doctor is mandated to have no direct patient contact for a given period and cannot practice in any other capacity, during this time,

without the supervision of a superior doctor.

It is this autonomy enjoyed by the Medical Council around discipline and punishment in terms of 'fitness to practice' that many interviewees argue has contributed to the ability of the dominant social group within medicine in Ireland to exclude IMGs from progressing in the profession. Many interviewees claim that the process is not fair and they think that while complaints are being made against many white Irish doctors, they are not frequently referred to a Fitness to Practice inquiry like their non-Irish counterparts. According to an interviewee, the 'Fitness for Practice Inquiry':

> … is a means of disciplining many foreign doctors whom they don't like. I am not trying to claim that some IMGs are not guilty of professional misconduct. What I am saying is that there are many of them that their cases shouldn't have been referred to the 'Fitness for Practice' committee. I know some Irish doctors who had complaints against them. Many of them were never referred to the 'Fitness to Practice' committee. I believe the system punishes IMGs more than their white counterparts. (Dr Nkechi, A)

Another female interviewee has this to say about the 'Fitness for Practice Inquiry':

> A complaint was made against me some time ago. The problem I have with the whole set-up is you have been pre-judged before you are judged. You see, we cannot separate White people's bias and their preference for their kind from the result of the inquiry. And you know the committee is full of them (White people). What do you think will be their verdict? Some of them in the first place believe you are incapable of practicing medicine. So, for a little complaint, they jump to the conclusion that, look! She is not able to practice. The greater challenge is if you want to appeal it. It takes up all your time and resources. The lawyers don't come cheap you know. And sometimes, I want to believe that lawyers make it expensive for us. May be the thinking is, they are making the money here in this country. So, we take it from them (laughs). (Dr Doyin, A)

A third interviewee argues that she believes that there is an ethnic penalty attached to being an IMG in Ireland when summoned to 'Fitness for Practice Inquiry'. She explains that she believes IMGs are severely punished for mistakes for which an Irish doctor would just have been warned. To her, this contributes to the inability of IMGs to fully integrate professional into medicine in Ireland. She argues:

> It is like in the US, where Black people are heavily punished for the same offenses that White offenders are lightly punished for. You might be removed from the medical register for the same mistake an Irish doctor may just be warned or referred to a psychiatrist for some sessions. I remember a Nigerian doctor that was charged with sexual harassment of a colleague a few years ago. The news became an instant sensation in the national newspapers. He was already stereotyped. You know, so he had no chance of being absolved, because it was trial by the press. Another angle is, they always believe what an Irish said. They find it hard to believe what you say as a foreigner. So, how can you be treated fairly in the 'Fitness for Practice Inquiry'? Even though they claim the process is fair and transparent, there is what I call subjective bias against non-Irish doctors especially, those of us that are black. They are easily convinced that we have committed professional misconduct and arbitrarily punish us. Whereas, an Irish doctor who committed the same offense, will be excused as, committing a mistake. It is a shame, but that is the way it is. (Dr Onyebuchi, D)

This perception of IMGs is supported by an article by Fiona Gartland (2012, August 20th) in the *Irish*

Times[38]. In this article, Gartland stated that considering the numbers of doctors referred to 'fitness-to-practice inquiries, it would suggest that while doctors who graduated in Ireland had a higher likelihood of being complained about, they had a lower probability of being referred to a fitness-to-practice inquiry'. She continues that, 'doctors working in Ireland who graduated outside the State were almost five times more likely to face a fitness-to-practice inquiry if complaints were made against them compared with doctors who graduated in Ireland'. This opinion was reinforced in an article in the *Irish Examiner* on Monday, 6 January, 2014[39]. This article stated that in 2012 foreign doctors made up 60 percent of those brought before the Medical Council's fitness-to-practise inquiry and a similar percentage was expected for 2013. However, it is worth noting that from the Annual Report and Financial Statements 2013 of the Medical Council, only 14 percent of the 503 doctors about whom complaints were made in 2013 were IMGs of non-EU/EEA origin (Medical Council, 2014).

In conclusion, the processes of professionalisation within medicine in Ireland such as complete autonomy over the process of recruitment, training, certification, promotion and even punishment by suspension or expulsion of members, may be neutral and aimed at protecting the public by promoting and ensuring high standards of professional conduct and professional education, training and competence of all doctors. However, evidence from arguments the interviewees have presented above, suggests that these processes may also become strategies of closure against physicians who are deemed to be outsiders because of their nationality, gender and country of training. IMGs from outside the European Union and Western countries are an embodiment of these markers of differences and as a result, may experience exclusion through the utilisations of these inclusionary and exclusionary closure strategies.

Processes of Social Closure within Medicine in Canada

In present day Canada, like many technologically advanced societies, medicine enjoys significant prestige as one of the highest paid and most respected occupations. This is exemplified in a national level study of occupational prestige in Canada in 2005. This survey collected by telephone interviews, included prestige ratings of the twenty-six major occupational groups in Canada's National Occupations Classification (NOC). Top most on the rank are medical specialists, followed by judges and general practitioners; family physicians rank third (Foster, 2008, p. 5). This popularity, enjoyed by medicine in Canada reiterates the claim that the profession is characterised by the power and high prestige it has in a society. It is argued that a profession is more clearly defined by the

[38] http://www.irishtimes.com/news/foreign-doctors-investigated-more-frequently-1.539788
[39] http://www.irishexaminer.com/ireland/medical-council-to-introduce-new-training-for-foreign-doctors-254329.html

power, prestige and value that society confers upon it. As claimed by Treiman (2013) the specialised knowledge possessed by professionals creates the basis for power, privilege and prestige.

The question to be asked is how did medicine in Canada come to enjoy such a high status and prestige? It is evident that the medical profession in Canada, besides having a clearly defined hierarchical system, has been able to achieve professional autonomy, ability to self-regulate and maintain monopoly over recruitment, training and training of members, training, and discipline of members. It also enjoys ability to control access to professional medical practice to new members through the requirement of educational credentials. These processes and practices, regarded as 'medical colonisation' by Ivan Illich (2008, p. 8) are believed by Freidson (2001) to be aimed at monopolising the provision of medical services. Therefore, the setting of educational qualifications for licensure in Canada, a responsibility of the Medical Council of Canada (MCC) through provincial Medical Councils is part of the autonomy enjoyed by the medical profession. The MCC is an organisation that has the sole responsibility of assessing medical candidates, evaluation of physicians through exams and granting a qualification called Licentiate of the Medical Council of Canada (LMCC) to persons wishing to practice medicine in Canada. In short, the MCC gives the right to practice in Canada to individuals wishing to practice medicine.

Besides the MCC, the Royal College of Physicians and Surgeons of Canada enjoys a monopoly over the setting of national standards for medical education and continuing professional development in Canada for eighty medical specialties (Royal College, 2015). The Royal College, through its provincial branches, ensures that the training and evaluation of medical and surgical specialist's programmes in Canada meet the required standards of quality. The Royal College also has the responsibility of assessing the training of IMGs to determine if they have successfully met the Royal College training requirements. In case where the training of the IMG is deemed comparable and acceptable to that of Canada, the IMG becomes eligible to take the Royal College certification examination. Success at this certification examination leads to Royal College certification.

When it comes to training, the seventeen Faculties of Medicines of Canada (see Appendix VIII) represented by the Association of Faculties of Medicine of Canada (AFMC) maintain a monopoly over research, medical education and clinical training in Canada. When it comes to certification, colleges such as the College of Family Physicians of Canada enjoy a legal monopoly over certification. The College of Family Physicians of Canada, based in Mississauga, Ontario, is the professional association that legally certifies the practice of family medicine in Canada. It establishes the standards for the training, certification, and lifelong education of family physicians. It accredits postgraduate family medicine training in the medical schools in Canada, carries out the certification

examination in family medicine, and awards the certification of the Canadian College of Family Physicians – Emergency Medicine certificate (CCFP) and Fellowship in The College of Family Physicians of Canada (FCFP).

The features of the medical profession in Canada mentioned above, as claimed by 11 out of the 21 interviewees in this study in Canada, seem objective and neutral. Some of the interviewees claim these processes and practices are focused on the delivery of high quality healthcare to Canadians. However, according to some other interviewees, these same processes and practices, even though they are aimed at maintaining and improving the quality of health care in Canada, have the potential to be converted into strategies of social closure around medical practice and utilised against IMGs. Some interviewees claim that the monopolisation of regulation, training and certification by the bodies mentioned earlier, results in the ability of the dominant social group within medicine in Canada to exclude members of subordinate social groups to include members of their own group. To gain an insight into this in this study, experiences of the professional integration of IMGs are presented below. As detailed in the case of medicine in Ireland, these experiences are discussed thematically, according to three professional features of Canadian medicine.

Control of Access to Medical Practice via Imposition of Rigorous Preregistration Requirements

The professional monopoly enjoyed by the Medical Council of Canada (MCC) and Royal College of Physicians and Surgeons of Canada (RCPSC) over who gets registered to practice medicine is perceived by some interviewees as a mechanism for social closure. According to these interviewees, the autonomy enjoyed by the MCC and RCPSC in the area of regulating doctors in Canada may appear objective and neutral. However, they claim that some barriers they and some of their colleagues who are IMGs, experienced in relation to access to professional practice in Canada may be because the dominant social group within medicine in Canada seek to monopolise the reward of medicine practice there. As a result, they close off access to professional practice to IMGs who are perceived as outsiders. This perception is in line with the argument of Parkin (1979, p. 44) on reasons why dominant social groups close access to other groups. According to him, 'social collectives seek to maximize rewards by restricting access to resources and opportunities to a limited circle of eligibles'. This perception was also reinforced by an interviewee from Asia, who claimed to have waited seven years before becoming licensed to practice in Canada. According to him, the autonomy enjoyed by these bodies whose main members are 'White, European Males' leaves room for discrimination against IMGs who are in some cases non- 'White/European Males'. He argues that:

Canada claims to be pluralistic and multicultural, but, you still have the dominant groups who control everything. These are the British and the French. I will agree that Canada has progressed better than most countries in terms of anti-

discrimination and anti-racism. However, you need to understand that white people still dictate the conversations about multiculturalism and they give only what they want to give. In medicine, the British and French are the majority and they pursue policies they want to and since they enjoy a monopoly over admittance, training and certification, they operate the medical profession like a tap. What they do is they turn it on when they like, especially when the candidates are candidates they like, and turn it off when candidates are those they don't really like. (Dr Vincent, E)

Also, another interviewee from Africa claims that the ability of the medical profession in Canada to self-regulate has imbued the profession with the dominant group's culture: 'white culture'. According to this interviewee:

Anybody from outside the mainstream white culture is seen as inferior, must be suspected as dangerous and be gated out. So, the dominant group pursues policies and practices that will help in keeping out these 'other' doctors of inferior culture. And since the white doctors have monopolies over licensure, training, etc. it is easy for them to exclude IMGs from medical practice by using laws aimed at regulating the medical practice. (Dr Hycinth, A)

However, another male doctor of African origin argues that even though the processes of controlling access to medical practice may amount to disadvantage for certain IMGs, he does not agree it aims to exclude IMGs:

I don't agree with the claims that the exclusion suffered by some IMGs especially in the area of registration to practice is aimed at them specifically by Canada. No, the processes of licensure in Canada are cumbersome because Canada has the best health care in the world. To have the best health care, you need the best doctors. How do you get the best doctors? Doctors need to be trained and the training tested through rigorous tests. I am an IMG and I have been able to achieve everything I could in Canada. In fact, do not see a difference between me and the Canadians. (Dr Aboderin F.)

Another female interviewee from Africa supports this perception of Dr Aboderin. She claims that the monopoly enjoyed by the medical profession in Canada was not utilised by the dominant group to exclude the IMGs. According to this interviewee, monopolisation helps strengthen the medical profession and increase the quality of care delivered by the profession. She argues that:

Some IMGs are complaining because they cannot pass the examinations. As a result, they think the requirement should be relaxed. Why should the requirement be relaxed? It will be unfair to some of us that passed it and the Canadian people. Quality is the key in healthcare. If a doctor cannot pass the required exams, then, the doctor must not practice. And if the doctor thinks he or she has been discriminated against, the case should be taken up against the Medical Council of the province. I think the processes of licensure are transparent enough. Therefore, Canadian healthcare is one of the best in the world. (Dr Funmilayo O.)

Looking at the perspective of Dr Funmilayo, the same set of processes and practices that are inclusionary for some people can be perceived as exclusionary by others. In this case, the doctor claims that monopoly over the provision of medical care and professional autonomy, as features of the medical profession, help maintain the quality of doctors employed and subsequently, the quality of care delivered.

However, looking at the view of Dr Vincents and Dr Hyacinth, it can be interpreted that even though, the aim of the regulation of medical practice may be objective and neutral, the potential of these processes to be utilised by the dominant social group for excluding members of the subordinate groups cannot be underestimated. The processes of professionalisation within the medical profession in Canada were perceived by these interviewees to have the potential of becoming strategies of occupational closure against IMGs.

Interviewees maintain that closure strategies are utilised to exclude IMGs from practicing medicine, a profession regarded as a highly prestigious and economically rewarding. As a result, according to some of them, the unusually and consistently high wages of doctors may also serve as the basis for the dominant social group's formation of closure around medical practice in Canada. This quest for monetary reward, Stevens (2001) argues, has been the basis of the moving away of professions from their perceived role of benevolent agents of the public, toward that of self-interested players in the economic marketplace. As a result, according to interviewees, the dominant social group within medicine in Canada tries to maintain monopoly over both economic and social resources available within medicine by firstly, achieving professional market monopoly and collective social mobility (Macdonald, 1985). It is this achievement, according to interviewees, that affords the dominant social group within medicine in Canada the opportunity to set rules for entry for new members and standards to control those already in (Macdonald, 1985, p. 541).

Control of Access to Training Posts via State Legislation

Contrary to the policies and practices in Ireland, there is no legislation in Canada that actively disallows IMGs from practicing in any specialties or getting into any training posts as soon as they can get licensed to practice. However, some interviewees mentioned that, because of the prestige and respect associated with certain specialties, it is harder to get into them than other specialties that are not so prestigious. There was no mention by any interviewee, of any known legislation or policy that excludes IMGs from practicing in any specialty. Some interviewees said the ROS programme which is used in many provinces to make doctors, especially IMGs, take up practice in less-served rural areas of Canada may hinder them from practicing in urban centers initially, if they want to. However, they are quick to mention that IMGs of Canadian origin also participate in this and, in most cases, after the agreed number of years, the doctor is free to relocate and practice anywhere in Canada. One point that all interviewees agree with in Canada is that there is parity in the post-licensure experiences of IMGs with the post-licensure experiences of Canadian trained doctors, compared with pre-licensure experiences.

Monopoly over Disciplinary process

In Canada, the responsibility of responding to concerns and investigating complaints from members of the public about doctors licensed to practice medicine lies solely with the College of Physicians and Surgeons of the province where the alleged misconduct took place. Hence, the Royal College of Physicians and Surgeons of Canada, through its Provincial Medical Regulatory (Licensing) Authorities, maintains discipline amongst doctors and makes sure doctors conform to the code of ethics of the profession. Complaints are dealt with, firstly, by the staff of the college and if they cannot resolve it, it then goes to the Inquiries, Complaints and Reports Committee of the Royal College of Physicians and Surgeons of Canada. This Committee is made up of physicians and government appointed public members. If a complaint cannot be resolved by college staff, then a panel from among the members of the Committee is selected to direct each investigation, consider the doctor's response to the complaint, and make a reasonable effort to consider all relevant records and documents.

According to the College of Physicians and Surgeons of Ontario (2015), when all the information has been reviewed, the Committee decides to do one of the following:

In Cases where the doctor's actions or care provided were deemed appropriate, render advice to doctor if the Committee believes it will help doctor conduct himself or herself in the future or require that doctor participate in training or educational programs to improve his or her practice.

If there is a question about the doctor's fitness to practice on health grounds, the doctor can be referred to a panel of the committee.

Pursue no investigation because it believes the complaint is frivolous, vexatious, made in bad faith or is an abuse of process.

A striking similarity between the disciplinary procedures in Ireland and Canada is the composition of committees in both Ireland and Canada. In Ireland, the Fitness to Practice Committee is made up of three members, two non-medical people and one doctor. In Canada, the Inquiries, Complaints and Reports Committee is made up of physicians and government appointed public persons. Another similarity is the ability of a complainant or the defendant doctor to appeal the decision of the committees. In Ireland, committee decisions can be appealed to a High Court. In Canada, all committee decisions, except in cases where a doctor was referred because of concerns about their health, can be appealed to an independent government body, called *The Health Professions Appeal and Review Board*. However, a very sharp dissimilarity exists in that the initial attempt to deal with the complaint in Canada is by the staff of the Royal College and not any committee member. In Ireland, complaints are dealt with, initially, by the Preliminary Proceedings Committee (PPC).

This autonomy over disciplining members that lies solely with the provincial Royal Colleges of Physicians and Surgeons, according to some interviewees may also amount to constituting too much power in a body that can misuse it. As claimed by one interviewee in Ontario:

Even though the disciplinary process is somewhat transparent because of the overarching equity legislation here in Canada, yet, the processes of dealing with complaints may still be hijacked by some rednecks sometimes. You know what I mean? Of recent, an African GP was struck off the register after practicing in Canada for nearly 20 years. I believe if he is White European, he will not be struck off like that. There will be cautioned and proper investigation into the case. (Dr Gray M.)

This line of thought does not, however, represent the thinking of many of the interviewees who insisted that the system in Canada does not allow room for abuse of the system dealing with the complaints of patients against doctors in Canada. According to many interviewees, there are many ways to challenge procedures that are not transparent or decisions that are arbitrary when it comes to disciplinary actions. For this group of interviewees, this makes it hard for the dominant social group within medicine in Canada to utililse the disciplinary procedures of the medical profession in Canada for closure purposes.

In conclusion, features of the medical profession in Ireland and Canada such as control of access to medical practice via the imposition of rigorous preregistration requirements, control of access to training posts through state legislation and complete autonomy over disciplinary procedure, seem to be objectively aimed at protecting the public by promoting and better ensuring lofty standards of professional conduct and professional education, training and competence of all doctors. However, evidence from this study suggests that, more in Ireland than in Canada, there is a room for these processes to become strategies of social closure and utilised by members of the dominant group against doctors who are deemed to be outsiders because of their nationality, gender and even country of training. IMGs from outside the European Union and Western countries are an embodiment of these markers of differences and as a result, may not experience full professional integration because of the utilisation of these inclusionary and exclusionary closure strategies against them. However, it becomes evident that policies and practices aimed at maintaining and improving professional and ethical conducts of doctors, which can be hijacked and utilised for inclusionary or exclusionary purposes, depending on who is to be included or excluded, may not be used as such if there are robust legislation and policies in place to oversee the disciplinary procedure. Also, if there is an avenue for redress that is transparent, those processes that can be manipulated for the purpose of social closure may not be manipulated. Hence, an IMG may seek redress if he or she thinks discrimination has taken place. The end result of this is doctors become professionally integrated into their profession, be it in Ireland or in Canada.

Chapter Seven

Credentialism and social closure: The case of Irish and Canadian Medical Profession

As mentioned in Chapter Three, from recent academic research, there is increasing evidence that there is a direct link between formal qualifications required for a job and its desirability, status and pay. This link suggests that access to desirable professions or occupations within professions may be restricted by the imposition of educational requirements. That is, the more prestigious and desirable a job is, the more qualification required to do the job. As a result, credentialism refers to the 'imposition of educational requirements upon candidates before they can be considered for certain jobs' (Carter, 2003, p. 66). Credentialism can sometimes be utilised for purposes of protecting the more prestigious and respected professions or occupational positions within such professions by members of the dominant social groups within the profession.

Credentialism, an essential feature of a profession can be used to restrict access to supply of workers into prestigious and respected occupational positions within a profession. According to closure theorists such as Murphy (1988); Parkin (1979, 1974) and Collins, 1979), credentialism is a form of social closure. This form of social closure makes academic or educational qualifications and training a prerequisite for the appointment of candidates into certain positions. Parkin (1974) describes credentialism as 'a reliance upon examination certificates as a means of controlling entry to valued positions in the division of labour' (p. 7). Therefore, the more prestigious and desirable the job is, the more the qualification required to perform it. In this study, prestigious and desirable jobs are occupations with high earning potential, excellent chances for progression and opportunities for maximising one's potential.

Subsequently, this study examines if credentialism, in the form of recognition of qualifications and certification, impacts access into and progression within medical practice for IMGs in both countries. It goes on to ask, if it does, how does it advance access and progression or constitute closure in the contexts of both countries.

At this junction, it is important to note that for credentialism to be an effective strategy for professional closure, it must be legalised. As claimed by Parkin (1979) and quoted by Macdonald (1985. p. 543), 'the professions generally seek to establish a legal monopoly over the provision of services through licensure by the state'. This legitimation is validated via the legal monopoly given to people who render professional services' (Macdonald, 1985, p. 543). Even though, the concept of credentialism starkly contradicts the core principles of neoliberalism (Berlant, 1975), it appears as a

widespread practice in many Western societies. For example, in Ireland, the Solicitors Acts 1954 to 2013 established the Law Society of Ireland. In similar light, for the medical professions in Ireland and Canada to achieve legal monopoly over the medical marketplace, they needed to be incorporated by legislation. The legislation then established distinct bodies that regulate the registration and licensure of its members. In Ireland, the Medical Council, created by the Medical Practitioners Act 1978, enjoys a legal monopoly over the registration of new members. It also oversees what division of the register a doctor may be registered and in cases where there is a doubt about a doctor's fitness to practice, it has the power to restrict or revoke licenses. In Canada, it is the Canadian Medical Council with its provincial bodies that enjoy the monopoly. The Canadian Medical Council was established by the Canadian Medical Act of 1912. It enjoys the monopoly over assessing medical candidates, conducts evaluation examinations for doctors and grants a qualification called Licentiate of the Medical Council of Canada (LMCC) to those who wish to practice medicine in Canada. It also maintains the national register of physicians and their qualifications in Canada. These two bodies enjoy legitimate monopolies over access and progression within the medical professions of both countries. It is these monopolies over setting of entry requirements in terms of credential requirements and licensure that this study evaluates. It examines, through the lens of social closure, how rules such as credentialism and recognition of prior qualification that guide entry to professional practice can amount to professional closure against IMGs

Another significant aspect of credentialism is its appearance of neutrality. Educational, vocational, and professional requirements are believed to be fair and objective measures of ability of an individual, which in no way have any relationship to that individual's social identity. However, previous research in the UK and Ireland (see Coker, 2001; Dadabhoy, 2001; Birchird, 2001, Carter et al. 1999; Payne, 1998) reveal that country of qualification and membership of a specific racial, ethnic or social group are sometimes, regarded as an indication of competence or incompetence within medicine. For example, Dadabhoy (2001, p. 67) narrated how his clinical competence was called into question by some patients because he was not English. Unwin (2001) also argues that members of ethnic minority groups in the UK are more likely, than 'White British', to end up in the staff grade positions. Staff grade positions are permanent career grade positions in hospital medicine in the UK, which doctors can enter from the senior house officer grade, i.e. instead of moving into higher specialist training.

Consequently, this chapter analyses and scrutinises the use of credentials as the basis of access into, and progression within medical practice in Ireland and Canada. Hence, it focuses on processes of access and progression within medicine in both countries, the role credentialism and recognition of foreign qualification play in these processes and how these processes produce inclusion and

exclusion. It does this from the perspectives of interviewees.

The analyses and discussion starts with Ireland and are then, followed by analyses of and discussions about credentialism and recognition of foreign qualifications within medicine in Canada.

Credentialism, Professional Closure and Medicine in Ireland

This sub-section presents and discusses, from the perspectives of interviewees how credentialism or non-recognition of prior qualifications can amount to professional closure against IMGs in Ireland. It does this by presenting the views of interviewees on the academic requirements for access to practice in Ireland and the processes of recognition of foreign qualifications for IMGs within the medical profession in Ireland.

Credentialism and Professional Closure via Recognition of Foreign Qualification

How can I become a consultant in Ireland? Tell me. How can I do it when progression is based on your trainings, examinations attempted and passed and certifications acquired? And I cannot access the training and obtain the qualification because the qualification I brought from Nigeria is not recognised as good enough to get on the training positions. Then tell me, how can I progress with such a barrier? I believe the barrier was put in place to close-off training positions and consultants' positions to the majority of non-Irish doctors here. It is a matter of closing off opportunities for progression to foreign doctors and condemning them to a life of servicing Irish doctors-abandoned rural hospital posts (Dr Bolaji, A.)

The quote above from an IMG of Nigerian origin suggests that credentialism, a feature of the profession, may have been converted into a strategy of professional closure against IMGs in relation to training posts within Medicine in Ireland. Friedson (2001), refers to credentialism as the device that sustains monopoly and social closure in the professional labour market. According to the interviewee above, credentialism may have been used to close off opportunities to IMGs from some countries in the context of medicine in Ireland. About recognition of prior qualifications obtained by IMGs before their arrival in Ireland, many interviewees believe the Medical Council in Ireland and the training bodies have invented an artificial barrier to prevent access to training posts by IMGs. The basis of their perceptions is because the Health Service Executive and the Irish Medical Council provides very clear information on the medical hierarchy in Ireland. They state that the consultants are the most senior grade in the Irish hospital system and they have the ultimate responsibility for the patients and the training of junior doctors in their teams within hospitals. However, it is not possible to become a consultant without being in the Specialist Division of the Register of Medical Council. It is important to note that the Specialist Division of the register is specifically for medical practitioners who have completed specialist training recognised by the Medical Council and can practice independently as a specialist. As mentioned in Chapters Four and Five, the post-graduate training bodies and their faculties handle post-graduate/specialist training. Furthermore, one can

only access postgraduate medical education through acquiring undergraduate education from certain countries, as provided for in the Medical Practitioners Act (2007). The reason given by the Medical Council for disallowing IMGs who originate from outside of the areas mentioned is that the training received by candidates from such countries is deemed not to be equivalent to that received in Ireland.

The perception of interviewees is that a barrier is constituted at the entry point to prevent IMGs from accessing medical posts that carry with them opportunities for progression. Rather, they are mostly allowed into medical positions with limited or no opportunities for progression. There is a common question asked by many interviewees. The question is, why is the qualification deemed not equivalent to that of Irish qualifications, and what makes the holder ineligible to access a training position in Ireland, but be accepted as sufficient to allow such an IMG to practice as a junior doctor in a service post? Interviewees perceive this practice as amounting to professional closure around training positions. From the evidence available here, credentialism, in this case, a requirement for EU/Western medical qualifications, creates situation where potential competitors, are excluded, and employment or progression opportunities are restricted to those with recognised credentials.

As discussed in Chapter Three, one of the features of the profession is the requirement of long duration of training as well as specialised skills for aspiring members. This acquisition of specific skills translates into a kind of formal education qualification requirement for those seeking to enter the profession (Carter, 2003). Therefore, professionals may be distinguished as prestigious by the virtue of the kind of education, knowledge and skills their members possess. In Ireland, the profession of medicine is regarded as an extremely technical occupation that requires specialised skills and expert knowledge. However, many interviewees in Ireland argue that IMGs are excluded from formal training that leads to a doctor becoming a consultant. According to all interviewees in this study, the system of non-recognition of prior medical qualification and internships completed by IMGs for the purpose of accessing training posts present a barrier to access to practice and progression of IMGs within the medical profession in Ireland. The result of this practice is that many IMGs are left with the only available option: filling service posts.

As mentioned in Chapter Five, some overseas internships from Australia, New Zealand, South Africa, Pakistan (Internships commenced from January 2009), Sudan and Malaysia are recognised by the Medical Council as equivalent to an Irish internship internship and granted the equivalent of an Irish Certificate of Experience. As stated in Chapter Five, the Certificate of Experience confirms that an IMG in question has completed an internship in his or her country of origin or training which is equivalent to one completed in Ireland. However, qualifications and experiences of doctors outside

the catchment areas mentioned earlier are not considered equivalent to an Irish Certificate of Experience. Therefore, doctors who possess qualifications not recognised as equivalent to the Irish qualification may be allowed to register in the General Registration Division of the Medical Registration after writing and passing the Pre-Registration Examination (PRES). As stated in Chapter Four, the General Division of the register of the Medical Council is the division that registers doctors who are not in any specialist training, proposed for a post in the Supervised Division, and who have not completed recognised specialist medical training. Doctors registered in this division cannot represent themselves as holding specialist or trainee specialist registration (Medical Council, 2015).

Besides the initial registration hurdles with the Medical Council, the inability of IMGs to apply to Higher Specialist Training Programme in Ireland and the subsequent acquisition of a Certificate of Satisfactory Completion of Specialist Training (CSCST), a pre-requisite for becoming a consultant in Ireland makes becoming a consultant a far-off dream for many IMGs. The reason is that many IMGs are registered in the general division and they are only eligible to work in service posts where the opportunities to transfer to specialist training schemes are minimal or not available. In other words, the lack of access into the training scheme for IMGs constitutes a career blockage. An IMG from India with nine years of experience in Ireland puts this perception clearly and concisely when she says:

> I am from India. I have worked here now for five years. Yet, the Medical Council says it does not recognise my qualification as equivalent to the Irish qualification. This practice makes me ineligible to compete for training posts. The basis of my inability to progress is the non-recognition of my foreign qualifications. This case is ridiculous! They recognised it as good enough for a service post, but not well enough for getting on the training scheme to become a specialist. I can smell foul here! (Dr Gupta, S.)

The quote above from an IMG also negates the argument that credentials are important in highly technical occupations like medicine because of the health of patients. According to the Medical Council, the reason why it is paramount that it regulates doctors is because the 'Council's purpose is to protect the public by promoting and better ensuring lofty standards of professional conduct and professional education, training and competence among doctors' (Medical Council, 2015. p. 7). However, if the health of patients is the dominant factor in not recognising some foreign medical internships, for instance, a medical internship gained in Nigeria, then, why are doctors with internships from Nigeria employed in service posts where they are allowed access to patients? The evidence from this research suggests that the employment of some IMGs in service posts and their inability to transfer to formal training, owing to the country of origin of their medical certificates, is consistent with the argument that educational certification is a historical legitimation of advantage. This advantage empowers holders of certain degrees or qualifications in occupational and

organisational recruitment (Brown, 2001, p. 20). As the evidence indicates, the credential requirement for training in Ireland is not only concerned with concrete academic knowledge and professional skills of doctors. It is used for closing off access to training for doctors who acquired their basic medical qualifications, skills and experience outside of the catchment countries mentioned earlier. This perspective is consistent with what previous research on migrants in Ireland revealed. For example, Coakley and MacEinri (2007) identified non-recognition of foreign qualification as one of the barriers facing African families in Ireland. Additionally, a Nasc Ireland's Report of 2008 and Integrating Ireland's Report of 2009 both acknowledged non-recognition of foreign qualifications as a major barrier to migrants' economic integration in Ireland.

In the global context, direct relationships between specialised skills required for a job and its desirability, status and pay was established. Increasing evidence in employment globally continues to suggest that access to jobs with high status and pay is restricted by imposing certain requirements on aspiring new members. For example, Bauder (2003) argued that regulatory institutions actively exclude immigrants from the upper segments of the labour market in Canada through de-skilling and the non-recognition of their foreign credentials. In Australia, researchers such as Ho and Alcorso (2004); Hawthorne, (2002) and Iredale (1997) identified the lack of recognition or downgrading of qualifications, skills and experience obtained in non-English-speaking countries as one barrier to successful labour market integration. Also, Wagner and Childs (2006) claimed that the recognition processes of foreign qualifications in Australia are 'mediated by gatekeepers mandated to protect the status quo, forcing skilled migrants to keep standing on the doormat of professional work, not invited in' (p. 51).

Another perception of interviewees is that high monetary rewards attached to the position of a consultant in Ireland is one of the motives behind the tightening of access to it. According to many interviewees, the high status and financial rewards enjoyed by the consultants is the reason behind the closure formed around the position of a consultant. This perception can be interpreted through the lens of arguments of theorists such as Freidson (1988, 1975, and 1970), Murphy (1988); Berlant (1985) and Witz (1993). According to them social closure strategies can be used to protect specific occupational areas to ensure that wages and working conditions are kept at a relatively prominent level. Therefore, organised groups of workers can legitimately demand high wages for scarce skills if they can maintain their monopoly over an occupational area. Therefore, professional closure strategies such as credentialism and non-recognition of foreign qualifications can be used to protect occupational areas and ensure that wages and working conditions are kept at a relatively prominent level. In the context of medicine in Ireland, many interviewees argue that maintaining high status, high wages and excellent working conditions enjoyed by consultants in Ireland are the reasons why

it is closed off professionally to IMGs perceived as 'outsiders'. It is important to remember that professional closure can only be successful if insiders are identified against outsiders. In other words, to maintain the high salary, it is important to control access into the consultant's grade. According to a consultant of Asian origin interviewed with over twenty years of experience in Ireland, consultants' wages are outrageous. So, for him, maintaining these high wages is one reason why there is a conscious effort by many consultants to make sure the numbers of consultants are never many. He argued that:

Look at the state of the health system in this country! We have patients on trolleys everywhere, and there are cut backs now and then. But, we [consultants] are getting paid fat salaries. It doesn't make sense. If the country is broke, why does the government pay us that much? I take the money too, and I ride a Jaguar, but in all fairness, we are being paid too much. I think it is the money that causes the problem. Number one, to maintain the high wages, the numbers of consultants needed to be regulated. Number two, the few opportunities that are there, must be filled by insiders who are mostly Irish. I have the feeling some of my colleagues look at me and think I don't deserve to be paid that much because I am Irish. That is why every little thing, they keep singing it into your ears that you must be appreciative of what they are giving you. (Dr Malik, G.)

The claim above by the Asian doctor was supported by a Nigerian doctor who migrated to Ireland in 1995 and transferred to a training scheme in 2005. He exited the training scheme in 2010 and became a consultant in 2011. So, he claims:

The difficulties experienced by an IMG in becoming a consultant in Ireland are due to so many reasons. One of those reasons is the prestige and money attached to it. You should remember that like the society, the medical profession too is a pyramid. The majority are at the bottom and are paid less compared to the few at the top who are paid much. What happens then is, everybody wants to get to the top to have a slice of the pile, but the top does not have the space for all. So, different hurdles are put in the way of upcoming doctors. One of the hurdles is the requirements for certificates. Unfortunately for many IMGs, this requirement affects them adversely than their Irish or European-trained counterparts. (Dr Ogbunna, O)

It is worth mentioning here that some IMGs have invented strategies to circumvent closure. They achieve this by studying while working full time. Some interviewees said they funded themselves and went to the UK to do a postgraduate degree in medical specialties. A few interviewees who are now consultants mentioned they privately funded themselves to study for Masters and Doctoral degrees alongside their full-time work commitments. After completing and passing these degrees, they transferred to the training posts or had the new degrees recognised in Ireland. The fact that the degrees are obtained from the UK or Ireland makes it recognised. A few of them, according to interviewees, are extremely fortunate to be successful in getting transferred onto the training scheme or becoming consultants. According to many interviewees, successful transfers are few compared with the numbers of IMGs excluded from the training posts.

Another perception of many interviewees in this study is that IMGs are required as the workhorse of the Irish health system. According to them, the highly respectable and prestigious positions of consultants and trainee registrars are reserved for members of the dominant social group. It is interesting that an interviewee came up with what I refer to as a 'desirability and privileges gradient'. She claimed that the most desired doctors and the ones who enjoy most privileges are the Irish doctors. This, according to her, is followed by doctors from the EU and Western European countries, then, citizens of old Commonwealth (South Africa, Australia, New Zealand and Canada). Then there are the others. Another interviewee called the Irish doctors the 'most favoured' doctors. According to an interviewee who came from Nigeria in 2006 as a doctor and works as a registrar in a hospital in the East of Ireland:

After spending time within the health system in Ireland, I come to the conclusion that many of us will never progress here. There is so much power, prestige and money attached to the position of a consultant and sincerely, to many Irish, we are not entitled to that kind of privileges because we are outsiders (non-Irish). Sometimes ago, in one of the training colleges, there is a consultant that is very condescending to IMGs from outside of Europe. When I went to challenge him, he told me point blank, don't ever dream of becoming a consultant here. Our children have migrated outside. So if there is an opportunity, it will be to bring back one of our children outside of Ireland, to fill it. It cannot be for you. You can also go back to your country to become a consultant'. (Dr Chwuendi, O)

Another story from an interviewee corroborates the above quote, even though the context within which the IMG says the consultant said it, is different. She said the consultant was sympathetic and was trying to encourage her. So, the consultant said:

… if you have the opportunity to practice outside of Ireland, please utilise it because there is very little opportunity here for you. I don't think most Irish are not open-minded enough for now. We kind of look after our own and I don't see that changing soon. But I promise you, I will always support you if there are opportunities for you here. (Dr Benson, C)

The suppositions of the interviewees above may not be entirely peculiar to IMGs, because previous research in this area has identified that Irish women are equally disadvantaged within the medical profession in Ireland. For example, Cannon (2003) and Meghen et al. (2013) both argued that female doctors are disadvantaged when it comes to progression into the position of a consultant within medicine in Ireland. As a result, professional closure may not only be formed based on country of origin of medical degree, but because of gender as well. The role of race and gender in medicine in Ireland is explored in Chapter Nine. Nevertheless, the experiences of IMGs quoted above indicate that many doctors with medical degrees from a certain part of the world are excluded from the position of consultants in Ireland based on non-recognition of the medical degrees and professional experiences gained in those countries. Hence, doctors with such qualifications are identified as outsiders and undeserving of the privileged position of medical consultants in Ireland. The possession of credentials within this sphere serves as the basis for inclusion or exclusion from the

prestigious positions.

In conclusion, according to many of the interviewees in this study in Ireland, credentialism plays an exclusionary role when it comes to the professional integration of IMGs in Ireland. Furthermore, even though the requirement for the possession of a credential such as the Certificate of Satisfactory Completion of Specialist Training (CSCST), to get appointed into a consultant's position, may often appear class, gender and colour-blind, it is perceived by interviewees as a strategy of exclusion. They claim it serves the interest of members of the dominant social group within the profession.

Credentialism, Social Closure and Medicine in Canada

Similar to Ireland, Canada relies on formal recognition of medical qualifications or certification to determine if an individual is qualified to practice as a doctor in Canada. There is also increasing evidence to suggest that licensure, an important aspect of the medical profession in Canada, is utilised as a mechanism of professional closure against IMGs. When it comes to recruitment, credentialism is enforced primarily by the imposition of both formal and informal rules on an organisation, an organisation's standards, and the practices of gatekeepers. The formal part of credentialism uses licensure, that is, state-legislated restrictions imposed on the supply-side of workers to control access into and progression within a profession. In the case of medicine in Canada, licensure requires that individuals, including IMGs, aiming to practice medicine get permission from the state to practice either provisionally or fully. As mentioned in Chapter Four, full licensure permits a registrant to practice medicine within the scope of his/her education, qualifications and experience without any restrictions or supervision. On the other hand, the provisional license permits a registrant to practice medicine with the limits and conditions granted by the Registration Committee. Therefore, the effect of licensure requirements is the restriction of access to the medical profession, even though aspiring IMGs may already have met a set of requirements in terms of academic qualifications, certifications and residence or immigration. These sets of requirements, in the case of Canada, are developed and administered by the Medical Council of Canada and the Royal College of Physicians and Surgeons of Canada (RCPSC). Usually in Canada, the professional medical bodies justify the arduous licensure process by arguing that it is important to evaluate new practitioners so that patients are protected from incompetent and malfeasant doctors.

Like Ireland, evidence from this research reveals that the restrictions placed on new entrants to medical practice in Canada is aimed at controlling the numbers of practitioners coming into the profession to enhance its market value. This perception is consistent with the argument of Parkin (1979) on social closure. According to him, efforts to control the 'moral and technical standards' of

occupational incumbents are not antithetical to, and in fact, can be used to justify, efforts to control the supply of practitioners and enhance the market value of the occupation (pp. 54–55). Therefore, according to some interviewees in this study in Canada, the mechanism put in place to regulate the medical profession in Canada, controls the quality of doctors licensed to practice, and simultaneously, it serves as a mechanism of social closure aimed at closing off medical practice to as many IMGs as possible.

As discussed in Chapter Four, accessing professional medical practice in Canada can be very complex and can involve a lengthy process due to the provincial based system of medical practice regulation. What this means is that licensure requirements are province-specific. Licensing of IMGs in Canada falls under the jurisdiction of the General Medical Council's medical regulatory authority in each province (Audas, Ross and Verdy, 2005). As a result, academic requirements can vary slightly depending on the need of the province. As mentioned earlier, in Canada, there are two types of medical license, full and provisional. As noted in Chapter Five, the colleges of physicians and surgeons in each province act as the medical regulatory bodies and medical licensing authorities in the jurisdictions. These bodies handle verification of credentials and determine the eligibility of a physician to practice in the provinces. An IMG is not permitted to practice until he or she receives either a provisional or full license from the college. The fact that an IMG meets the credential requirement in one province does not mean he or she will meet the requirement in another province. For example, an IMG may meet the requirement to practice in Quebec and not meet the requirement to practice in British Colombia. However, the requirements to obtain a full medical license are uniform across Canada, although, some variations do exist. A fully licensed physician in Canada can practice anywhere in Canada. As explicated by Campbell-Page et al. (2013, p. 4), the possession of a full medical license permits the physician to practice medicine with no terms, limitations or restrictions in Canada. According to them, the main qualification a physician must possess in order to receive a full license include:

1. A degree in medicine from an approved medical school
2. Completion of two years of residency training
3. Possession of the Licentiate of the Medical Council of Canada (LMCC)
4. Certification by examination from either the College of Family Physicians of Canada (CFPC) or the RCPSC.

The challenge posed by this process for many IMGs is that it is very long. Hence, many IMGs need time to achieve this standard. It is important to note that in some provinces, an IMG may begin

practicing with a provisional license (Campbell-Page et al., 2013). When a doctor practices with a provisional license, he or she does so with restrictions such as the scope of practice, location of practice and other restrictions.

Talking about professional closure via credentialism in Canada, it is this over-reliance on credentials and licensure that some interviewees, when questioned about their perception of registration and licensure requirements, claimed to be exclusionary. In fact, all interviewees agreed that both academic qualifications and professional certification requirements directly and indirectly prevent IMGs from fully participating in medicine in Canada. Some interviewees are more radical in their perception of the process of licensure by interpreting it as solely a strategy of excluding IMGs from medical practice in Canada. Other interviewees' claims are moderate about absolute professional exclusion. They argue that in the process of Canada trying to maintain its high standard of health care delivery, it unconsciously excludes IMGs via the rigorous process of licensure. This finding supported by an interviewee of Indian origin with nearly twenty years of medical practice experience in Canada. He says:

> It is quite unfair to make foreign doctors wait in queue for 6, 7-10 years just to receive licensure for the purpose of practice in Canada. These are highly qualified people from their country, but on arriving in Canada, they are completely de-skilled. Their previous qualifications and experiences are devalued, and the standard for access is now, re-certification in Canada. You must retrain basically in Canada. I believe this is aimed at excluding IMGs from practice. The process in some cases is too long. It ultimately discourages IMGs. That is why many IMGs are now taking alternative careers such as becoming paramedics or clinical research assistants. Some of my friends who are qualified doctors from their home countries, you can't believe, are now carers or working as paramedics. I think this is what the process wishes would happen to IMGs. (Dr Ikrahm, M.)

This perception was also shared by a Pakistani doctor who waited for eight years to be licensed in Canada. He maintains that the fact that IMGs cannot work as a doctor even after passing the Medical Council of Canada Evaluating Examinations (MCCEE) is a testament to the perception that the aim of the process is professional closure against IMGs. In his words:

> No matter how well rhetorically presented is the rationale behind the requirements that IMGs must go through residency again and complete all those certifications with different medical and licensing bodies for licensure is discrimination. My belief is that opportunities are just being denied IMGs. It is not peculiar to Medicine in Canada. My cousin is an engineer, the engineering profession is also closed off to immigrants through the requirement for various forms of certifications and subsequent licensure. The difference is Canada knows how to camouflage discrimination. So, they hide under the canopy of 'in the interest of clients' to discriminate against IMGs using requirements for Canadian acquired qualification that they made hard for IMGs to acquire. (Dr Khan, F.)

This finding agrees with the findings of previous research on this subject in Canada. For example, Audas, Ross and Verdy (2005. p. 1315) in their study of the use of provisionally licensed international

medical graduates in Canada, stated that the 'requirement for an IMG to have completed postgraduate medical training in Canada to practice, without providing adequate numbers of residency positions is an obstacle for IMGs wishing to obtain a full license'. This perspective is consistent with the findings of another study by Bourgeault et al. (2010). Evidence from this study suggests that the time-consuming nature of the process and the bureaucratic nature of the process of licensure can be barriers to the professional integration of IMGs (pp. 63-64).

However, there are interviewees who argued along the other line. For example, an interviewee who now runs a family GP practice in Toronto and considers herself a success story of IMGs' integration in Canada. Although, she agrees the lengthy and arduous process of licensure as a form of closure, however, she thinks the aim of the process was not closure per say. Rather, according to her, the aim is to minimise the numbers of doctors entering practice. For her, it is nevertheless, worth the lengthy process because as soon as you are in, you are in. She puts it this way:

> Have you forgotten this saying in English: 'no sweat no sweet?' That is what the process of registration and licensure in Canada is. It is to include the best. And the best could mean in terms of endurance and patience. So, anyone who is not willing and ready to pay his or her due is not worthy of medical practice in Canada. (Dr Oyatioye, B.)

When I asked her that from what I gathered during the research, the professional integration experiences of IMGs, especially, pre-licensure is unfavourable compared with Canadian Medical Graduates (CMGs). She responded, arguing that:

> But we IMGs need to understand that we must pay a price. Canada is not our country of origin neither did we train here. Remember, some people trained here. Those people deserved to be considered first as the quality of their training is known. As a result, IMGs must be willing to endure any hardship they encounter in the process of registration and licensure. Look here, we are the ones coming here to look for work. So, we must play by the rule here. Yes, there is limited access to practice, and the process is long. But my argument is every Dick, Tom and Harry cannot just come and become doctors straight away. The system must be able to screen and prune to get the best and the brightest. (Dr Oyatioye, B.)

Critically examining the perception of Dr Oyatioye, can it be that he has normalised the discriminatory and exclusionary practices of the medical licensing system in Canada? Analysing this perception, through Du Bois' internalised oppression, it may be that some IMGs have started to see themselves through the eyes of others, and they are interpreting their experiences through that lens. The reaction of some IMGs to the utilisation of licensure as a mechanism for professional closure in medicine in Canada, may be interpreted through the lens of internalised discrimination. In this case, IMGs, who may be victims of professional closure, are subjected to the mystifications of the very professional closure ideology that excludes and marginalises them. Hence, they perceive it as fair and deserving of it. If an IMG is a victim of it, then the IMG blames himself or herself for being a victim and believes the victimisation is well deserved.

Even though evidence from this study and previous studies in this field in Canada (Bellange, 2010; Globe and Mail, 2010; Foster, 2008) suggest that the credential and licensure requirements in Canada is utilised by the dominant social group to exclude IMGs, some interviewees hold a contrary opinion. All interviewees agreed that the protracted process of getting into a residency in Canada and obtaining full licensure is a form of closure. However, a few disagreed that it is aimed at excluding only IMGs or members of visible minorities within the profession. Rather, they opined that there are limited residency spots, therefore, making getting into a residency and eventual licensure hard to obtain, is the only way to ensure that the supply of doctors is restricted. Then, the few vacancies that exist are filled by quality candidates. As contended by an IMG of Nigerian origin, with a family practice in Alberta:

> What I see in this is management of professional positions are that positions are very limited, especially, the positions in urban Canada. So, the government must be able to control the numbers of people getting into the profession and where they serve. For example, the government knows how many doctors they can cater for. So, they allow those numbers into residency. The problem is there are usually too many people applying for these posts. The system cannot accommodate everybody. So a system to streamline people must be instituted. (Dr Arabambi F.)

Another doctor from the Middle East supports this argument and argues that:

> We must always remember that the government must generate revenue. And residency posts in Canada are a means through which the government generates needed revenue. What happens then is government fills the positions with candidates that pay before filling the remaining with Canadian IMGs, and the remaining slots will go to non-Canadian IMGs. The closure is not aimed at non-Canadian IMGs *per se*, they are just victims of circumstances. For example, I heard the Saudi (Saudi Arabia) doctors pay around $60, 000 per annum to train as doctors in Canada. This is a lot of money. If it is your country, will you not take the money? Let us be realistic. I agree there is closure, but the closure is just a result of circumstances that are beyond anybody's control. (Dr Abdul. K)

This perception was corroborated by a Director in Health Canada[40], who in 2011, admitted during our interview with him that yes, Canada has not done enough to integrate IMGs and there may be some barriers to their professional integration. As stated by him, one of the challenges Canada faces is finances. As a result, when there are residency posts, the first group considered are Canadian graduates, those who Canada paid for to attend medical school. This group is followed by foreign doctors on foreign governments' scholarships (Visa Trainees) such as doctors from the United Arab Emirates (UAE), Saudi Arabia, Qatar, etc. There are also Canadian IMGs (Canadians who train outside Canada and the USA) and lastly, non-Canadian IMGs. According to Walsh et al. (2011), visa trainees are primarily from the Middle East, particularly Saudi Arabia, and are selected directly into training programmes through financial agreements with the country of origin. According to the Canadian

[40] Health Canada is the Federal department responsible for helping Canadians maintain and improve their health, while respecting individual choices and circumstances (Health Canada, 2015).

Post-M.D. Education Registry (CAPER) 2013/14 IMG database, there were 646 visa trainees in 2012/2013 and 617 visa trainees in 2013/2014 in postgraduate training positions (p. 23). This figure represents 30 percent of the total number of IMGs enrolled in postgraduate training posts in those years.

Summarily, the evidence in this study suggests that the strategy of imposing educational credentials as a prerequisite for licensure in Canada can be perceived as the basis of the difficulty many IMGs experience when they want to practice in Canada, despite the wealth of experience many of them have from their countries. The restrictions on access to medical practice via imposition of various regulations and layers of bureaucracy, close off opportunities to prospective entrants who do not possess those credentials. As Weeden (2002) argues, 'licensure cannot fail to restrict supply unless criteria are so lax, fees so low, and the process so painless that no potential licensees are discouraged or denied' (p. 9). The case of medicine in Canada is the opposite. The criteria are strict; the fees for sitting the pre-registration examination are high, the process is painfully long and potential licensees are discouraged, and in some cases, completely denied access to practice.

Conclusion

After examining the educational, certification and licensure requirements in Canada and Ireland, it can be deduced that common to both countries are the devaluation of previous academic qualification acquired by IMGs from outside of the EEA/Western societies and deskilling of IMGs. Common to both countries are also the imposition of rigorous academic and certification requirements as prerequisites for registration and licensure. These formal requirements present a barrier to the professional integration of IMGs Canada and Ireland. In the case of Ireland, evidence from the study suggests that credentialism, as used by the Medical Council and supported by the government, is a rational means of regulating entry into and progression within the profession. Many interviewees think the non-recognition of their foreign qualifications from countries outside of the EU and old Commonwealth countries is the basis of their inability to transfer to training posts and subsequently, become consultants. They interpreted this practice to be professional closure. Furthermore, evidence from the research suggests the government is complicit in perpetuating this closure because it legitimated, via the Medical Practitioners Act, 2007, the denial of access to training to many IMGs. As a result, even when an IMG, occupying a non-trainee post performs work of equal value with a doctor, who occupies a training post, they are unequally rewarded. The non-accreditation and certification of the clinical work of doctors not-in-training puts them at an automatic disadvantage compared to trainee doctors, whose training counts towards credentials required for progression into the position of a consultant.

Similarly, in Canada, evidence from this study suggests that the combination of credentialism and licensure, as prerequisites for either provisional or full professional medical practice, impacts negatively on the professional integration of IMGs. Evidence from the study also suggests that the government of Canada is also complicit in the perpetuation of this professional closure. This finding validates the findings of previous studies in this field in Canada (see Lofters et al. 2014; Campbell-Page, 2103; Bourgeault et al. 2010). These previous studies found the strenuous and cumbersome registration process; lack of residency posts for IMGs and lack of transparency in the procedure for selecting doctors in to residency posts to be significant impediments to the integration of IMGs into the medical profession in Canada are. These barriers technically disallow them from practicing in Canada. It must be remembered that to practice, an IMG must be licensed. And to become licensed, the registration and certification via residency requirements must be satisfied by many IMGs, especially, those from outside Canada, USA and the old Commonwealth countries. Therefore, if an IMG cannot access residency, such an IMG cannot obtain licensure to practice medicine in Canada.

These barriers also reinforce the notion of migrants' deskilling. In this case, a few IMGs, for their inability to scale thorough the rigorous and lengthy process of licensure end up working in sectors other than their original training. They end up working as paramedical and in some cases, they work in jobs they are over-qualified for. This finding aligns with claims by many studies that deskilling is a common experience for immigrants. According to kofman (2012, p. 69) talking about skilled migrant women, deskilling results in skilled migrant women taking jobs outside their initial training and secondly, taking up roles below their qualification within their profession. In this study, many interviewees claim the deskilling experienced by many IMGs have made them to chose to pursue careers in other paramedical professional such as laboratory sicence, forensic science, and even, ambulaotory care.

Another aspect of the perceptions of IMGs about the impacts of credentialism and licensure on their professional integration in Ireland and Canada is the internalisation of credentialism as a closure strategy by some IMGs as a legimate and acceptable practice. This idea of seeing the long and arduous process as a best practice, seeing others who could not succeed in the process as villains and seeing successful ones as the 'special' ones can be the result of the 'double consciousness' of IMGs. Some IMGs in Canada see themselves through the lens of the popular dominant discourse of the main social group within medicine in Canada. The crucial point of this is that access to practice in Canada needs to be controlled to ensure a good quality of healthcare service to patients. Besides, controlling access to medical practice by practitioners will help maintain good reward to the few practitioners who can make it into the fold. Likewise, in Ireland, some IMGs have internalised exclusion, in some cases, decided to overlook discrimination and in other cases convinced

themselves that they deserve to be discriminated against. A few interviewees claim some of the IMGs they know, believe it is acceptable to work twice as hard as some of their mainstream Irish counterparts and not get recognition for it. This is because they are not Irish, and their primary medical degrees are not from Ireland. Some even told me, some of their IMG colleagues told them that they should be grateful to the Irish for getting the service post because, without the generosity of the Irish, who let them occupy the service posts, they would be on the dole.

Conclusively, credentialism and licensure are claimed by their proponents as the best means to ensure that new entrants into a profession or occupational area are of the highest quality in terms of training and expertise. Evidence from this study, in both Ireland and Canada, indicates that credential requirements and licensure may be constructed initially as an objective testing tool of aspiring medical practitioners' skills and expertise. There is an indication from the study that over time, this measuring standard may then be used to exclude members of subordinate social groups within the profession. This is because, for example, in Ireland, even though, many IMGs are employed to work in non-training, service posts based on their foreign academic qualifications and clinical skill, they are denied access to the training posts which serves as the ladder to becoming a consultant. Their exclusion is because their qualification is not comparable to Irish qualification. In other words, it is inferior to an Irish qualification. However, the qualification that is deemed not comparable to the Irish qualification, and because of which many IMGs are denied access to training positions, is considered safe enough to employ them into service posts, sometimes for many years, with no means of progression.

In the case of Canada, many IMGs are unable to access residency even when they have passed required provincial based examinations because of limited numbers of residency posts. As a result, many IMGs find it difficult to commence the journey to practice professionally in Canada. In many cases, as mentioned earlier, IMGs end up giving up the hope to practice medicine for alternative jobs such as care jobs, paramedics, etc.

Summing up these evidences, it is suggestive that credentialism and licensure requirements in Ireland and Canada may not be as objective as they claim to be and in fact, they can be mechanisms of professional closure against IMGs.

Chapter Eight

Informal Social Networks, Sponsorship and Patronage as forms of Professional Closure: The Case of Irish and Canadian Medical Professions

Introduction

In this chapter, I discuss the role access to informal social networks, and sponsorship and patronage by senior and eminent members of these networks, play in relation to the professional integration of International Medical Graduates (IMGs) into the medical professions of Ireland and Canada. Besides rendering the definitions of informal social networks, sponsorship and patronage, I present the perceptions of interviewees on the role these notions play in relation to access and progression within medicine in Ireland and Canada. Attention is particularly drawn to how access to informal social networks, sponsorship and patronage can be utilised as closure strategies against IMGs within medicine in Ireland and Canada. This argument is based on the perspectives of interviewees in this study and it is presented thematically. The role of informal network is discussed first and sponsorship and patronage discussed subsequently. The case of Ireland is presented first, followed by that of Canada.

As stated in the introduction, the interviewees in this study identified the dominant social groups within the medical profession as 'White', Catholic/Christian, Male and Western European doctors. As for the definition of informal social networks, the definition provided presented earlier in p. 61 by Bourdieu and Wacquant is adopted. They define social capital as 'the sum of the resources, actual or virtual, that accrue to an individual or a group by possessing a durable network of, more or less, institutionalized relationships of mutual acquaintance and recognition' (Bourdieu and Wacquant 1992: 119). As mentioned earlier, belonging or non-belonging or a perception of belonging or not belonging to certain social and informal networks, can serve as a basis for inclusion or exclusion into some occupational niches.

Informal social networks are claimed to be 'non-organised in nature' (Alcock, 1996) and they 'provide informal structures of opportunity (or in some cases, barriers) that may facilitate (or hinder) access to a variety of resources' (Policy Horizons Canada, 2013: para 5). It is claimed that informal social networks are thought to facilitate access to information, resources and career sponsorship and patronage (Seibert, Kraimer and Liden, 2001. p. 2).

Employing these concepts of sponsorship, patronage and membership of social networks, the impact of access to powerful social networks within medicine, membership of the dominant groups and sponsorship by older and more powerful members of these groups in the area of access to employment as a doctor and appointment into other prestigious and well remunerated positions within medicine in Ireland and Canada is examined. Besides, the role played by patronage is also

scrutinised. Therefore, the impact of access to and membership of powerful social networks within medicine, and sponsorship by older and more powerful members of these groups, in access to employment as a doctor and appointment into other prestigious and desirable positions, in both countries, is assessed. Besides, the role patronage plays are examined. For clarity, in this study, the patron is the older and more powerful doctor who acts as a mentor while the client is the younger and a less powerful doctor who is a protégé. It is to be noted that even though the impact of membership of informal social networks, and sponsorship and patronage are interrelated and interdependent, in this Chapter, an attempt is made at analysing them independently and the roles presented separately. Doing this independent and separate analysis will allow us to get an insight into the independent workings of these concepts and then how they can interrelate.

Roles of Informal Social Networks, Sponsorship and Patronage on Professional Integration of IMGs in Medicine in Ireland

The research indicates that social networks play a role in progress and promotion in medicine in Ireland. These networks are thought by interviewees to work to the advantage of white Irish doctors, who share similar class, school, and cultural backgrounds. According to an interviewee:

To progress in medicine in Ireland, you need to know the right person in the right post. (Dr Marcus, D.)

Another interviewee mentioned this:

I arrived in Ireland with high expectation regarding my career. Those expectations were short-lived though as I couldn't just progress. I began to despise myself. I became very angry and depressed. Then, an Irish colleague and friend who was a consultant then told me, 'don't kill yourself, sometimes in this profession, it is not what you know that, but who you know that matters'. (Dr Bamma G.)

The above statements reveal the perceived significance of informal social network membership in relation to the career success of doctors within medicine in Ireland. In recent scholarships on social processes and career successes in workplaces, social network theorists such as Podolny and Baron (1997), Burt (1992; 1997), Kanter (1977) and Bolles (1992) have demonstrated the importance of social capital in advancing the careers of people with access to certain powerful networks within employment. In a study by Luthans, Hodgetts, and Rosenkrantz (1988), it was revealed that the most successful managers spent 70% more time engaged in networking activities than their less successful counterparts. Furthermore, Podolny and Baron (1997) reiterated the significance of social relations in relation to career progression within organisations. They claimed that, the 'pattern of social relationships is a meaningful determinant of an individual's fate, including intra-organizational advancement' (p. 689). As a result, the significance of informal network cannot be over-emphasised within employment.

Likewise, in medicine, in Ireland, evidence from this research suggests that even though selection criteria for employment, promotions and appointments are objective and appear neutral, other

factors such as access to informal networks within the medical profession can favour doctors who have such access, and disadvantage doctors who lack it. As claimed by an interviewee:

I feel appointments in medicine here in Ireland especially, consultants' appointments are dependent on being part of the old boy' network. And if you are not part of this network, forget it (Dr Bamma G.).

Another doctor stated:

What happens is they [Irish doctors] are friends and support themselves even when they do not know themselves from Adam. As far as you are white and Irish, you are automatically accepted into the fold. But if you are not Irish, it is difficult for the Irish to accept. (Dr Amadi. E)

This 'the old boy' network' phenomenon, as perceived by the above interviewee was described as 'medical mafiasm', by Altaf Naqvi, a consultant surgeon, founder and past president of the Overseas Medics of Ireland, when he was describing practices of consultants and senior health service employers within Irish medicine (McDonald and Butler 2006, 23 April). According to Carter (2003), 'the 'old boy' network is one in which only other 'old boy' are deemed suitable for recruitment to desirable positions within an occupational hierarchy (p. 72). According to many interviewees, access to these informal networks are socially closed and they claimed what facilitates access to these socially closed networks is sharing similar social identities to those already in. According to many interviewees, social and informal networks serve as an important form of social closure because; who you know, in some cases, takes precedence over what you know when it comes to hiring or promotion. This perception agrees with Carter's (2003) argument about the impact of hiring through social networks on the employment experiences of black health care workers in the NHS. Carter (2003) argues that hiring through informal social networks can be exclusionary because it provides room for personal judgements about individual candidates. These judgements sometimes can be tainted with bias (Carter 2003: 74).

To further support the importance of 'old boy' network in the process of professional integration of doctors, some interviewees identified access to recommendations and vital information in terms of career opportunities and advise facilitated by access to informal networks as, vital. According to an interviewee:

The advantages of cliques within medicine are the information and recommendation available to its members. But, for foreign doctors, it is hard to break into these cliques. Many members of these cliques went to the same primary and secondary schools and universities. Many belong to the same social circle, go to pubs together, play golf or go rowing together. Most of the time, foreign doctors are regarded as outsiders and they find it difficult to access these networks. (Dr Khan. B)

The above statement highlights the significance of information and recommendations available to doctors with access to informal social network and it also emphasises the processes of accessing informal networks. As opined by the interviewee in the above quote, in most cases of informal social networks, access to vital information and recommendations from members carries significant

weight. This interviewee line of argument aligns with what I earlier discuss in Chapter Two that informal social networks increase one's access to information, which in-turn can amount to power. An employee with power can, more than one without power, secure valuable organisational rewards independent of her or his actual performance.

As for the significance of processes of accessing informal networks, it is important to understand that access to these informal networks is socially closed. Moreover, according to interviewees, access to these socially closed networks is facilitated, sometimes, by sharing similar social identities as those already in, being able to toe the line or subservient to existing members who, in return, will sponsor such access. Therefore, according to the quoted interviewee, access to informal social networks within medicine in Ireland can be through attendance of the same *alma mater*, socialising in the same pubs, playing golf or go rowing together, etc. Significantly, doctors who do not share these characteristics can be perceived as outsiders. As a result, when the networks are linked to employment/promotion, even though they are not always linked to this, informal social networks serve as an important form of social closure because; who you know, can take precedence over what you know.

Further examination of the quotes highlights the significant role sponsorship and patronage *via* informal social networks plays in the career success of a doctor in Ireland. The experiences of the interviewees above draw our attention to recent studies on the importance of sponsorship and patronage on career progression of junior doctors in medicine in Ireland. In a study of the prevalence of bullying of junior doctors in Irish hospitals, Cheema et al. (2005) argue that bullying of junior doctors by consultants and more senior staff of medical teams continues in Irish hospitals because the 'medical profession still works on a system of patronage and word of mouth' in relation to promotions and appointments (p. 274). Besides Ireland, a study of medical recruitment practices in the UK by Maddock (1996) reveals that 'candidates with sponsorship from established surgeons and physicians are perceived as preferred candidates' (p. 148). It also finds that women and black doctors suffer from a lack of patrons which inadvertently influence their career outcomes negatively (p. 148). More generally, research on social networks point out the importance of social capital in advancing the careers of people with access to certain powerful networks within employments (Burt, 1992 and 1997; Kanter, 1977 and Bolles, 1992). A study in the USA by Luthans, Hodgetts, and Rosenkrantz (1988) reveals that the most successful managers spent 70% more time engaged in networking activities than their less successful counterparts. Furthermore, Podolny and Baron (1997) in their study on how the structure and content of individuals' networks in the workplace affect intra-organisational mobility in the USA reiterated the significance of social relations in relation to career progression within organisations. They claim that, the 'pattern of social relationships is a

meaningful determinant of an individual's fate, including intra-organizational advancement' (p. 689). Together, these studies indicate the role social networks can have in career progression in diverse work contexts. It also draws our attention to the way they work in conjunction with more formal qualifications and processes.

Significantly, the utilisation of informal social networks as an effective strategy for professional closure, is not peculiar to medicine or to Ireland. The evidence available from this study agrees with the findings of some international research in this field. For example, a study of women deans in the US by Glazer- Raymo (1999, p. 150) found that women without informal networks of support find themselves blocked as they near the top of the administrative hierarchy where promotions are more likely to be based on trust than on performance. More so, Crampton and Mishra (1999) in their work on Women in Management in the US claim that academia is still highly dominated by men and the existence of 'good old boy' networks' (p. 96). As mentioned earlier, in the UK, Maddock (1996) found 'candidates with sponsorship from established surgeons and physicians are still perceived as preferred candidates' during medical recruitment (p. 146). Furthermore, describing experiences of ethnic minority nurses in the UK, Carter (2003) argues that hiring *via* informal social networks can be exclusionary because it provides room for personal judgements about individual candidates. These personal judgments based on stereotypes attached to gender, ethnicity and class of the candidate and in some cases, perceived loyalty of the candidate to some consultants and senior medical team can sometimes be tainted with bias (Carter, 2003: 74).

Going back to the issue of the old boy network, another interviewee opined that Irish doctors could easily be accepted and integrated into workplaces and that other white doctors are willing to assist them more than the way she, as a black female IMG, experienced assistance from white doctors. Her perception relates to suitability. According to her, the Irish doctors hardly need to struggle for acceptance because, they are assumed to be suitable for the workplace. She concluded:

What happens is they [Irish doctors] are friends and support themselves, even when they do not know themselves from Adam. As far as you are white and Irish, you are automatically accepted into the fold. But if you are not Irish, it is difficult for the Irish to accept you. (Dr Amadi. E)

Another interviewee stated that 'old boy network' grants whoever has access to it vital information in relation to available opportunities and recommendations for existing members of this network. He also explained how this network is formed and how to access it. According to this interviewee:

Besides the initial hurdle to be crossed when it comes to registering with the Medical Council and getting into training posts, another problem in medicine in Ireland is the problem of cliques. There are too many cliques and if you are unfortunate not to belong to any of these cliques as the case with many foreign doctors, you are doomed. For example, there are the Cork cliques dominating hospitals in Cork. Then, you have the Dublin clique, dominating hospitals in Dublin and so on. The advantages of these cliques are the information and recommendation available to its members. But, for foreign doctors, it is hard to break into these cliques. Many members of these cliques went to the same primary and

secondary schools and universities. Many belong to the same social circle, go to pubs together, play golf or go rowing together. Most of the time, foreign doctors are regarded as outsiders and they find it difficult to access these networks. (Dr Khan. B)

The perceptions above may not necessarily be true because, not all white Irish doctors who compete for positions get appointed. However, these perceptions draw our attention to the interpretations IMGs give to their everyday experiences of professional integration in medicine in Ireland. It is noteworthy that these experiences, as revealed in this study, have previously been documented in Ireland. For example, a newspaper article by McDonald and Butler (2006, April 23) titled: 'Race 'block' on Ireland's hospital jobs'. Altaf Naqvi, a consultant surgeon, founder and past president of the Overseas Medics of Ireland, claims that IMGs staff more than half of all hospital jobs in Ireland, but they are blocked from consultant positions because, Irish doctors 'look after their own'. This practice, he referred to as 'Medical Mafiasm'.

To interpret the experiences of how informal social networks works within the medical profession, I applied the 'Social Capital' theory of Bourdieu (1986). As mentioned in Chapter Two, Bourdieu (1986), as quoted in Portes (1998, p. 12), conceptualise social capital as 'assets gained through membership in networks'. According to Bourdieu 'social capital is the sum of resources, actual or virtual, that accrue to an individual or group by possessing a durable network of more or less institutionalised relationships of mutual acquaintance and recognition' (Bourdieu and Wacquant, 1992, p. 119). It is vital to note that there are the elements of social capital, which include norms, reciprocity, trust and networks (Putnam, 1993, p. 169). Norms refer to a standard set of behaviour expected from members of the community or group. Significantly, the group punishes transgressors of the prescribed norms. Therefore, members of a network are supposed to share and observe the same values or what Portes (1998) refers to it as *bounded solidarity* (p. 8). Reciprocity refers to the practice where it is the duty of each member of the informal social network to look after each other. In the words of Field (2008), 'connections bring obligations to other people, but by the same token, those people then acquire obligations to you' (p. 3). It is important to note that a member can reciprocate in a manner that is different from what was received in the first place. For example, reciprocation can come in the form of loyalty and allegiance to patrons. As for Trust, it is a sense that members of the group are faithful in their dealings with each other. That is, members can trust they are going to be looked after by other members. Then, the network is the 'wider set of relationships and norms that bind people together as a group and allow them to pursue their goals (Field, 2008, p. 3).

Within the medical profession in Ireland, these elements of social capital manifest in terms of the requirements imposed on members of informal social network within the medical profession in Ireland. For example, a doctor must share the same value with other members of the network. In as

much as same values come from shared experiences, there must be shared experiences between the intending member and the old ones. Hence, they are expected to belong to the same family, or have attended the same college, share the same religious values and beliefs, speak with the same accent, dress in the same way, etc. According to an earlier quote of Dr Khan on p. 191, 'many doctors of the dominant social group belong to the same social circle, go to pubs together, play golf or go rowing together'. This implies that members of this network are not expected to 'bowl alone'. Rather, they are expected to participate with other members in the activities mentioned or they seize to be part of the network.

As for reciprocity, members are expected to look after other members of the network. That loyalty to other members is important, as the interests of the other members must be well served. The implication of this is that junior members of the network reciprocate with loyalties to the most senior members who supply sponsorship and recommendations. Total allegiance is expected of junior doctors who are aiming to get recommendations from more experienced, eminent doctors in order to secure jobs within the hospitals. According to an interviewee:

> … as a foreign-trained doctor in Ireland, to get employed, I needed a referee to recommend me. To get a reference, I took up clinical observership position. This unpaid position, introduce me to clinical practice in Ireland and to a consultant who will likely act as your referee later. What happens then is I have to really prove that I am loyal to this consultant. I needed to demonstrate a sense of allegiance to the consultant because, that is what will get me the required recommendation. (Dr Amadi E.)

Besides this form of loyalty, some junior doctors who could access these social networks are bound to the rules set by the older members. This means in some cases, IMGs who are granted access to the network are unable to provide mentoring to other IMGs who are outside the network. At best, I can say membership of informal social networks can be enabling as well as constraining for some IMGs. Enabling when utilised to achieve an end such as access to employment and promotion and constraining when it imposes loyalty on them to the extent that they are unable to mentor other IMGs who may need mentoring. It is important to note that relationships within informal networks are of unequal power and status. As a result, when a consultant assists a junior to secure employment or promotion via the rendering of informal or formal recommendation. The junior doctor is expected to reciprocate by his or her loyalty to that consultant.

In the case of a trust, Granovetta (1995) argues that when agreements are 'embedded' within a larger structure of personal relations and social networks, trust is generated (p. 488-493). As a result, it is easier for members of the same network to trust themselves and distrust others who are perceived as outsiders. In the case of medicine in Ireland, the study suggests lack of trust as a factor when it comes to professional access and outcomes of IMGs in Ireland. Lack of trust of the references brought by IMGs from their home countries or even the abilities of IMGs who are not

part of the dominant social group are cited as a barrier to their professional integration. As stated by an interviewee:

When I came to Ireland to work as a doctor, as a foreign-trained doctor then, you needed a referee to recommend you. If you can't get a reference from Ireland, there is high probability you will not get a job then because, they do not trust your reference from your home country. (Dr Amadi E.)

In the case of trusting the clinical and professional abilities of IMGs, another interviewee stated that:

They (members of the dominant group) don't trust you. They don't even trust your certificate talk less of trusting your ability. (Dr Bamma G.)

These statements highlight the importance of trust in relation to the career access and advancement of doctors within medicine in Ireland. What happens then is doctors, who can garner trust via their social network are likely to access employment and progress faster than those who cannot. The fact that many IMGs do not have access to the network makes them unable to acquire this trust. Hence, their inability to progress into the prestigious and highly remunerated positions such as consultants, which are filled on the bases of objective as well as subjective criteria such as trust can be linked to the exclusion from the informal social networks that facilitate trust. In other words, because, access to informal social networks can grant access to powerful sponsors and patrons, in cases where members of minority groups such as IMGs are denied access, such networks become 'instruments of exclusionary closure' (Murphy, 1988. p. 18).

This leads us to the significant role played by sponsorship and patronage within medicine in Ireland because membership of such networks facilitates access to recommendations that carry considerable weight from existing members.

Sponsorship, Patronage and Professional Integration of IMGs in Medicine in Ireland

We doctors are the best 'arse' lickers in Ireland. We lick arses to get recommendations for jobs and promotions. (Dr Banghui K. L)

Another has this to say:

When I came to Ireland to work as a doctor, as a foreign-trained doctor then, you needed a referee to recommend you. If you can't get a reference, there is a high probability you will not get a job then because they do not trust your reference from your home country. So, what most of us did then, because we did not have referees that are known, was to take up observership positions. These positions are without pay. It introduces you to clinical practice in Ireland and a consultant who will likely act as your referee later. What happens then is you must really prove that you are loyal to this consultant. Sometimes, you must become totally submissive. Mind you, during observership, you are not allowed to attend to patients. All you do is observe. Yet, you need to demonstrate a sense of allegiance to the consultant. Then, you might get recommended for a job by the consultant. (Dr Amadi E.)

Another interviewee said this:

… Godfathers control the medical field. If you have a godfather who is powerful, you will progress. If you don't, you might, but the chances are very slim. For example, if your father or uncle is an existing consultant that is powerful, then your chances of making the consultant grade is high. This is because, you will easily be recommended. But, if you are like me from Africa with no existing powerful sponsor here, you just have to know how to lick boots very well. Without that, you

might remain a registrar for life. (Dr Marcus, D.)

Researcher: what about your qualifications and clinical experiences? Don't they count at all?

Interviewee: oh! They say before you can become a consultant, you have to have certain qualifications and some research done and publications. But this is when you don't have a godfather. Our Specialist Registrar (SPR) is a … What he has is a godfather who is powerful.

Critical examination of the quotes from Dr Marcus and Dr Amada above reveal that besides merit, having a powerful 'godfather', is perceived to be of critical importance when it comes to career progression within the medical profession in Ireland. As discussed in Chapter three, being a member of the dominant social group within an organisation can facilitate vertical mobility more than when one is not a member. As described by Cameron and Blackburn (1981), there is the expectation that in a merit-based system, such as the medical profession, the more able secures the position. This means a candidate is selected based on technical knowledge demonstrated and previous achievements and not because of the reputation of a sponsor. However, evidence from this study suggests that sponsorship by more eminent doctors is an important consideration when it comes to selections or appointments. This finding echo finding of previous studies on the importance of social networks on career success within professions. Some previous studies demonstrated the importance of sponsorship, especially from older and more prominent members of a particular social group within the profession, in relation to access and progression of younger and newer members. For example, in medicine, Hall (1951) argued that 'medical schools select students on bases far removed from their academic qualifications and that the career of the doctor is crucially dependent on obtaining hospital connections' (p. 643). Therefore, hospital connections are vital if a doctor is going to succeed within medical practice and the 'door to hospital connections lies in the realm of sponsorship of the protégé. Another study that focused on gender and medicine by Reichenbach and Brown (2004) explains gender inequality in progression in medicine through 'the institutional and cultural structure of academic medicine, which relies heavily on sponsorship and patronage' (p. 794). By and large, in medicine, the positive impacts of sponsorship and patronage on career outcomes can be demonstrated in mentoring, more promotions, higher incomes received, and more job satisfaction enjoyed by junior colleagues who receives sponsorship and patronage from senior and eminent colleagues.

As a result, medicine in Ireland can be conceived, not as composed of individual, atomised workers, but of groups and persons continually engaged in the sponsorship of members of a group and exclusion of other groups and persons regarded as outsiders. This is because access to powerful 'godfathers' can facilitate career progression for doctors with such 'godfathers'. On the contrary, doctors without 'godfathers' can suffer exclusion from career progression. As stated by a consultant of Asian origin:

We are orphans in this profession in Ireland. Nobody cares or looks after us. (Dr Burghee A.)

From the definition of career sponsorship presented earlier in the Chapter and previous discussion in Chapter Three, sponsorship and patronage could be demonstrated in many forms, such as informal mentoring in the form of offering advice; encouragement to apply for certain positions, as well as informal and formal recommendations. An acceptable practice in relation to recruitment within the labour market in Ireland is the requirement for work and personal references from prospective employees. These referees are persons who can vouch for the professional abilities and moral latitudes of the candidates. In medicine in Ireland, evidence from this study suggests that this practice is prevalent. Formal written or informal word-of-mouth recommendations from an eminent consultant vouching for the technical skills and moral standing of the candidate carries a lot of weight. Some interviewees claim they could not get positions as registrars because their consultant did not give good recommendations on their behalf. As stated by Dr X (2007, p. 196) 'one bad reference can ruin everything' in the medical profession in Ireland.

After the vital role played by recommendations was established, as perceived by the interviewees, the role of merit became the next factor that was explored. Merit warranted attention because in a technical profession like medicine, one expects the more competent to secure the job. That is, entry and progression is to be based on the demonstration of adequate clinical knowledge, technical skills and achievements and not because of the reputation of a sponsor. In the next subsection, I present some of the responses of interviewees on the place of merit within medicine in Ireland.

Selection Process, Merit and the Integration of IMGs into the Medical Profession in Ireland

Responding to the question on meritorious selection and sponsorship for promotion within medicine in Ireland, the views of interviewees differ. All interviewees acknowledged sponsorship as an important part of the selection process in Ireland. 19 out of the 27 interviewees believe that in most cases of selection for training and appointments into consultant positions, sponsorship counts more than merit. The remaining 8 interviewees claim there are more principal factors that can contribute to the successful integration of an IMG, other than sponsorship. An IMG of African origin who is now a consultant thought that even though recommendations from an existing consultant is requested by the selection committee or appointment board, it is the Curriculum Vitae of the candidate that matters most. She argues that:

One thing IMGS do not understand when it comes to selection into a registrar or a consultant's post is that it is not only technical skills that matters, other soft skills are equally important. For instance, your attitude is very important. Besides, when competing for the position of a consultant, do you have any research done? What is the quality of the training you received? And how well have you prepared yourself? All these factors count towards selection. (Dr Ikechi M.)

Another doctor, originally from the Middle East explains that the:

Selection process, to a very reasonable extend is fair. The problem is the inability of IMGs to access training posts or secure jobs in hospitals that offer quality experience and training to junior doctors. For example, IMGs move from one local

hospital to another local hospital. Then, you have an Irish doctor who moves from one urban hospital to another. When there is a vacancy for a superior position, who do you think is going to have the best CV? The Irish doctor, of course! He has worked in renowned and respectable hospitals. (Dr Akbar. H)

This perception is corroborated by another African IMG who is now a consultant. He says:

…the selection process for the position of a consultant in Ireland is based on merit even though, references from previous employers and consultants count. It is basically a doctor's knowledge of medicine and achievements that gets the doctor the job of a consultant. The problem is many foreign doctors are caught up in service posts that do not give room for improvements. They moved circularly from one local hospital to another without access to training available in teaching hospitals and without time for research and publications. The impacts of these factors on their CVs are negative. So, when an opportunity arises, a doctor with the glossiest CV gets the job. This is what the Irish candidates know from the beginning and they go out to acquire experience in prestigious hospitals in the UK, USA, Canada and Australia. Then, when the opportunity arises, an Irish doctor with those experiences will get the job.

Another interviewee of Middle Eastern origin puts it more succinctly:

Many IMGs do not understand the system. They do not understand that it is not only their qualifications from their home countries that matter. The system works on what I describe as PCCAP. PCCAP means Professional and Cultural Competence with Attitude and Personality. Your PCCAP opens the door to progression. It knocks off every form of bias and barriers. (Dr Maturi O.)

The quotes above highlight another aspect of the processes and practices that influence the professional integration of IMGs. This aspect highlights the impact of the attitude and personality of an IMG on his or her ability to access and progress within medicine. The question here is, is the IMG a good fit with the existing team? This point acknowledges the vital role soft skills play when it comes to the professional integration of an IMG. As a result, the lack of access to vital information about acceptable attitudes combined with stereotypes held by senior colleagues, as perceived by interviewees, can be the basis of unfavourable career outcomes of IMGs when compared with members of the dominant group. An interviewee refers to this inability of IMGs to access vital information that will impact positively on their career progression as 'being thrown into a blind *cul-de-sac*'.

Evidence from this study indicates that references from senior doctors are vital for junior doctors seeking to advance their careers within the medical field in Ireland. Consequently, doctors without access to powerful sponsors may not be able to advance like their counterparts with powerful sponsors. Besides, members of the dominant social group within medicine in Ireland with access to eminent sponsors and patrons can monopolise opportunities for advancement by closing off opportunities to an IMG, who merits such a position on the basis of qualifications and clinical experience, but is perceived as an outsider. Furthermore, recommendations from sponsors and patrons, other forms of sponsorship such as informal mentoring in the form of offering advice and encouragement to apply for certain positions, were mentioned by interviewees as closure strategies too. The next sub-section discusses other forms of sponsorship and patronage and how the

interviewees perceived them as being utilised as closure strategies within medicine in Ireland.

Other forms of Sponsorship and Patronage as Closure Strategies within Medicine in Ireland

There are several challenges faced by foreign doctors in Ireland. I think the biggest challenge besides, the inability to get on the training posts is the lack of mentors and mentoring. One opportunity an Irish doctor is likely to have over an IMG is a mentor who will tell him what, when and how to do within the profession. Many IMGs came and we became lost in the system because they have no mentors or guidance. (Dr Akhmad J.)

… Fortunately, you (referring to me, interviewer) are in academia. So you know the importance of research, working with eminent professors and publishing with them, etc. it is still like that within medicine. Who you work with and the type of advice you get from him or her, matters. Just because you are a foreigner, some consultants sometime assume you are here to make money and not get training. Or maybe they just behave like that. Such consultants will never encourage you to engage in professional development. (Dr Gboyega A.)

Sponsorship and patronage can be demonstrated in many forms. Informal mentoring in the form of offering advice and encouragement to apply for certain positions can amount to inclusion for doctors who enjoy this privilege, but the exclusion for doctors who are not privileged to have access to such mentors and patrons, as perceived by the two doctors quoted above. According to the evidence available from this study, career sponsorship within medicine in Ireland can take the form of a senior and more established doctor giving some more junior doctor opportunities to be exposed to and engage in challenging assignments, career counsel and coaching that may lead to career advancement. These findings align with findings of existing research in academia on academic careers and progression. These findings suggest that after controlling for several demographic factors, education, and organisational variables, individuals who reported having more extensive mentoring received more promotions, had higher incomes, and were more satisfied with their career (Wayne, Liden and Kraimer, 1999; Chao, 1997; Chao, Walz and Gardner 1992; Whitely, Dougherty and Dreher, 1991 and Dreher and Ash, 1990). Additionally, the outcome of this study supports the findings of Reichenbach and Brown (2004) in their work, *Gender and academic medicine: impacts on the health workforce.* In this work, it was explained that gender inequity in promotion within academic medicine in the USA results from an 'institutional and cultural structure of academic medicine, which relies heavily on sponsorship and patronage' (p. 794). They concluded that:

Medical school faculty and practitioners serve as informal and formal gatekeepers; they influence students' selection of specialty and serve as mentors, grooming students for careers in clinical or academic settings. A plausible explanation for gender disparities in promotion is that women have fewer mentors and professional networks and less collegial support while in the academic medical system (Reichenbach and Brown, 2004. p. 794)

However, it is important to note that when interviewees were asked about how well existing consultants, who are IMGs, provide mentoring to other IMGs who are junior doctors, there was a

near unanimity that such mentorship is nearly non-existent. Some interviewees claim that there is no way those minority group consultants can provide mentoring because many of the junior doctors are already on a career path that does not facilitate progression. A few others claim that consultants who are IMGs are worse off than their white Irish counterparts, when it comes to closing off opportunities to other IMGs. According to an interviewee:

> This consultant thing is like the mafia or a secret cult. As soon as they get in the door, they join the group of other consultants who becomes thin gods. Sometimes, I feel they even distance themselves from you more than the Irish ones. (Dr Bambo I)

Another interviewee explained that:

> Migrant consultants are toothless bulldogs. They are still subjected to the caprices of the senior consultants who sponsored them. So, they can't do anything. (Dr Bambi A.)

The quotes above by interviewees suggest that as some IMGs progress and become consultants they distance themselves from those lower in the hierarchy and take on the characteristics of the existing group of consultants? This point agrees with Clarke (2010) who, in his analysis of the Russian labour market, stated that 'in accepting a job based on patronage, the supplicant is immediately accepting his or her subordination in a relationship of dependence, marked by mutual obligations of loyalty and trust that may persist for a lifetime' (p. 496). However, one interviewee made an interesting point about the cultural heterogeneity of IMGs, which in some cases serve as the basis of mistrust amongst them and contributes to an inability to cooperate. According to him:

> … this notion of IMGs is misrepresenting. It makes it appear as if they are a monocultural and homogenous group. No, there are too many nationalities within this group that uniting and assisting each other is nearly impossible. Can I tell you the truth? There is so much in-group division and fighting that an Indian doctor sees him or herself as superior to a Pakistani doctor. A Pakistani doctor also believes he is superior to the African and so on. So, what happens is a Pakistani doctor may not be able to provide mentoring to a Nigerian junior doctor or vice versa. (Dr Adegbola K.)

The perception above was captured by researchers considering inter-group cooperation amongst migrants. For instance, Harrison, Price and Bell (1998), in their analysis of the impact of diversity on group social integration within workplaces, argue that members of different ethnic groups always distrust each other. This distrust provokes competition from the dominant group within the in-groups and the tendency for such groups to show less affiliation and commitment to each other. As a result, one member of a particular ethnic minority group may find it difficult to trust a member of another ethnic minority group even when they are from the same country.

On the contrary, when consultants, who participated in this study, who are IMGs were confronted with this claim of not offering mentorship or sponsorship to fellow IMGs, they all claimed they are doing their best. They claimed the system chokes their efforts and in some cases, many IMGs are too steep in their ways to be easily mentored. One interviewee consultant, who claims to be the first non-national specialist in his specialty in Ireland, claims:

Many IMGs come in without any sense of vision of purpose. The question I ask new IMGs is where do you see yourself in the next 5-10 years and how do you get there? While many responded they wanted to become a consultant. Most times, there are no clear plans mapped out. So, how do they achieve it? (Dr Emmanuel, E.)

The quote indicates the IMGs who are consultants are open and willing to supporting IMGs who are junior doctors. However, they are doing it from within the existing system, not by attempting to change the existing system.

Further, in support of the efforts of consultant IMGs, another consultant of Asian origin mentioned that in the bid to create a network of IMGs to facilitate access to information and mentoring by more experienced and senior colleagues, they founded an association called, *Overseas Medics of Ireland*. According to this interviewee, *Overseas Medics of Ireland* was founded to provide information and practical assistance where possible to foreign trained doctors in Ireland that would help solve problems in their professional and domestic lives. This claim speaks to the evidence that they have actually put structures in place to help support IMGs to progress.

Another interviewee claimed that some IMGs just do not listen to advice. She explained:

I have on several occasions mentioned to foreign doctors who are just coming into the system the importance of further training, no matter how hard. Even if they have to use their annual leave to do it via distance learning to do it, they must do it. That is what I did myself. I paid to train myself because I was in the service post. I was working full time and I was studying. I told them the central role research plays in medicine and how to get ahead. But sometimes, maybe they do not intend to stay or they think magic will happen? I do not know. They refuse to engage in these professionally productive activities. (Dr Ewatae. H)

This last argument was countered by an interviewee who sighted the practicalities of the workload of junior doctors as a considerable barrier to them engaging in research activities. She said:

How do I do research or register for a course in the UK, when I work 30 hours straight with 24 hours break.

It is no longer news that most junior doctors in Ireland work more than the maximum forty-eight-hour work week directed by the European Commission in the EC Working Time Directive 93/104/EC[41]. There is a serious contention by junior doctors of this violation of European Commission Directive by the Health Service Executive (HSE) in Ireland. As far back as 2007, doctors such as Dr X (2007) had decried the practice within Irish hospitals where junior doctors work long hours. He claims that working long hours by doctors, result into sleep deprivation and fatigue that reduces their efficiency and increases the probability of committing clinical errors (p. 137). Since IMGs makes up 24% of junior doctors not in training (Medical Council, 2014) who are likely to engage in such precarious job arrangements, it can be suggested that non-compliance with the EC Working Time Directive prevents IMGs from fully integrating into the professional medical field in

[41] This Directive basically provides that workers are prohibited from working, on average, in excess of 48 hours for each seven-day period. This does not mean that a working week can never exceed 48 hours; it is the average calculated over a six-month reference period that is important.

Ireland. As claimed by some interviewees, it is being used within the profession as an instrument of exclusion to keep IMGs too busy to develop themselves professionally. According to an interviewee:

> This is a means of keeping you out of competition. You are kept so busy that you cannot develop yourself. What you are busy doing is working long hours and keeping up with a professional competency requirement every year. There is no professional development. This means, when the opportunity comes up, you cannot compete with Irish doctors who are in training positions, do not work such long hours and are encouraged to develop themselves, socially and professionally.

Conclusion

In conclusion, evidence from this study suggests that even though formal selection procedures that rely on merit exists within medicine in Ireland, an informal procedure that relies on informal networks, sponsorship and patronage also exists. The inability of many IMGs to access this informal social network of membership of the dominant social group, identified by the interviewees as 'white', Irish/European and mostly male, can prevent IMGs from fully integrating into the professional medical field in Ireland. IMGs, often, cannot acquire sponsors and patrons because access to such sponsors and patrons requires access to a socially closed network of consultants within the profession. Furthermore, the inability of IMGs to access this network prevents them from gaining access to information that would help foster career advancement or mentoring that will lead to career success. Finally, evidence in the study suggests the requirement for recommendation from eminent sponsors to be appointed into desirable and positions with high social status within medicine in Ireland can be exclusionary and the lack of knowledge of accepted workplace culture and attitude is perceived by interviewees as impeding on their ability to fully integrate into the professional medical sphere in Ireland.

Roles of Social and Informal Networks, Sponsorship and Patronage on Professional Integration of IMGs in Medicine in Canada

One thing interviewees kept mentioning in Canada is the importance of access to information prior to and upon arrival in Canada to the career success an IMG. It was unanimously agreed by interviewees that, in as much as the greatest impediment to professional integration IMGs in Canada is licensure, then, more emphasis must be placed on getting an accurate picture of the career pathways of Canadian medicine prior to arrival in Canada. How does an IMG get this? All interviewees agreed that informal social networks play a vital role. A friend already practicing in Canada, sends information out to a friend planning to migrate to Canada to practice, about licensure requirements. At the moment, IMGs waiting to be licensed are being proactive in changing and influencing the system. They have formed networks to exchange information and even influence government policies in the area of recognition of international qualifications and increasing residency spots allocated to IMGs. Prominent amongst these IMG groups are the *Association of*

International Physicians and Surgeons of Ontario[42]; *The Alberta International Medical Graduates Association*[43] and *The Manitoba International Medical Graduates Association*[44].

Besides the importance of access to information prior to arrival, a few interviewees also acknowledged the importance of access to information on navigating the system after licensure. According to an interviewee of African origin:

> … one of the greatest challenges preventing IMGs from fully integrating into the medical profession here is lack of cultural competence amongst IMGs. Many IMGs don't understand the Canadian workplace culture, such as communication, inter-personal relationships with clients and colleagues. Here there is the saying here in Canada, 'technical skills get you hired, soft skills keep you hired'. And one thing about cultural competence is, if you don't tell me, I don't know. So, there must be some forms of mentoring through which this vital information will be passed on to IMGs (Dr Ahmed K.)

Judging by the statement by Dr Ahmed above, we can easily deduce that informal networks are an important part of professional medicine in Canada because they provide members with information prior to arrival, works towards influencing the system and informs IMGs on acceptable codes of behaviour within workplaces. Consequently, the inability of an IMG to access informal networks in Canada can amount to exclusion or prevent integration into Canadian medicine because such an IMG may be unable to access that vital information of acceptable work practices and ethics. According to an interviewee of African origin in Alberta, the greatest challenge facing IMGs in Canada is a lack of information about the system. According to him, because the system is complex and the fact that different provinces operate on different rules, it is vital for an IMG to have access to one or more informal network within Canadian medicine to be able to navigate the system successfully. The interviewee went on to tell the story of his successful integration into Canadian medicine as a result of his ability to link up with old colleagues who migrated earlier and had already integrated into medicine in Canada. He narrated:

> … I don't know where people get the idea that Canada excludes IMGs from! The failure of most IMGs to become licensed is due to their failure to seek accurate information and plan ahead prior to migrating to Canada. I did my homework, contacted friends for information, searched websites and made countless phone calls requesting to know how the system works, before coming to Canada. I was advised by a friend to write qualifying exams before migrating. So, I wrote and passed all my exams before my arrival in Canada. Also, I already had a residency spot before packing my baggage and

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[42] *The Association of International Physicians and Surgeons of Ontario (AIPSO)* based in Toronto 'is a non-profit, independent professional association which represents physicians and surgeons trained and licensed in jurisdictions outside Canada. AIPSO's mission is to ensure that internationally-trained physicians are integrated effectively and equitably into the Canadian health care system (AIPSO, 2015). Amongst the objectives of AIPSO is the provision of information to members on licensing and meaningful employment in the healthcare field and facilitate access to the licensing process for internationally trained physicians in Canada.

[43] The *Alberta International Medical Graduates Association (AIMGA)* consists of doctors trained or educated in countries other than Canada. It also includes individuals and organizations interested in the various challenges facing International Medical Graduates in Alberta. It renders support to IMGs in the form of information about policies and issues that face IMGs.

[44] The Manitoba International Medical Graduates Association aims at supporting international medical graduates (IMGs) in the path to become licensed to practice medicine in Manitoba.

saying I am migrating to Canada. And since my arrival 10 years ago, I have never experienced any form of barrier. Life is not a bed of roses. People must be prepared to work hard and be patient. I have worked hard and now I have my own family practice here in Alberta. (Dr F. A)

Another interviewee of African origin stated that:

The bible says, 'my people perish because of lack of knowledge'. It does not say because the medical profession is closed to IMGs. What I tell Nigerians aiming to practice in Canada is, seek knowledge about the system before you migrate. The system is different from that of Nigeria and the only way to beat it is, to know it inside out by reading about it and asking questions from those who are already in it. (Abel. F)

The above quotes highlight accessing adequate information about the career structure in medicine in Canada as a prerequisite to the career success of an IMG in Canada. Access to this information can be through formal or informal social networks. As mentioned earlier, social capital theorists, Podolny and Baron (1997) reiterated the significance of social relations in relation to career progression within organisations. They claimed that, a 'pattern of social relationships is a meaningful determinant of an individual's fate, including intra-organizational advancement' (p. 689). As a result, the significance of informal social networks cannot be overemphasised within the profession of medicine in Canada. Sadly, lack of access to such informal social networks by IMGs was identified as a major barrier to their professional integration. Although, IMGs have tried to put a lot of effort into creating their own networks, evidence from this study reveals there is still a long way to go in solving this problem completely. It is important to mention one thing that stands out in Canada and that was not really evident in Ireland during the research. It is the role of the Canadian government-sponsored and non-government organisations in providing much needed information and support in the form of mentoring and career guidance to IMGs in Canada. For example, there is the *Health Canada's Internationally Educated Health Professionals Initiative (IEHPI)*. This initiative aims to facilitate the 'integration of internationally educated health professionals into the Canadian health workforce by increasing access to assessment and training programs' (Health Canada, 2015). Through the IEHPI, the Government of Canada 'works with the provinces and territories, the health regulatory authorities, post-secondary institutions, and professional associations to help more internationally educated health professionals to put their skills to work in Canada's health system'. Another project of note is the *Health Force Ontario's Access Centre*. This center was funded by Ontario's Ministry of Health. It provides a one-stop-shop for newcomer health workers, including IMGs, to find out more about practicing their profession in Canada. Additionally, the *Catholic Immigration Centre* in Ottawa, Ontario, offers *Medical License Bridging Program*. International medical doctors (IMDs) can take this programme to gain more knowledge about Canadian medical practice. The programme provides medical communication training, health care culture training and

helps students become familiar with the Objective Structured Clinical Examination (OSCE)[45]. All these programmes are state funded and proactively attempting to fill an information gap for IMGs. Subsequently, evidence in this study suggests access to informal social networks and vital information is crucial when it comes to successful integration of IMGs in Canada. This finding is consistent with the notion that social networks can act as labour market intermediaries for immigrants (Cutler, Glaeser, and Vigdor 2008). It is, however, significant to acknowledge the dissimilarity observed in this study between Canada and Ireland in relation to the acknowledgement of lack of vital information as a barrier to the professional integration of IMGs. According to interviewees in this study, the government of Ireland is yet to acknowledge lack of vital information as a barrier to the professional integration of IMGs into medicine in Ireland. Contrastingly, in Canada, the government acknowledges this barrier and has already put in place some initiatives to deal with this barrier. Some of the successes of these initiatives were mentioned by interviewees, although, many interviewees claim there is still a lot to be done. In fact, I attended the November 23rd, 2011 *Health Canada IEHPI Policy Roundtable*. This Roundtable, attended by health workers, IMGs, Health employers, different stakeholders and health workforce observers acknowledged that access to vital information will help IMGs navigate the cumbersome medical career path in Canada. They all agreed that lack of adequate information prior to arrival and inability to access mentors, especially mentors who will guide an IMG through organisational cultural practices, are some of the greatest barriers to the successful integration of IMGs into medicine in Canada.
Surprisingly, during this roundtable meeting, other factors such as sponsorship and patronage and their roles in the professional integration of IMGs were not mentioned. This made me ask interviewees if sponsorship and patronage play any significant role in the professional integration of IMGs in Canada. The responses of interviewees to the significant role played by sponsorship and patronage within medicine in Canada is presented in the next subsection

Sponsorship, Patronage and Professional Integration of IMGs in Medicine in Canada

The question that, besides merit, does having a powerful sponsor have any significant impact on the career prospect of an IMG within the medical profession in Canada, received a near consensus, 'No', as a response from interviewees. 17 out of the 21 interviewees said no, that it is irrelevant, while the remaining 4 interviewees said it can be relevant and advantageous, especially, if one chooses to go into academic medicine, post licensure. Academic medicine, according to the *United Kingdom Royal College of Physicians,* refers to the field of medicine that deals with the discovery and development

[45] An Objective Structured Clinical Examination (OSCE) is a performance-based test which allows for the standardized assessment of clinical skills. During an OSCE, candidates are expected to perform a variety of clinical tasks in a simulated setting while being assessed by examiners using standardized rating instruments (MCC, 2014. p. 4).

of basic principles, effective policies, and best practices that advance research and education in the medical sciences, ultimately to improve the health and well-being of individuals and populations (RCP, 2015). According to the interviewees who claimed that sponsors are unimportant, Canada is a level playing field for everyone that is licensed. As explained by an interviewee:

I started my career in the UK where the requirement for a sponsor is vital to your career success as a young doctor. Here in Canada, unlike in the UK, where there is a lot of preferential treatment based on who you know, and whether you are a 'White' English or a 'Black' IMG, once you have the Canadian experience here, there is no discrimination. There is no need for anybody to sponsor you. All you need is the ability to properly sell yourself. (Dr Kassim, O)

Another interviewee in Canada supported this perception and stated:

When I got here, I didn't know anybody. The only thing is I did my homework perfectly from South Africa. I had already attempted and passed all my exams while I was in South Africa. I got my residency spot while I was in South Africa. And since my arrival, I have proved that I can fit in. As a result, I have been allowed to participate in all areas of my career without any fear or favour from anyone. It has always been on merit. Mind you, Canada engages with competent doctors, regardless of where they come from. Competence is different from excellence. Competence involves understanding the culture, style of communication, humility and very good personality. (Dr Femi K.)

Contrarily, interviewees that belong to the group that argued that 'godfatherism' is relevant and an important aspect of Canadian medicine, stated that sponsorship and patronage can be utilised as an inclusion or closure strategy against an IMG because members of the dominant social group try to control the numbers of people in the academic medical field. For members of this group, to become a professor, you need to engage in research and publish original papers in top medical journals. Hence, there is a high social status attached to these positions. As a result, the numbers are controlled and access to this prestigious field requires sponsorship by an existing member of the network. According to these interviewees, new and upcoming doctors need guidance and mentoring of more experienced doctors. As succinctly put by an interviewee:

Medical professorship in Canada is highly prestigious. As a result, existing researchers that have made names try to make it so hard to get into it. So, one might need what I will not call a sponsor, but will refer to as, a mentor, to guide one through the system. This mentor will guide one through the choice of subspecialties, funding applications, research and publishing of research outcomes in top academic journals, etc. (Dr Khalid A.)

As a result, according to this group of interviewees, the inability of IMGs to access the different forms of sponsorship or mentoring available to members of the dominant social group impedes their ability to fully integrate into medicine in Canada. According to them, if an IMG has access to a robust support system, such as support for research jobs and availability of collegial support, there is a high probability for such an IMG to professionally integrate. However, when such a system is absent, the IMG may not be able to fully integrate into the system.

As mentioned earlier, professions, such as medicine are expected to be meritocratic because it is a profession that is assumed to be knowledge based. That is, a candidate is selected on the basis of his/her technical knowledge, clinical ability and previous achievements and not on the basis of the

reputation of candidates' sponsor. Evidence from this study suggests that although, selection is based on formal selection procedures and merit is an important aspect of these procedures in Canada, mentoring and both formal and informal also guidance play vital roles. However, it strongly indicates that academic qualifications and clinical achievements still take pre-eminence over formal and informal recommendations by powerful sponsors and patrons. This does not mean previous work references are not required, it only means technical skills take the center stage.

On the contrary, according to evidence from this study in Ireland, sponsorship and patronage play important roles in the process of selection, especially of a consultant. Interviewees claimed that even though, there is a structured interview process when it comes to the appointment of consultants, sponsorship from an existing and eminent consultant is crucial to becoming a successful candidate. Evidence from the study shows that in Ireland, references from senior doctors are vital for junior doctors seeking to advance their careers within the medical field. While, in Canada, mentoring, provided formally or informally, in the form of providing advice and counselling about career options and choices, guiding, and educating new IMGs on workplace culture proves to be central to the professional integration of IMGs into the profession of medicine. Can we then say that merit is the most crucial factor in the selection process in Canada? The next subsection presents how interviewees perceive the selection process in Canada in retain to merit.

Selection process, Merit and IMGs in the Medical Profession in Canada

Responding to the question on meritorious selection and sponsorships from more senior and eminent doctors for promotion within medicine in Canada, many interviewees stated that from their experiences, the licensure process is not meritorious. According to an interviewee, there is formal and institutional discrimination based on country of schooling, at the point of entry to medical practice in Canada. They consider that, if merit is supposed to be based on performance, then, medicine in Canada does not operate on merit at the licensure point. What counts is where you obtained your medical degree. Canadians are sorted first before anyone else. However, there is a near unanimity amongst interviewees that as soon as you can get through licensure, selection becomes meritorious. They claim the system provides you with both technical and soft skills to successfully integrate. I was told that in many medical settings, cultural competence training is part of the induction package for IMGs. This, they claim, is setting the stage for integration professionally. Post-licensure, the experiences and perceptions of IMGs who previously practiced in Ireland gave a rich point of comparison. According to this group of interviewees, after licensure in Canada, merit takes precedence over everything. They claim personal references are not required, but only work references. According one interviewee, comparing his experience in Ireland to that of Canada, he stated:

… yes, it can be a little difficult getting licensed here in Canada, but you know if you are lucky to become fully licensed, your

success does not depend on towing the line or being a 'yes' man to any consultant. In Ireland, besides the discrimination in relation to training and service posts against IMGs, there is this sad reality of IMGs and most junior doctors living in awe of consultants. In fact, there is this consultant in a hospital I once worked in Ireland who throws chart at IMGs and curse and swear at them. Yet, they must take those humiliations because they need his recommendation. This can never happen in Canada. (Dr Aboderin J.)

Another interviewee said this about the role of merit in the selection process in Canada:

If there is going to be any recruitment, the hospital management strives to employ the best man for the job. Who has the right skill and attitude for the job gets it. Who you know does not matter. If you know me, probably, what I can do for you is tell you there is a job opening in my workplace. If I recommend you, and you do not have what it takes, forget it. This is completely different to Ireland, where even before interviews sometime, you already know that a doctor is tipped to be selected because of his affiliation to some other consultants. (Dr Ahmed A.)

According to another IMG who previously practiced in Ireland, but now practices in Canada commented that:

Canada is completely unlike Ireland. Ireland is rife with favouritism and cronyism. What you know does not matter most of the time and moreover, the barrier was set to prevent IMGs from competing adequately from the beginning anyway. Here in Canada, everything is dependent on what you know. The place where you experience slight difficulty is getting licensure. As soon as you are able to get past that, the field is a level playing ground for everybody. (Dr Bello A.)

Evidence from the experiences of these interviewees and that of many others about the selection process within Canadian medicine in the study suggests candidate's curriculum vitae and previous employment references are all that matter when competing for positions. However, some interviewees are concerned about lack of transparency about the job posting, which stems from a Canadian practice culture amongst physicians, leading to an unwillingness to share resources. Therefore, unlike in Ireland, where many IMGs perceives the system as unmeritorious and unfair to them. Many of the interviewees in Canada argued that the licensure process in Canada is not meritorious. However, post-licensure processes of selections and appointments into positions are reasonably meritorious and fair. Consequently, it can be suggested that factors such as national origin of an IMG's primary medical degree, knowledge of Canadian workplace culture and personal attitudes can be more important in the professional integration of IMGs than the backing of an assumed eminent sponsor. However, a few interviewees claim, being a Canadian of whatever ethnic origin makes a difference when it comes to becoming licensed because Canadians are always considered first. Moreover, other factors besides informal networks, sponsorship and patronage and merit are regarded as obstacles to the professional integration of IMGs into the Canadian medicine. What are these other factors and how do they impede the professional integration of IMGs?

Other forms of Sponsorship and Patronage as Closure Strategies within Medicine in Canada

As discussed earlier in relation to Ireland, sponsorship and patronage can be demonstrated in many forms such as informal mentoring in the form of offering advice; encouragement to apply for certain

positions as well as informal and formal recommendations. Similarly, according to some interviewees, within academic medicine in Canada, access to more experienced colleagues who can guide and provide vital information on how the system works, where funding is to be sourced, and what are acceptable attitudes, can prove advantageous in relation to professional integration of IMGs. Contrarily, doctors without access to mentors who can give them guidance on how to navigate the medical career pathway and how the system works can suffer exclusion from career structures that facilitate progression within the profession. However, generally within medicine in Canada, many interviewees believe besides the initial hurdle to access practice, entry and progression is based on the demonstration of adequate clinical knowledge, technical skills and achievement and not necessarily based on the reputation of a sponsor.

Another factor mentioned by some interviewees in Canada is ignorance of the culture in Canadian healthcare setting. According to an interviewee, ignorance of the system impedes professional integration. She stated:

One of the biggest challenges to integrating into the Canadian healthcare workplace is cultural differences. Most times, cultural practices are different between IMG's home country culture and Canadian culture. For example, around communication, when I was in Pakistan, the doctor does not need to talk much and s/he does not need to respect his/her client. Here in Canada, detail of everything needs to be communicated to the patient and the doctor cannot be condescending to the patient. So, if a Pakistani doctor now practices in Canada and does it the Pakistani way, he/she cannot go far.

However, unlike in Ireland, where many interviewees claimed they are thrown into workplace cultural deep end without any form of support, in Canada, as mentioned earlier, interviewees claimed there are quite a few supports in place to assist IMGs integrate into the medical profession although, more effort is needed to be done. I was once again informed of the existence of associations such as *The Association of International Physicians and Surgeons of Ontario (AIPSO)* based in Toronto; *The Alberta International Medical Graduates Association (AIMGA)* and *The Manitoba International Medical Graduates Association*. Besides, many interviewees claim there are a few mentoring programmes in their workplaces that are aimed at encouraging them to fully participate in every aspect of the profession in which they may be interested. Some claim these mentors do not necessarily have to be members of their ethnic group. Moreover, many claim that the fact that Canada has large migrant communities and many Canadians have migrant backgrounds makes it a unique place. Even though the Anglo-Saxons and Franco-phonies are still dominant, there are other large ethnic groups as well. So, what happens is workplaces encompass nearly all ethnic groups in Canada, therefore, no group, in most cases, can claim absolute domination. According to an interviewee who migrated originally from the Middle east and works in a hospital in Ottawa, as well as lecturing in Ottawa University:

In the hospital where I work, everyone looks after everyone. To be sincere, there is no majority ethnic group. Although,

'white' doctor may be numerically many than other visible minority doctors, we are all equally important. The message the hospital sends out is, we are all part of a team and we are all equally important

Conclusion

In conclusion, evidence from this study suggests that even though a formal selection procedure that relies on merit exists within medicine in both Ireland and Canada, an informal procedure that relies on informal networks, sponsorship and patronage also exists. In Ireland, sponsorship and patronage in the form of formal and informal face-to-face recommendation from more senior and eminent consultants are perceived by many interviewees as crucial to the career success of an IMG. Although, a few interviewees believe that merit, dedication to one's work and careful career planning are more crucial than recommendations from the consultant. As for Canada, all interviewees believe the system is biased at the entry point against IMGs, but fair and meritorious post-licensure. A few interviewees dissented with this perception. They claimed 'godfatherism', favouritism and cronyism may not be as pervasive within medicine in Canada, as it is in Ireland. However, there are still elements of sponsorship and patronage, especially, in academic medicine in Canada. They argued that even though what an IMG knows matters, who an IMG knows and the information an IMG has about specialties, available funding, job postings, etc. are also crucial if an IMG is going to fully integrate into the medical profession in Canada. Therefore, the central roles, access to informal networks, sponsorship and patronage plays in determining career success of IMGs make these notions valuable as strategies of professional closure. In other words, these processes can be utilised by the dominant social group within medicine in Ireland and Canada to close off opportunities to IMGs who are deemed to be outsiders. All that needs to be done is deny IMGs access to social networks and powerful sponsors and patrons.

Chapter Nine

The Impacts of Race, Class and Gender on the Experiences of IMGs in Medicine in Ireland and Canada

Introduction

Do race, class and gender influence career outcomes of IMGs in Ireland and Canada? This is a question that is relevant today because evidence from studies around the world suggest that a doctor's ethnicity, social class and gender may shape the everyday professional experiences of doctors (see Naaz, 2001; Esmail and Carnall, 1997; Coombs and King, 2005). In this study, the question is, do race, class and gender have any effect on the professional integration experiences of international medical graduates within medicine in Ireland and Canada?

In 2001, a report published by the London based health charity, King's Fund, shook the medical world. That publication, edited by Naaz Coker, titled: *Racism in Medicine: An Agenda for Change,* shed light on the experiences of minority doctors in the NHS, about racism. All the contributors to the report indicted that the medical profession in the UK was racist. The editor, claimed discrimination against ethnic minorities within medicine in the UK begins in medical school and 'lasts till the day they retire from practice' (Naaz, 2001. p. 6). Also, in the words of the editor, as quoted by John Carvel of the online version of the Guardian newspaper, 'no aspect of a doctor's working life is untouched by racism. Discrimination begins in medical schools and affects the whole of a person's career' (Carvel, 2001. 19th June).

On the impact of race on the career progression of IMGs in the US, several studies claim the selection process into postgraduate medical training and some medical specialties such as psychiatry and internal medicine, is marred by racial bias against IMGs (see Desbiens and Vidaillet, 2010; Nasir, 1994; American Psychiatric Association, 2001).

As well as claims of racial inequality within the medical profession, there are claims of gender inequality at the higher echelons of the medical profession in Ireland, the UK and USA. For example, in Ireland, Meghen et al. (2013) claim there 'appears to be a deficit at specialist level with a greater than 2:1 ratio of males to females. They also state that in academic medicine, women physicians have not substantially ascended to professorial positions (p. 2). In the UK, Sandhu, Margerison, and Holdcroft (2007), reviewing academic medical workforce data from 2004 to 2005, identified that only one in ten medical clinical professors in the United Kingdom were women. In the USA, Stratton et al. (2005. p. 400) revealed that across all specialties, more women than men experienced gender discrimination and sexual harassment during residency selection.

Another area where the medical profession has been scrutinised in recent times is that of the social

status of candidates entering medical schools and doctors progressing within medical practice. Several studies in the UK have considered the profile of doctors both in practice and in training and concluded that people from lower social classes are underrepresented in the medical profession. A 2013 report on socio-economic status of trainee- doctors, conducted by the General Medical Council in the UK (National training survey, 2013)[46], states that people from the lower socio-economic backgrounds are proportionally underrepresented in medicine in the UK. Another progress report on fair access to professional careers in 2012 by the UK government argues that medicine in the UK can throw open its door to a far broader social intake than it does at present (Fair Access to Professional Careers, 2012, p. 3)[47].

As a result of existing knowledge on the roles of race, class and gender play within medicine globally, interviewees in this study were asked questioned about how they perceive race, class and gender as having shaped their professional integration experiences within medicine in Ireland and Canada. Therefore, this chapter presents the perceptions of interviewees on the roles race, class and gender play in shaping their experiences during access to medical practice and subsequent career progression within medicine in Ireland and Canada.

It is important to note that the relational definition of gender was drawn upon in this study. I drew on this definition to answer questions on the role gender plays in the everyday professional integration experiences of female IMGs.

In the study, race, class and gender were explored on two levels: individual/relational and systematic/institutional. The individual/relational refers to the way race, class and gender shape the everyday professional and relational experience of an IMG with their colleagues, managers, supervisors, nurses and clients. On the other hand, systematic/institutional refers to how race, class and gender shape their experiences of systemic and institutional policies and practices about access and progression within medicine in both countries. To be able to present a systematic analysis in this study, the perceptions of interviewees are presented thematically. Race is presented first, followed by class and lastly, gender. It is also important to note that the case of Ireland is presented first while that of Canada follows.

Race, Class and Gender and Professional Integration Experience of IMGs in Medicine in Ireland

As mentioned above, the experiences of IMGs as shaped by the notion of race is presented first. This is followed by class, and then, gender.

[46] http://www.gmc-uk.org/Report___NTS_Socioeconomic_Status_Questions.pdf_53743451.pdf

[47] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/61090/IR_FairAccess_acc2.pdf

Race and Professional Integration of IMGs in Ireland

As discussed in Chapter Three, the professional closure within the medical profession can occur when a dominant social group restricts the access of other social groups into medical practice especially, to the most desirable and prestigious positions within the profession on the basis of difference and otherness. This act of differentiating and 'othering' the 'others' is regarded as the axis upon which social exclusion rotates because of the social connotations attached to these groupings. According to the interviewees, within the medical profession in Ireland, the experiences of IMGs are shaped by these notions of difference and otherness because of their race, nationality and in some cases, religion. According to many interviewees, race is an important feature of the medical profession in Ireland. They claim it features in nearly every area of their career, from access through progression, to retirement. According to a consultant, discrimination based on race starts from the point of entry into the medical profession in Ireland, through medical practice, from colleagues, clients and medical and government institutions.

As mentioned earlier, the discussion is presented according to relational and systematic thematic areas. The individual/relational perspective is presented firstly. That is, experiences of racism by IMGs, from 'white', Irish and mostly Christian colleagues, team leaders, managers and clients. Secondly, it presents the experiences of system and institutions that exclude based on race, ethnicity and nationality.

Individual/Relational Experiences of Racism by IMGS

Perception of racism from colleagues by IMGs

According to many interviewees in this study, the experience of racism starts from the points of entry into professional practice through progression, to exit from the practice in Ireland. Many interviewees stated how surprised they are about the ignorance of their colleagues when it comes to issues of culture that differ from the Irish culture. Many claimed some of their colleagues have the perception that non-European culture is inferior and non-Europeans are not assimilable, culturally. A doctor originally from Pakistan, who has working in the Midlands stated for over 20 years:

> It is sad how many colleagues still see non-European culture as backward. Then they base their judgement of you on their wrong perception. For example, there was a social function for doctors in one hospital I was working some time ago. I attended the function with my wife. Could you believe, because my wife was in Hijab, some colleagues were joking with her and they asked her, 'we hope he [me] is not domestically abusing you'. I was very angry and demanded an apology, but was told it was just a banter. Can you imagine that kind of joke? (Dr Kahlid S.)

This quote shows the culture of women wearing Hijab and its associated negative stereotypes was the basis for asking the wife of Dr Khalid if she was being abused by his husband. This differentiation and othering of the culturally different as abuser/victim is the core of the new form of racism, cultural racism. As discussed in Chapter Three, the principal discourse of this mode of racism is the

use of culture instead of biology as the basis of hostility and taking exclusionary measures against non-European 'others' perceived as threatening the rich cultural fabric and identity of European nations. Subsequently, non-European 'others' were stereotyped, pathologised and criminalised like their nineteenth century predecessors (Stolcke, 1995)

Besides the reference to cultural racism, many interviewees claimed there is covert racism from colleagues, especially, when it comes to non-white foreign doctors. They claim there is the feeling of superiority expressed by some white Irish doctors. According to an interviewee of African origin:

It is obvious how segregated Irish hospitals are when you come into the hospitals. The white Irish doctors prefer to hang out with each other, while other doctors, depending on where they are from hang out with each other too. Some Irish doctors do not see black doctors as equals. They still have this colonial mindset of associating Africans with barbarity and incivility. In fact, you will be surprised to know that some still find it difficult that you are intelligent.

On the other hand, another interviewee claimed, on an individual level, some Irish doctors, especially the junior ones, do not care about where you came from or the colour of your skin. According to that interviewee, such Irish junior doctors do not believe they are superior to the non-Irish, non-western/European IMGs. The only problem such doctors have and they say it most times is:

Ireland is a small place with very few opportunities, why should we now share these opportunities with foreign trained doctors. Hence, Irish doctors should be considered first for consultant positions. (Dr Marcus D.)

According to the above interviewees, it is not because these junior doctors think they are culturally or genetically better than the IMGs. Their views originate in a sense of entitlement based on citizenship. Another interviewee, who is originally from Africa agrees with this perception and claims:

There is serious racism in Irish medicine. I came into this country for my postgraduate degree in surgery at the Royal College of Surgeon. Right from the beginning, you can see the attitude of the 'White' lecturers. We (Blacks) are treated as not-knowing anything. Even, sometimes when we ask questions, the look on the face of the lecturer is like, 'what kind of foolish question is that'. What happens then is, we stop asking questions. And sometimes, they just completely ignore you and pretend as if you are not there at all.

A few interviewees claim they believe the feeling that Africans are unintelligent is also a contributing factor to negative relational attitudes from some Irish doctors. They claim this attitudes manifest through some consultants' behaviour when dealing with IMGs who are junior doctors. According to interviewees, some consultants completely ignore IMGs and prefer to deal with nurses when it comes to being briefed about patients in the hospitals. One interviewee who cried when narrating her experience, said:

Can you imagine? It is like you are expected to fail from the beginning. I believe they set you up for failure, so they can justify their beliefs. I once worked with a consultant who did everything to destroy me. He would not engage with me and when he comes in for the ward round, he will completely ignore me. He just acted as if I was not there. The worst of it is when there are patients that he needed to be briefed as to what has taken place and so on. He just comes in and go

straight to the nurse for the brief. Can you imagine that kind of humiliation?

The evidence from the above perceptions suggest exclusion based on race or nationality operates within the Irish health system. Many interviewees who claimed to have experienced such treatment interpreted it as racism because, according to them, some Irish consultants, and some of their Irish colleagues, treat them condescendingly because of their perceived inferiority or non-entitlement to the benefits of the profession, such as progression to the position of consultant. An interviewee narrated, how a White, Irish consultant disrespects IMGs to the extent that, he throws medical chats at them. Besides, according to some interviewees, some of their colleagues think they do not deserve a position of authority because they are perceived to be intellectually inferior to the Irish or in some cases, because they are not Irish.

Another interesting finding that relates to racial image and stereotypes is the belief that the non-European/Western doctor image does not fit an accepted global image of a consultant. According to an interviewee, who thinks some Irish doctors believe the system was not made for 'every Tom, Dick and Harry', the image of a consultant matters when it comes to the image of a doctor. So, according to him:

Hospitals love to employ consultants whose international image will bring prestige to the hospital. Unfortunately, many of us, IMGs, are not perceived to possess that kind of image that is preferred by such hospitals. (Dr Bamma G.)

These findings are consistent with those of Kim (2004) on racism in the accounting profession in New Zealand. Kim claims that racial stereotyping of ethnic minorities as intellectually inferior, incapable of being outstanding persons and, sometimes, uncivilised, was the basis of their exclusion from educational, political and economic reward structures associated with competence and independence within the accounting profession in New Zealand. This finding is also consistent with theories of citizenship and entitlements. For example, Goldberg (2002) argues the modern states, each in its own way, are defined by their power to exclude (and include) in racially ordered terms, to categorise hierarchically, and to set aside. The implication of their categorisation on the basis of citizenship is, those perceived to be outsiders, are excluded from the benefits of the nation state which includes political, legal, economic and social.

Another interesting deduction that can be made from the perceptions expressed above is the modern and covert way in which racism can be perpetrated. It can include making the workplace environment toxic by socially excluding the perceived 'outsider', in this case, an IMG. Another way is devaluing through ignoring. These are modern ways of carrying out racist acts against others who are perceived as different and unwanted. Further evidence from the study, according to the interviewees, also suggest that besides covert racism, overt racism can also be at play within medicine in Ireland. The narrated experiences racism of interviewees quoted above are consistent with the description of racism by Memmi (2000). According to Memmi (2000), racists make

references to biological differences for the purposes of suppression and the establishment of certain privileges and advantages for themselves (Memmi, 2000). He further argued that racism or subjugation, not based on biological differences for the purposes of privileges and advantages, is also possible. Subsequently for him, racism is:

> a generalising definition and valuation of differences, whether real or imaginary, to the advantage of the one defining and deploying them (accuser), and to the detriment of the one subjected to that act of definition (victim), whose purpose is to justify (social or physical) hostility and assault (aggression) (p. 100).

In addition, the experiences of the interviewees quoted above suggests that the kind of racism prevalent within medicine in Ireland is based on the need to identify the other for exclusion from privileges perceived as belonging to a specific social group. Even when some interviewees try not to use the word racism, their descriptions of their experiences still depict racism. For example, a female interviewee said she will not say there is racism, but she can conveniently say, the Irish doctors are more favoured than IMGs. She claimed the doctors are preferred when it comes to rotation around hospitals. According to her, it is usually an Irish doctor who will enjoy a rotation from one prestigious hospital to another. Whereas, IMGs can expect to be rotated from one rural hospital to another. Another male interviewee said he will refrain from using the word racism, but believed the Irish doctors progress faster than IMGs. As argued in Chapter Three, racism involves the act of differentiating the 'others' from 'us' and fitting those 'others' into a box of established stereotypes so as to arrogate power to ourselves and, sometimes distribute resources. Evidence from this study suggests the IMGs experience exclusion socially and professionally because of their race and nationality through both overt and covert means.

Another aspect of the individual/relational experiences of racism by IMGs from their colleagues is that of their relationships with nurses. When asked the question about racism and their experiences with nurses, many interviewees responded that in some cases, nurses can be difficult to deal with. Some claimed that, if nurses dislike an IMG, then, they are in trouble because their pager will not stop beeping. An interviewee claimed nurses have this idea that IMGs do not deserve to be in their positions. According to this interviewee:

> From my experience, I think some nurses assume we are doctors not because we are very intelligent, but because the academic requirements to become doctors in say Africa, where I came from is not as high as in Ireland. So, there is this feeling of, you are not intelligent than us, you are just fortunate to be doctors because, in your country, becoming a doctor is not as competitive as it is in Ireland. And since many of them wanted to be doctors originally, there is this ego thing that I think made them hate us. Most time, they try to rubbish our clinical knowledge and teach us our jobs. (Dr Amadi E.)

A female interviewee from Africa supported the above argument and say there is a kind of rivalry going on between female nurses and female doctors, most especially. According to her:

> One of the hardest parts of being a black female doctor is working with white nurses. They try to devalue us and put us down. As soon as you enter the hospital, you can see the animosity. I had a terrible experience some time ago when I was

working in a hospital in the Leinster area of Ireland. It was so horrible that I nearly ran away. The nurses frustrated me so much that I lost all my confidence and self-esteem and it became a struggle to go to work daily. At a point, I thought of quitting my job and returning to Nigeria. (Dr Bambo I.)

The interviewee above is not alone in experiencing such treatments from white nurses in hospitals in Ireland. A male interviewee told me how he is being watched by nurses for signs of incompetency all the time. He said:

Most times, my clinical decision was questioned. Questioned not because the nurse wanted to positively engage in discussions that will result in better prognosis and treatment of the illness. Rather, it was usually done in a way that came across as a conscious effort by some nurses to rubbish my clinical knowledge. On an occasion, a nurse told me what I was doing was wrong in the presence of the patient, despite the fact that I was doing the right thing. I had to tell her, I was in-charge and will be responsible, if a problem arises.

He concluded by saying:

Many nurses are very petty. They are constantly waiting for you to make a mistake, and before you know what, they go straight to the consultant to report you. In short, they make life hell for us (IMGs).

Negative experiences of working in unfriendly environments such as these impact negatively on the professional integration of IMGs and on their health. As Edmond (2001, p. 6) discusses, when a person's authority is questioned, his or her confidence goes. According to her, as quoted by Das Gupta (2007):

When a person's authority is constantly questioned and undermined, it will negatively impact self-confidence… without a strong sense of ego, it can be difficult to keep going in the face of these obstacles (p. 78).

Evidence from this study suggests that race and ethnicity of IMGs affected their relationships with white Irish nurses and prevent many of them from integrating well into the profession because, the environment is not conducive enough for such ambition.

IMGs Experiences of Racism from Patients

When this question came up, the response was mixed. Five out ten interviewees claimed they got on well with patients while, the others narrated some negative experiences they have had with patients. An interviewee stated that there are two groups of patients: the enlightened and the unenlightened. The enlightened, according to her, are exposed and civilised because of travel. Consequently, they are nice and do not see you as different in that sense. On the other hand, the unenlightened ones are closed-minded, untraveled people. She claimed this group of patients even use bad languages and rain abuse on them sometimes. She said one woman once said, 'I cannot allow that 'Paki' to touch me'.

Another female interviewee who is a consultant corroborated this story with her own experience. She said:

There was a day a woman scheduled to meet the consultant came in and, as the consultant, I was to see her. As I came in, I was trying to introduce myself, but she just cut in and said she did not want to see a nurse. Then, I told her I am a doctor and I will see her. She really became uncomfortable and you would see it on her face. She demanded she wanted to see

the consultant as she will not see me. I then surprised her, I said, I am the consultant. (Dr Chukwudi, A.)

This type of story was corroborated by another interviewee of Asian origin. The interviewee has this to say:

I was working in this hospital in the Munster region of Ireland. A man was brought in and I was paged and as soon as I came in, I heard him say, I will not agree to that 'Paki' treating me. (Dr Mensah, O)

The experiences of the interviewees quoted above suggest that even though, many interviewees have pleasant experiences when dealing with white Irish clients, half of the interviewees claim their experiences of dealing with Irish clients are not that pleasant. All the interviewees who claim they have had unpleasant experiences in the study, claimed those experiences were perpetrated by older people in the forty to eighty years age bracket.

Experiences of Systemic/Institutional Racism by IMGs with Medicine in Ireland

All interviewees agree there are one or more forms of institutional barriers impeding the progress of IMGs when compared with their Irish/Western European counterparts. Although, a few, three out of ten interviewees chose not to call it racism. According to an interviewee, the system is not racist, but it appears to be created for the Irish/Western European doctors because of the embargo placed on the training needs of many IMGs. He argued that there is a bit of bias not racism because the Irish doctors take precedence over IMGs when it comes to training and promotions. According to him, it is because Ireland spent money to train those doctors and moreover, IMGs do not know how to navigate the system in the form of embarking on research.

On the other hand, many interviewees claimed the profession is rife with systemic discrimination and institutional racism. As opined by an interviewee who is from Asia, on the institutional level, policies pursued by the Medical Council and the training bodies are racist. As put by him:

Racism starts from the entry point. The Medical Council puts in place racist registration criteria. That is why you see majority of IMGs, regardless of their qualification and experience, are registered in the general registration division. Then, there is racism from the training bodies. They control who gets what training, based on colour. Although, they will never agree to it, but just scratch the surface of every policy they have in place. You will be surprised to find this belief that 'intelligence belongs to the white people' still in their heads. (Dr Bambo I.)

The experience of another interviewee corroborates the perception of the above interviewees. The interviewee, originally from Africa claimed:

They don't think you are good enough. There is always discrimination on the basis of your skin colour. For example, why do they require your passport photograph if you apply for a specialist position? It is to ascertain your skin colour for the purpose of discrimination because many of us are now naturalised and some have names that could not be identified as foreign. (Dr Ahmed S.)

The evidence from the perceptions expressed by the interviewees above suggests, the act of differentiation and othering of IMGs by the Medical Council and training institutions when it comes to training positions, excludes them from the benefits and privileges enjoyed by their local Irish and

other EEA/Western colleagues can amount to racism. According to Memmi (2000), racism is when references are made to biological differences for the purposes of suppression and the establishment of certain privileges and advantages for themselves (Memmi, 2000). For him, racism is

> a generalising definition and valuation of differences, whether real or imaginary, to the advantage of the one defining and deploying them (accuser), and to the detriment of the one subjected to that act of definition (victim), whose purpose is to justify (social or physical) hostility and assault (aggression) (p. 100).

The fact that this racist mode of classification and exclusion is perpetrated at the institutional level makes it institutional racism. As mentioned in Chapter Three, institutional racism as defined by Sir William Macpherson in his report in 1999 on the shortcomings in the police inquiry into the racist murder of the London teenager, Steven Lawrence, is:

> … the collective failure of an organisation to provide appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness, and racist stereotyping which disadvantage minority ethnic people (McPherson Report, 1999)

What is new and different about the definition of racism as defined by MacPherson is:

Institutional racism is not restricted to the realm of the individuals' interrelationships. It can be a collective action or inaction. It distinguishes between people's attitudes, behaviour and long-term patterns of practices (processes).

Most significantly, his claim that racism could be unintentional (unwitting), makes organisational processes and procedures (even though not intended to be racist) that have unfavourable outcomes for some groups while favouring some groups to be racist.

Racism is not just something someone does. Rather, institutional racism is reflected in the absence of any specific implementation mechanism to examine the effectiveness of present policies and to translate the new employment equality policies into action. According to Sir MacPherson, 'it is incumbent upon every institution to examine their policies and practices to guard against disadvantaging any section of their communities' (MacPherson Report, Section 46.27).

Something that is worthy of note is the response of the government of the UK to the report of MacPherson. The report can be claimed to, undoubtedly, have a profound impact on race relations in the UK. For example, Alan Travis wrote in the online version of the *Guardian* that:

> It was Macpherson's insistence that the full force of the 1976 Race Relations Act should be brought to bear not only on the police but across the whole of the public sector. It is not released now, but until the 2000 Race Relations (Amend) Act, the police and many other public bodies, including the immigration service, were exempt from the race relations legislation. The new legislation extended protection of the law to the victims of discrimination by public bodies for the first time. It made clear that discrimination could take place indirectly as well as directly. It also placed a general duty on public bodies to promote equality of opportunity and good race relations (Travis, 2013, 22 April).

The question this study asks is, what can Ireland learn from the Stephen Lawrence report and the response of the government of UK to it? Why have we not borrowed ideas of how the UK responded

to race issues in its public service and society at large to deal with institutional practices that migrants and members of other minority groups claim to impede their career advancement?

As the evidence suggests in this study, the inaction of the government of Ireland when it comes to the inability of many IMGs to access specialist training can amount to racism. Furthermore, the claim that practices by the training bodies of disallowing many IMGS from accessing training posts as a by-product of policies to maintain the standard of care within the profession, can, according to MacPherson, amount to unwitting racism. According to him, unwitting racism makes organisational processes and procedures, even though, those policies are not intended to be racist, racist because they have unfavourable outcomes for some groups while favouring some groups. Moreover, the fact that the government continues to uphold the section of the Medical Practitioners Act 2007, which bars many IMGs because of their countries of training, from applying to the training posts, despite their acceptance into service post can amount to racism. According to Macpherson. 'It is incumbent upon every institution to examine their policies and practices to guard against disadvantaging any section of their communities' (MacPherson Report, Section 46.27). Therefore, the non-appraisal and upholding of the system that disadvantages many IMGs within the profession of medicine in the last eight years, despite the lamentation and cries of the affected IMGs, can mean that there is an element of racism in the formulation of the policy in the first place. It is important to note here that the immediate former Minister for Health, Leo Varadkar promised to remove barriers preventing many IMGs from accessing training positions leading to consultant posts (Cullen, 2015. August 17th). Well as it is, at the time of writing this thesis, it looks as if that is another political statement that pays lip service to creating equality and the present government removing the barriers?

Another important finding from this study worth noting is that only one interviewee in the study in Ireland accused the Health Service Executive (HSE) of racism. All other interviewees claimed the HSE is an equal opportunity employer, but powerless when dealing with the Medical Council and the training bodies.

The findings in this study are consistent with findings in previous similar studies in Ireland. For example, studies by Humpheries et al. (2013); Bidwell et al. (2013) and Humpheries et al. (2014) even though, they did not call it racism, all identified policies pursued by the Medical Council and the training bodies as the reason for the inability of many IMGS to progress into positions of consultant. Also in the UK, Coker (2001); Esmail (2001) and Gill (2001) all acknowledged the existence of institutional racism in medicine in the UK.

Summarily, evidence from this study suggest that institutional racism is prevalent in medicine in Ireland and besides, disallowing IMGs from progressing, it affects their day-to-day interactions with their fellow Irish doctors, impacts negatively on their emotional well-being and prevents them from

maximising their potential.

Social Class and Professional Integration of IMGs in Ireland

As mentioned in Chapter Two, Max Weber (1946) believed it is not only one's economic position that determines one's class in a society. For him, in conjunction with wealth, the amount of prestige and power one commands, also determines one's social class. According to Weber as quoted by Giddens and Held (1982), classes consist of aggregates of individuals who share similar sets of 'life chances in labour and commodity market (p. 10). Therefore, social class refers to a group of people with similar wealth, prestige and power.

According to some interviewees, within the medical profession in Ireland, social class manifests in two separate ways. Firstly, the inability of an IMG to become part of an existing social network of Irish doctors within the hospital. Secondly, some IMGs claimed that because they came from Africa or Asia, some local Irish graduates believe them to be poor. As a result, they are assumed to be incompetent medical practitioners because competence is somehow associated with socio-economic status. The argument that associates high intelligence with high economic status is highly problematic and some researches has disproved it (see Korenman and Winship, 1995; Fischer et al., 1996 and Devlin et al., 2013). Nevertheless, some interviewees think the thinking that intelligence is associated with the upper socio-economic class is still prevalent amongst some white Irish doctors. An interviewee stated:

> The perception that Africa is poor and poor people may not be intellectually capable to excel in medicine is part of the problem we face as African doctors here. I am not claiming this perception is mainstream. It is, however the perception of some doctors and I think until they know you. But, how would they know you, when you are not given the chance. There is this professor in the UK, who, in 2008, argued that people of less economic power are underrepresented in medicine because, social class correlates with intellectual ability. That, I believe some of my colleagues still believe this in their closets, even though, they would not come out to say it, because it influences their attitude towards us, especially, from Africa.

According to some interviewees, they perceive that this thinking, combined with the media representation of Africa and Africans as poor and needy is behind the feeling of superiority exhibited by some of their white Irish colleagues. The first part was dealt with in Chapter seven, when the analysis of the role of credentialism and social closure was presented. As a result, it will not be addressed again in this subsection. The second part is addressed below.

Poverty, Irish Medicine and IMGs

> The problem is the wrong impression some Irish/Western doctors have about Africa. They believe Africa is so poor and all Africans are poor. Then, in their minds, they assume, if you are poor, how do you have the intellectual ability and resources to study medicine successfully. So, at the beginning, they distrust your clinical decisions because, they assume your training must be sub-standard. (Dr Banghui K.L)

Another interviewee from Asia stated that:

In some cases, there is still ignorance amongst some Irish doctors. If you are a foreigner from outside of the West, you are assumed to be very poor. As a result, they expect you to under-perform. In some cases, they believe you do not fit in socially. So, they completely overlook you when it comes to responsibilities. You know most times, you have to kind of shout: hello! I am here! They just assume you are not just capable. That is very frustrating.

The statements above are not at all surprising. Record has it that historically, women, ethnic minorities, and male candidates from the lower economic groups were rejected and sometimes even formally banned from medical schools (Hall, 1946; Glazer and Slater, 1986; Pringle, 1998). Presently, even though women have gained some ground, and many ethnic minority persons, women and men have been accepted into medical practice, the trend is still that, persons from the middle and upper middle socio-economic class are in the majority in medicine. For example, in an article in the *British Medical Journal*, as quoted by the UK's *Daily Telegraph* (Beckford, 2008), MacManus and Hugh (2008) claimed that 'UK medical students tend to come from higher socio-economic classes, perhaps not surprisingly, as social class correlates with intellectual ability.' This supposition of MacManus and Hugh is highly contestable. Various studies have disproved MacManus and Hugh's claim. As mentioned earlier, Korenman and Winship (1995); Fischer et al., (1996) and Devlin (2013) all claimed that social class does not correlate with intellectual ability. Rather, lack of opportunities, supports and high cost associated with educational training affect people from lower social class and prevent them from competing successfully with people from higher socio-economic class. Therefore, the under-representation of members of the lower social class in medicine has nothing to do with their intellectual ability, but lack of opportunities and high cost of medical training. As a result of this perception by some white doctors, some IMGs believe the social class they are perceived to belong to, affects the way those white Irish doctors interact with them.

Using the definition of social class, as stated earlier, as a theoretical lens to interpret the professional integration of IMGs in Ireland, the evidence from this study suggests that the class some Irish doctors perceived IMGs to belong to shape their professional and social interaction with them on a daily basis. This perception of some interviewees about the attitude of snobbery from some white colleagues, agrees with the argument of Hall (2005) on the value of the medical profession. According to Hall (2005), the organisation of the medical profession has traditionally reflected the values of the middle and upper classes, because social class was a factor in the development of the profession. For example, according to Witz (1992), in 1858, Medical Registration Act was passed in Britain. This Act required physicians to pass examinations before practicing medicine. As at this point, only middle and upper class men could access university education. This resulted in the exclusion of candidates from the lower class. Similarly, about nursing, Witz (1992) stated that most health care in the pre-industrial era was provided by women to their families and neighbours, with

little or no financial reward. Paradoxically, as nursing education became professionalised and feminised, women were encouraged to go into it. However, as noted by Stuart (1993), only women from high socio-economic backgrounds could afford the training.

Likewise today, the profession of medicine is regarded as the terrain of the wealthy and people of the middle social-economic class. For example, in the UK, Greenhalgh et al. (2004) as quoted in Southgate, Kelly and Symonds (2015) found that school students from lower socio-economic class backgrounds, viewed a medical career as the domain of 'posh' people and under-estimated their chances of admission and of finishing the degree (p. 74). Further, in the UK, Mathers and Parry (2009) in their study found that students from working class backgrounds possess a sense that pursuing a medical career would threaten working class identity. Another study by McHarg, Mattick and Knight, (2007) found that prospective medical students from lower socio-economic background were discouraged on the basis they 'are not doctor material' (p. 815).

In Australia, a study by Southgate, Kelly and Symonds (2015) elucidated why students from lower socio-economic classes and who may be first in their family to enter university continue to be under-represented in medical schools. They found that students from lower socio-economic status backgrounds, 'who attended schools situated in poorer geographic locations had limited access to suitable work experience and, despite their participation in gifted and talented classes, were considered to be at greater risk of not achieving the high level of academic achievement required for admission to medical school' (p. 73). Therefore, the under-representation of students from the lower socio-economic classes in medical schools and the profession has nothing to do with their intellectual ability, but with their environment and the opportunities afforded them by their economic state.

According to some interviewees, the association of medicine with middle and upper socio-economic classes, the association of middle-upper class with intelligence, the automatic association of non-European/Western migrants with poverty and poverty with less intelligence, increase the tendency by upper, middle class, white male to think that, non-Western European doctors, perceived to be poor people, are excluded from clinical and economic reward structures associated with competence and independence within medicine in Ireland. The perception of some interviewees is, poverty is associated with intellectual inferiority and incapability to be professionally outstanding. I perceive this perception reflects the opinion of these interviewees on class and poverty.

It is interested to observe that class and kits consciousness play a role in the how IMGs migrate and access professional practice. It is imporatant to point out that class shapes the perception of many interviewees in this study. In some cases, interviewees perceive themselves as better than the asylum seekers and refugees because they are professionals. As a result, many of the interviewees

believed they deserve better treamtment than those meted out on non-professional migrants. For example, an interviewee claims:

We foreign doctors never had any problems in Ireland until the late 1990s and early 2000s when many asylums seekers and refugees came to this country. That is when the people changed their attitude and they think everybody is a parasite. (Dr Ahmed S.).

This type of perception reinforces the central role plays in creating inequality within the society and labour market especially.

Gender and Professional Integration of IMGs in Ireland

Another important physical marker of difference that all female interviewees in Ireland mentioned as shaping their professional integration experience is gender. All female interviewees claimed their gender as female physicians impacted negatively on their progression as well as day-to-day interactions with colleagues especially, male colleagues. One finding of this study is the claim by some female interviewees that they experience serious bullying from nurses. In the word of an interviewee of African origin:

We suffer so much harassment from the nurses to the extent that we have to always work on a thin line. (Dr Ewatae H.)

Another interviewee said:

Nurses' attitude is very bad toward female foreign doctors. I assume because some of the nurses originally wanted to be doctors, but probably couldn't make the CAO points, there is this kind of envy towards us. There is also this feeling of: 'you are not better than us, you are just lucky because, you are from countries where competition for medicine is not so hard'. (Dr Nkechi N.)

Interestingly, this aspect of the findings in this study goes contrary to the conventional belief that doctors typically bully nurses. Although a few research studies in the UK evidence nurse-doctor bullying, there is still very little on this topic in Ireland. For example, Paice et al. (2004) claimed that in the UK, besides doctors harassing doctors, nurses and midwives are also sources of negative behaviour, particularly towards junior doctors. Supporting this is a 2006 report in the UK by *Health Policy and Economic Research* Unit. This report also acknowledged bullying of junior doctors by nurses (p. 10).

Further evidence from this study suggests policies and practices pursued by the medical profession especially, in relation to promotion into the position of a consultant have an androcentric bias. An example of a practice perceived to be androcentric, according to all the female interviewees, is the non-female-friendly rotational system of the training scheme. They claim these family unfriendly systems discourage them from participating in the training scheme in the first place. They also claim it is difficult for female IMGs especially, to participate because, the majority of them are on temporary contracts with individual hospitals. At the end of a specific contract, either the contract is renewed or the doctor looks for another job in another hospital. According to majority of the interviewees, the usual practice is to apply for another job in another hospital and the doctor moves

to another town. For the female interviewees, this kind of moving around the country is inimical to family life because female doctors, like other women, are also expected to fulfil gender roles, such as looking after the children and being a housewife. Parenthood has been identified to have negative impact on the ability of women to move and take up opportunities in cases where mobility is required (Kofman, 2012).

This further reinforced the argument about the patriarchal nature of the society dictates that women perform roles subservient to men. These roles include, but not limited to caring for the children, looking after the home and looking after the elderly. What is problematic in the case of female IMGs is that, borrowing the words of O'Riordan (2003) in her discussions on the gendered interaction of employment, 'upon entering a world constructed on norms and practices that do not allow for their traditional caring roles' (p. 2), female IMGs found it difficult to balance their professional and family lives. This perspective is supported by an interviewee who claims:

> The worst part of the system of moving from one rural hospital to another is the impact on families. I know families that broke down as a result of this moving around. Can you imagine the effect on kids when they never put down root anywhere? As soon as they are settling down and making friends in a community, it is time to leave again. It destabilises and destroys them completely. That is why my husband at a point told me he was not moving again. The effect of this is, I have to go to rent an apartment in the present village where I work and return to my family when I am off. Besides being expensive, it is also time consuming. I do not get to see my kids as much too. This is very sad.

The critique of this finding is the traditional socialisation towards the private sphere applies to women generally, and not specifically, non-EU/Western women. As a result, the experience of finding it hard to balance family life with professional demand is not peculiar to female IMGs, but to all professional women. This critique is consistent with previous findings in this area in Ireland. For example, more than three decades ago, Kelly et al. (1982) demonstrated in their study of female medical graduates in Ireland, that 'Irish female medical graduates with children had difficulty combining parental responsibilities with medical training to the point that one-third of them were not working' (p. 34). Two decades later, Cannon (2002) identified having children as restricting the choices of female doctors in medicine in Ireland.

Another factor identified by interviewees in this study as impeding on the ability of female IMGs to professionally integrate fully is the long hours associated with medical practice in Ireland especially, for the non-consultant hospital doctors (NCHDs). Previously, Cannon (2002) identified this in her study. She, quoting from the report of the PA Consulting group on the *Working Hours of Non Consultant Hospital in Ireland*, stated that 'doctors were working 77 hours per week on average. In areas such as Surgery, Anesthetics and Obstetrics and Gynecology, the average working hours were higher at 89, 84 and 83 hours per week respectively' (p. 32). Doctors' working hours in medicine have traditionally been long, but presently, this has generated a lot of controversy within medicine in Ireland. However, the reality is Ireland has not been able to achieve the maximum 48 hour

working week as required by the European Union Working-Time Directive (EWTD). According to a statement made by the Irish Medical Organisation (IMO) on March 19th 2015, the organisation 'has welcomed the opinion published by the Advocate General of the European Court of Justice (ECJ) that the Irish Government is in breach of the European Working Time Directive (EWTD) by requiring Non-Consultant Hospital Doctors (NCHDs) to work excessive hours'. It is important to note, according to the statement that '33% of NCHDs are routinely required to work in excess of the legal 48 hour limit', 230 NCHDs in over 21 hospitals are working over 24 hours and there remain some who are forced to work 32 hour shifts'.

It is significant to note the effort that has been geared toward compliance with EWTD by the Department of Health in recent times. According to the *Irish Times* (Cullen, 2015, July 9th), 'compliance with the directive currently stands at over 70 percent and average working hours for NCHDs have fallen from 60 hours a week in 2009 to 51 hours at the end of last 2014.' Nevertheless, interviewees in the study stated that they still work on the average of 70 hours a week with some shifts stretching up to thirty hours straight. This has a negative effect on the career progression of female doctors with young families who cannot in many cases, go that length of time without caring for their children. Evidence from the study suggests that female IMGs especially, those with young families, find it hard to cope with the excessive hours required to put into work and their competing family responsibilities, which the evidence suggests, places them under pressure to be present and actively involved in caring for their children. As a result, they are short-changed when it comes to progression or in extreme cases, they completely give up applying for positions that will require them to spend more time away from home, highlighting level of pressure of their competing responsibilities. An interviewee lamented how her marriage broke down and her husband returned to Africa because he complained of not getting enough attention from his wife, who used to work an average of 90 hours a week.

Another issue that came up in relation to gender and its effect on the professional integration of IMGs is the issue of maternity leave and childcare. All female interviewees in Ireland mentioned the present structure and system of medical practice as anti-children. Although, they all claim, on the surface, it does not look like that. However, according to them, when you scratch beyond the surface, it does not encourage the juxtaposition of having children with medical practice. According to an interviewee from Africa:

> As a woman, I feel particularly discriminated against because, no consultant wants someone who will be taking days off to take care of children.

Additional evidence from this research suggests that gender is a deciding factor when it comes to how well integrated, a female IMG can be in professional medicine in Ireland. Evidence suggests that even though there have been recent gains for women physicians in Ireland, the gain is yet to extend

to female IMGs. For example, according to the Medical Council's *Medical Workforce Report 2014*, 'at the end of 2013, 41.3% of registered doctors were women; this was a 12% relative increase versus 2008. More so, 58.3% of doctors registered in the Trainee Specialist division were women. Among doctors aged under 35 years who graduated from an Irish medical school, 69.6% registered in the Specialist Division were women (p 49). It is important to note that it is beyond the scope of this study to identify the factors that have impacted on women's success in professions that are previously, seen as a men's domain. Therefore, we may not be able to ascertain the factors that have influenced female doctors' considerable gains in medicine in Ireland. Nevertheless, in as much as female Irish doctors have gained so much professionally, evidence from this study suggests that female IMGs still lag behind their Irish and EU/Western counterparts when it comes to full participation in all areas of the medical hierarchy. Information available in this study indicates long hours of work, hospital-contract-shift arrangements that are family unfriendly, in some cases, an unfriendly workplace environment and gender-biased medical professional structure impact negatively on the professional medical experiences of female IMGs in Ireland. However, lack of family support networks may be an important factor.

Lastly, one interesting finding in this study is the intersection of race and gender on the professional experiences of black, female interviewees. Some female interviewees claimed their experience was horrendous and disheartening. One interviewee stated that is like carrying the weight of racism and sexism around the hospital all the time. She said:

> You can never imagine what is like to be a Black woman working as a doctor in Ireland. There is this idea of racial superiority from many White doctors and nurses. Then, on top of that, you have all the negative stereotypes associated with being a female. I think most of the time, female Black doctors are channeled into specialties that are deemed feminine like gynecology and obstetrics, geriatrics, etc. Besides, there is usually this sexualisation of African women and you can see that in the attitude of some of your colleagues. It is too much of a weigh to be carried around.

This perception of the sexualisation and discrimination of black women is consistent with previous studies in the academic field of race and gender and its impact on female labour market experiences. According to racial and gender writers, racialised gender identities are identified as distinct sources of inequality for ethnic minority women as these women experience the double negative impacts of sexual and racial discrimination in the labour market. For example, Nkomo (1988) argues that because the status of ethnic minority women is evaluated negatively in two ways, they are positioned at the very bottom of the occupational pyramid (Nkomo, 1988:135). This she claims has revealed the double impact of gender and race on immigrant women's career opportunities. Furthermore, the 'double-bind' or 'double-whammy' theory of Kim (2002) views ethnic minority women as victims of a double whammy in employment (Kim, 2002: 403). For Kim, 'while sexism is harmful enough to ethnic minority women, it is the practice of this phenomenon

within the context of racism that might differentiate the marginalisation experiences of ethnic minority women from those of white women' (Kim, 2002:403). According to her, the gendered nature of professions has exposed migrant women to a position of disadvantage and vulnerability. Agreeing with the views of both women quoted above, Carter (2003: 79) writing on the experiences of Caribbean nurses within the NHS argues that, the entire process of recruitment of nurses from the New Commonwealth had closure as an integral part. As a result, young women from the Caribbean were channeled into the less prestigious and defended parts of the nursing profession.

Conclusion

Evidence from this research suggests that gender is a deciding factor when it comes to how well integrated, a female IMG can be in professional medicine in Ireland. Evidence further suggests, even though there have been recent gains for women physicians in Ireland, these are yet to extend to female IMGs. In as much as female Irish doctors have gained so much professionally, evidence from this study suggests that female IMGs still lag behind their Irish and EU/Western counterparts when it comes to full participation in all areas of the medical hierarchy. Although, there are no official data to back it up, interviewees put the percentage of female IMGs registered in the trainee specialist division and those in the specialist division at 1% of the total number of female IMGs in Ireland. The total number of female IMGs from the 2013 *Medical Council's annual retention file* is 1,706. Besides, according to the evidence gathered in this research, long hours of work, lack of childcare facilities/accommodation for child caring responsibilities, precarious contracts, rotations and shift arrangements that are family unfriendly, and gender-biased medical professional structure impact negatively on the career progression of female IMGs in Ireland.

Looking at the perceptions of interviewees in this research, it is evident that the intersectionality of race, class and gender impacts negatively on the professional integration experiences of IMGs in Ireland. It is fair to acknowledge the improvement in the experiences of IMGs over the years in relation to race, class and gender. For example, the numbers of IMGs getting into the training posts have increased compared with the numbers in previous years. According to the Medical Workforce Report (2014), 21% of doctors registered on the specialist registration division of the Medical Council Register are IMGs. This is an improvement compared with reports of only 2% in 2001 (Birchard, 2001). Nevertheless, many interviewees still think, there is a form of institutional closure around the position of a consultant in Ireland which acts against IMGs. Furthermore, many interviewees think the absence of a clear method of dealing with racist incidences within medical workplaces encourages racist bullying within Irish hospitals.

All in all, 14 out of the 27 interviewees perceived the medical profession in Ireland as exclusionary on the basis of their perceived race, class and gender. Therefore, it can be suggested that differentiation, categorisation and 'inferiorisation' or 'superiorisation' of people on the basis of their physical, and social characteristics still sometimes marks the ability or inability to access and progress within the medical profession in Ireland.

Race, Class and Gender and Professional Integration Experiences of IMGs in Medicine in Canada

This section presents the experiences of interviewees about the impact of one or the intersectionality of more than one of the notions of race, class and gender on their professional integration experiences in Canada. The discussion starts with their perceptions of how race and racism shape their everyday experience within the professional medical practice. This is followed by class and gender will then be presented.

Race and Professional Integration of IMGs in Canada

As discussed earlier in the Chapter, the professional closure within medicine can occur when a dominant social group restricts the access of other social groups into medical professional practice especially, to the most desirable and prestigious positions within the profession, on the basis of difference and otherness. This act of differentiating and 'othering' the 'others' is regarded as the axis upon which professional exclusion rotates because of the obvious or subtle social connotations attached to these groupings. One of the objectives of this study is to find out how the perceptions of difference and otherness impacts on the professional integration of IMGs in Canada? That is, how do interviewees think, belonging to a visible ethnic minority[48] group shapes their professional experiences?

The response of interviewees to this question is that of near unanimity when it has to do with pre-licensure. Seven out of ten interviewees think geographical locations of training outside of Canada, the US and Western Europe, not race can be important when it comes to licensure. According to this group, the quality of medical education in countries outside of these regions cannot be ascertained. As a result, they believe, for the purpose of preserving Canada's standard of health care, it is imperative that the clinical competence of physicians coming from such countries are tested. However, this line of argument was countered by some other interviewees who reasoned that testing for competence is different to consciously 'gating' out doctors who white Canadian doctors think are of different and inferior races. They added that if Canada is really testing for competence, why is it that even when an IMG passes the Medical Council of Canada Evaluating Examination (MCCEE), he or she is still denied residency? According to the latter category of interviewees, there is a conscious effort in medicine in Canada to preserve medicine as the professional space for white Canadians and Western Europeans.

According to three out of ten interviewees, race plays a considerable part in the process of getting

[48] A visible minority is defined by the Canadian government as 'persons, other than aboriginal peoples, who are non-Caucasian in race or non-white in colour.

licensed. They claim institutional racism is being perpetrated under the guise of preserving healthcare standards by not outright exclusion, but by the devaluation and deskilling of IMGs of non-Western European origin. One interviewee from Asia said:

I am ashamed of IMGs who claim there is no racism within medicine in this country. How can anyone say that? Why do they have to make you jump through the hoop just because you are from India, Pakistan or Sudan? Do you think it is because in the heart of hearts they believe your training is inferior? While that may be part of the reason, the main reason is because they attach inferiority to our skin colour. But, you know in Canada, there is so much hypocrisy with political correctness that many Canadians are closet racists. (Dr Shabr E.)

Another female interviewee from the Caribbean, said:

Racism is part of Canadian medicine. The only reason why IMGs like myself are employed is because we serve the under-served rural areas. That is the only reason we are tolerated. (Dr Jacobs W)

These lines of thinking are consistent with the arguments of race scholars such as Omi and Winnant (1994 and 1986); Kim (2004) and Das Gupta (2007). Omi and Winant (1994: 1) argue that 'race' has been a profound determinant of one's location in the labour market and indeed, one's sense of 'identity'. Therefore, 'race' conflict and racism are perceived as the primary determinant of social inequality (Omi and Winant, 1986). Besides, Kim (2004), arguing that race is the basis for the exclusion of Black accounting professionals in New Zealand argues that social stereotyping of ethnic minorities as intellectually inferior, incapable of being outstanding persons and sometimes uncivilised are the basis for the exclusion of ethnic minority persons from educational, political and economic reward structures associated with competence and independence within the accounting profession in New Zealand. Das Gupta (2009) in her study of nurses in Ontario, Canada, argues that racism is part of the everyday experience of black nurses in Canada.

Consistently, evidence from this study suggests that although, the argument that the reason why the licensing procedure for IMGs from certain parts of the world is made arduous and complex is to protect Canadian healthcare consumers is plausible and has been internalised by many IMGs as rational. Then there is this other side to this argument that is not obvious, but makes sense as well. This is the perception that racism is the basis of the complex process of licensure for IMGs of non-European/Western origin.

Moving on from pre-licensure experience to post-licensure experience, two out of ten interviewees said their race shape their relationships with their colleagues, managers, nurses and clients. A few interviewees claimed they are not going to say racism is absent from medicine in Canada. However, their perception is that as a result of the Employment Equity Legislation[49], it is not prevalent and when it occurs, it does, subtly. It is important to note that for the purpose of clarity in presentation,

[49] Employment Equity Act, requires employers to engage in proactive employment practices to increase the representation of four designated groups: women, people with disabilities, Aboriginal peoples, and visible minorities

and as mentioned earlier, the discussion is presented thematically: individual/relational and systemic/institutional experiences. The individual/relational perspective presents firstly, experiences of racism by IMGs, from 'white', Canadian and mostly Christian colleagues, team leaders, managers and nurses. Secondly, it presents the experiences of racism from clients and service users by IMGs. Under the systemic/institutional experiences, institutional policies and practices that encourages or discourages integration of IMGs are discussed.

Individual/Relational Experiences of Racism by IMGS in Canada

As done in the section for Ireland, this subsection presents the experiences of interviewees in Canada with White Canadian/European/Western colleagues, managers, supervisors, nurses and clients. It starts with that of doctors, followed by that of nurses and lastly, with clients.

IMGs' experiences of racism from colleagues

As mentioned in Chapter Six, the striking difference between IMGs in Ireland and Canada is that of high representation of IMGs in Family/General Practice as compared with other specialties, in Canada. According, to the Scott's Medical Dadabase (SMDB) 2016 report, 28.5% of family doctors in Canada are IMGs compared with 22.7% in other specialties. The opposite is quite the case in Ireland. According to the Medical Workforce Intelligence Report, 2016, 14.8% IMGs are family doctors. As a result, experiences of many interviewees who are practicing in Canada are somewhat different from the experiences of interviewees in Ireland. According to an interviewee in Canada, the field becomes a level-playing field as soon as you get fully licensed. This is because, full licensure to practice medicine in Canada comes without any restriction. So, a doctor with full registration can aspire to any specialty or practice anywhere in Canada. According to many interviewees, the aim of many IMGs is to set up their private General Practice after getting their full licensure. The reason, according to them is that, there is a market for them, because of the large population of visible minorities in Canada. According to statistics in 2011, Canada had a foreign-born population of about 6,775,800 people. They represent 20.6% of the total population (Statistics Canada, 2011). Therefore, IMGs have many of their patients amongst members of their communities. An interviewee of African origin stated that his experience within medical practice cannot be more pleasant. According to him:

> The kind of respect accorded to me here as a doctor was never accorded to me in Nigeria where I trained. My colleagues here are heaven sent. There is mutual respect and my intellectual ability is also recognised. Besides having my own family practice now, I also lecture at the university here in Calgary and I am also a senior fellow of the Royal College of Physicians and Surgeons of Canada, here in Alberta. And this is all in fourteen years in Canada. It cannot get better than this. (Dr Femi K.)

Another interviewee agreed with this perception and corroborated it with his own simple explanation. This interviewee of Middle Eastern origin stated:

> There is a deeper understanding and respect of difference here in Canada. I have doctor friends in Europe and they tell me

their bizarre experiences. Here in Canada, multiculturalism is celebrated and there is equal right. As a result, we all treat ourselves with respect. I have never been disrespected by my colleagues or managers. (Dr Kassim O.)

The above quote suggests that respect is an important aspect of the integration process. Both interviewees quoted above mentioned respect of their difference, in terms of ethnicity and an individual as the basis of their perception of integration. They claimed that the respect accorded them by their colleagues and the system affords them the opportunity to integrate professionally into Canadian medicine. Besides, multiculturalism, a federal government policy in Canada, is a factor that enables people to tolerate and respect difference. It is important to mention here that Canada was the first country to adopt multiculturalism as its official immigrant integration policy and it remains the only country that has multiculturalism enshrined in its constitution. This quote above also suggests multiculturalism as the factor that help drive home equality. This perception is consistent with the findings of theorists and researchers such as Kymlicka (2012) and Bloemraad (2006). Bloemraad who compared the integration of Vietnamese migrants in Toronto and Boston found out the Vietnamese have effectively integrated into the political sphere of Toronto than that of Boston. Supporting this perception is the finding in an OECD Report in 2007 as quoted in Kylimcka (2012, p. 11) that compared to their counterparts in other Western democracies, the children of immigrants in Canada have better educational outcomes. Furthermore, Kylimcka (2012) quoting Heath (2007) claims that while immigrants in all Western societies suffer from an 'ethnic penalty' in translating their skills into jobs, the size of this ethnic penalty is lowest in Canada (p. 11). Contrastingly, even though, the claim that multiculturalism promotes tolerance and ensures equity may hold true when assessed empirically in a country like Canada, there are critics of it. For example, Bisoondath (1994) critiques Canada's multiculturalism policy as limiting the freedom of minority members within the country, by confining them to cultural and geographic ethnic enclaves. Garcea (2008) further argues that multiculturalism segregates the peoples of Canada. For him, multiculturalism hurts the Canadian, Québécois, and Aboriginal culture, identity, and nationalism projects; and, it perpetuates conflicts between and within groups. Hasmath (2012) contends that the multicultural project in Canada has the potential to hinder substantive equality in the labour market for ethnic minorities.

In line with the critics of multiculturalism, two interviewees stated their experiences are contrary to the broader 'multicultural-is-great' rhetoric that is prevalent in national discourses in Canada. They claimed to have experienced racism in their workplaces in Canada. According to a female interviewee of Asian origin, even though professional workplaces in Canada are censored when it comes to racism by the Equity Law, white Canadian colleagues still perpetrate it. She claimed they usually do it through singling IMGs out for tougher criticism, excessive monitoring, isolation from informal social networks, and being harassed when they try to complain about these experiences

and labelled as playing the race card.

An interviewee of African origin corroborated this perception and pointed out the fact that IMGs even prefer to go the route of family practice is a sign that something is wrong with medicine in Canada. She argued:

Why can't all doctors in Canada aspire to any specialty? Why should IMGs be GP all the time? That alone raises suspicion about the state of fairness within medical practice in Canada. Anytime you see migrants ghettoising themselves into a particular job or profession or an area of a profession, you must know it is because they experience less resistance, compared to other specialties, when they try to access such positions.

This perception of an interviewee presented above suggests that many IMGs chose to go the route of family practice because they are confronted with less resistance when compared with other medical specialties within Canadian. As a result, they are concentrated in this specialty of the medical profession in Canada. This line of thinking is consistent with previous research on migrants and the labour market elsewhere. According to Carter et al. (2003), between 1950s and 1980s, minorities in the UK were confined to certain areas of the labour market because of exclusion and segregation. For example, according to him, the 'migrants from the Caribbean Islands are clustered in transport and nursing, while Indians and Pakistanis were absorbed into textile manufacture and metalwork (p. 89). When he was discussing the professional roles of female Afro-Caribbean nurses in the National Health Service in the UK, Carter stated that psychiatric and geriatric nursing are spaces within the Health Service that were occupied almost exclusively by ethnic minority nurses. Bornat, Henry & Raghuram (2008; 2009) also argued that in the UK, geriatric medicine is a professional specialty where South Asian doctors are clustered.

Summarily, evidence from this study suggests that even though, medicine in Canada has progressed tremendously in the area of workplace anti-racist awareness and professional inclusion of IMGs, more research needs to be conducted to find out why IMGs tend to concentrate in the family practice specialty as compared with other specialties. It also needs to address covert forms of racism which are as damaging as the overt types.

IMGs' Experiences of Racism from Nurses

As mentioned earlier in this Chapter, another aspect of the individual/relational experiences of racism by IMGs is that of their relationships with nurses. When interviewees were asked this question, nine out of ten claimed they have pleasant experiences. According to an interviewee, if one respects oneself as a doctor, nurses will respect you. This interviewee from the Middle East said:

When doctors, especially, male doctors come from outside of Canada, it is important to understand the Canadian workplace culture. This culture is one that values and respect everyone, to the cleaners. If they understand that, they will not have any problem with nurses. For example, if a doctor is coming from a country where doctors are treated as demi-gods and he does not adapt to Canadian workplace of not expecting nurses to be running around and worshipping him, he will have a problem with nurses.

Another interviewee also mentioned cultural understanding of the Canadian workplace as the basis for a pleasant, professional experience within medicine in Canada. For her knowing culturally appropriate jokes are important. She said in Africa, where she trained, many jokes made by male doctors to female nurses are sexist and derogatory. If such jokes are made here to nurses, they are interpreted as sexist and offensive.

However, a young female doctor from Africa said she had an unpleasant experience when she was posted to a hospital during her residency and a nurse looked at her and tried to direct her to where the student doctors were. According to her:

I asked her, did she not see that I am a doctor from my name tag? But she was not just listening. She already in her mind put me in a box. So I sternly corrected her. That was the beginning of a very sour relationship with her in that hospital for me. She will disregard my directives, gave me bad looks and bad-mouthed me to other nurses.

The experience of this nurse, even though, it is not quite one way, because, the nurse made a mistake, the doctor reacted sternly, which made her authority as a doctor to be questioned. My opinion here is the IMG in question here may be too conscious of her status as a doctor and indirectly, committing he same offense she was accusing the white Canadian doctor about. Therefore, the questioning of the doctors' authority may be in part, a response to the stern reaction of the doctor. Nevertheless, some interviewees claim this kind of experience is not unique to Canada. It is comparable to the experiences of nurses in Ireland, where some interviewees claimed their authority as IMGs was constantly questioned and they worked in hostile environments because the nurses made it hostile.

Summarily, the majority of the interviewees claimed their everyday professional experience with nurses is not shaped by race, but based on mutual respect. Although, according to one interviewee, there can still be a few instances where some white nurses Pidgeon-hole young black IMGs into a box. Nevertheless, evidence from this study suggests that race and ethnicity of interviewees do not affect their relationships with white Canadian nurses.

Experiences of Racism from Patients by IMGs

When this question came up, the response was near unanimous. Nine out ten interviewees claimed they got on well with their patients, while the other ones claimed some clients could be racist. It is important to note that many of the doctors interviewed in Canada are family practitioners with their own family practice. As a result, many of their clients come from their communities or have seen their profile and accepted them, before engaging them as personal or family physicians. Hence, many of them may not experience the kind of instant negative reactions from clients, described by some IMGs in Ireland. Nevertheless, a doctor of the Middle Eastern origin narrated an unpleasant experience from a middle age, white woman who he claimed laughed at his accent every time she visited the hospital. He said he overheard her talking to a nurse one day and she said:

'Will you get me another doctor who speaks good English, I am tired of listening to this one with an Arab accent.' This really made me nervous. I became overly aware of my accent and I lost my confidence.

An experience such as this destroys the psyche of the doctor and can impact his/her ability to perform efficiently. Besides, this interviewee's experience in Canada is comparable to an interviewee's experience in Ireland, where a patient told the interviewee she did not want to be treated by a 'Paki'. A 'Paki', in Ireland, is the short form of Pakistani, but a derogatory term, used for a black foreigner. In essence, the patient did not want to be treated by a black doctor.

The experiences of the interviewees quoted above suggest that even though, the majority of interviewees have pleasant experiences when dealing with their White Canadian clients, many still encounter everyday racism from clients that impacts negatively on their professional integration experience in Canada.

Experiences of Systemic/Institutional Racism by IMGs within Medicine in Canada

The majority of interviewees perceived there is a systemic barrier at the point of entry to medical practice in Canada, but could not agree on its basis. A few interviewees think it is based on race, while some others think it has to do with the quality of training received and not the colour of their skin. All interviewees agree that there is one or more forms of institutional barrier impeding the ability of IMGs to access medical practice when compared with their Irish/Western European counterparts in Canada. Although, a few, three out of ten interviewees chose not to call it racism. According to one interviewee, the system is not racist, but it appears to be created for the Canadian/American/Western European doctors, because according to the interviewee, it is easier to evaluate the training of Canadian and other European trained doctors compared with the training doctors received outsides these regions.

On the other hand, many interviewees think the pre-licensure stage is rife with systemic discrimination, although, only a few named it, institutional racism. As opined by an interviewee who is of Asian origin, on the institutional level, policies pursued by the provincial medical boards are racist. For her:

The system here is a system that prefers the White Canadian and Western European doctors to us, the 'other 'doctors. I know doctors that have 15 to 20 years clinical experience in India. On arrival in Canada, their skills are devalued and in some cases, they are even advised to take an alternative path such as becoming a carer or laboratory technician. Why don't they give Western Europeans and Western European trained doctors such hassles? For me, it is pure racism. (Dr Mensah, O.)

The quote above highlights, as discussed in Chapter Three, two key factors that are pertinent in racism discourses: preference for a kind on the basis of race (Lentin and McVeigh, 2006) and the devaluation or subjugation of the 'other' (Memmi, 2000) or what Fanning (2002) refers to as a negative attitude towards the other. The quote highlights how the devaluation of medical degrees and clinical experiences acquired by IMGs from outside the European Union and Western Europe

and consequent deskilling of holders of such degrees by licensure authorities in Canada can amount to racism. This policy and practice by medical licensing authorities in Canada, if interpreted through the lens of Macpherson's definition of institutional racism as discussed in Chapter Three and presented earlier in this Chapter, can amount to institutional racism.

Looking critically at the process of licensure for non-EU/Western IMGs trained in countries outside the Western societies, and the experiences of interviewees, as narrated by interviewees, it becomes obvious that the government of Canada's refusal to make the process less cumbersome and stressful for IMGs to navigate can amount to racism. Furthermore, the present return-of-service (ROS) system in place in many provinces in Canada reinforces the notion of segmentation of the medical labour market in Canada. This programme means there are two different professional spaces for doctors in Canada. One space exists for Canadian graduate doctors, who have the luxury to choose where to serve and then, the IMGs, who, in most cases, are channeled into areas not attractive to locally trained doctors and areas with harsh weather conditions. As mentioned in Chapter six, return of service programmes are programmes targeted at IMGs in various provinces in Canada. They provide training and assessment opportunities for physicians in exchange for an agreement to provide service in the under-serviced communities of the provinces. As a result, the continued reinforcement and indirect coercion of IMGs into this kind or arrangement for the purpose of becoming licensed can amount to institutional racism. As reasoned by MacPherson, 'it is incumbent upon every institution to examine their policies and practices to guard against disadvantaging any section of their communities' (MacPherson Report, 1999, p. 369). Therefore, the non-removal and continual reinforcing of the system that disadvantages a large number of IMGs within the profession of medicine in the form of sending them to remote and under-serviced communities can mean that there is an element of racism in the formulation of the policy in the first place. This finding in Canada is comparable to that of Ireland, where IMGs are also, channeled to rural hospitals that offers little or no opportunities for progression.

Summarily, evidence from this study suggests that institutional racism is prevalent at the entry point to professional medical practice in Canada and in so many cases, used to block off access to many IMGs. As a result, the doctors affected by this institutional discrimination cannot integrate into the professional field of medicine. In instances where they manage to do, many of them remain on the margin of the practice for many years. This experience impacts negatively on their physical and mental well-being, erodes their self-esteem, affects their level of confidence, and demotivates them. Consequently, their ability to ultimately integrate into their profession is affected, resulting in a discontented group of doctors.

Social Class and Professional Integration of IMGs in Canada

On the question of how IMGs perceived their perceived socio-economic class shape their

professional integration experiences in Canada? Amazingly, all interviewees claimed social class does not usually come up within medicine in Canada. They claimed that because the immigration system of Canada is largely selective of the type of immigrants it allows in, immigrants are not usually perceived to be poor. It is important we note that in most cases, doctors IMGs are usually considered as middle class in their countries of origin. This perception affects treatments from host countries and how they interpret their experiences of this treatments. According to an interviewee who was originally from Africa, but now a Canadian citizen:

My cousins live in Europe and they tell me their experiences. They tell me how many Europeans still think Africans live on trees, have no shoes and are starving to death. Here in Canada, the perception is not like that. I guess because of the long history of immigration in Canada and the type of immigrants Canada takes, migrant doctors are not seen in that poor light here. In fact, migrants here, I think, are expected to be of upper or middle class.

Another interviewee who previously practiced in Ireland, but now practice in Canada said one thing that makes Canada stand out is the level of awareness of its citizenry as compared with the ignorance he claimed to have experienced in Ireland, even amongst his colleagues. He claimed that Canadians are open and free, unlike his experience of the close-mindedness of some Irish doctors. He stated the way he is perceived and treated by colleagues in Canada is different from the way he was in Ireland. He said:

I am married to a Canadian and we were both practicing in Ireland before we relocated to Canada. There was a clear difference with the way colleagues treated her compared to the way I was treated. In Ireland, there is this feeling of awkwardness when you are dealing with some Irish colleagues. In some cases, you can see they are physically petrified of you because they will be shaking and would not be able to talk when they needed to talk to you. It was a kind of negative energy that emanates from them. They make you feel you are strange and there is something wrong with you. But here in Canada, I have never experienced anybody, here in Canada, feeling awkward in my presence. In fact, my colleagues are friendly and we have gone out a couple of times. This never happened in Ireland except if there is an end of year party or something that we all need to go. Also, I have not experienced a colleague not able to understand my accent or think I am incompetent, like I always did in Ireland. I remember there was this consultant that that never heard what I was saying in Ireland, even after nine months of working with him. Mind you, it is not that I changed the way I speak now. It is because in Ireland, most of the time, they already made up their minds they can't understand you. So, they weren't even listening.

The above quotes from interviewees suggest that when positive perceptions are attached to a migrant as aresult of perceived social class, the expectations are different. As a result, many interviewees believed their perceived social class have positive influence on the perception and attitude of white Canadians about them. They claimed, this influenced the way they are accepted and overall. Increased their level if inclusion into the medical profession. Some interviewees argued that since Canada takes in many economic migrants, the relationship between native citizens vis-à-vis the foreigners is respectful and friendly. Unlike, in countries where the majority of migrants are asylum seekers and refugees. Negative perceptions about refugees and asylum seekers based on stereotypes that they are poor and needy, so, undeserving of compassion and benefits of the

welfare state taints the relationship between the migrants and locals, resulting in their social exclusion.

As stated earlier, a problematic perception identified in this study is the perception in both Ireland and Canada by interviewees that associates the medical profession with the middle and upper socio-economic class. Also, the belief by Europeans that non-European/Western migrants are poor. Hence, some IMGs, who perceived themselves as belonging to the middle class are sometimes perceived as poor and are stereotyped as belonging to the lower class, intellectually inferior. Therefore, they are deemed to be incapable of being outstanding persons, are excluded from clinical and economic reward structures associated with competence and independence such as the position of a consultant. This perception I will argue is contentious because, I perceive some IMGs in their arguments also reinforce this perception. The perception that associates socioeconomic class with the categories of migrants and subsequent social and economic integration with class is reinforced many interviewees. Many of my interviewees reinforced the stereotype that their ability to become doctors means they are more intelligent than non-doctor migrants and are deserving of acceptance. Hence, they, like their white counterparts, single out the asylum seekers and refugees to be pathologised and penalised. This perception is wrong and the belief that asylum seekers and refugees are people of low intelligence who do not deserve to be welcomed and accepted into their chosen societies is ludicrous. What I see here is the perception that asylum seekers do not deserve what the IMGs deserve. I still remember an interviewee in Ireland told me:

> We foreign doctors never had any problems in Ireland until the late 1990s and early 2000s when many asylums seekers and refugees came to this country. That is when the people changed their attitude and they think everybody is a parasite. (Dr Ahmed S.).

What I see in this kind of arguments presented by some IMGs, which scapegoat asylum seekers and refugees, is that of differentiation and otherness. Some IMGs, as a result of their perception about their social class, reinforces the idea that intelligence equals economic class and professional and immigration status should determine how a migrant is received in a host society. Besides the fact that this perception is a complete fallacy, it amounts to exclusion as well.

Gender and Professional Integration of IMGs in Canada

As argued in Chapter Three, the medical profession is a highly gendered profession, where female physicians face numerous challenges such as being segregated into feminised specialties within the profession, glass ceilings, and systemic discrimination (Pringle, 1998; Laurence and Weinhouse, 1994). In the medical profession in Canada, female IMGs, similar to women in other professions, previously found it hard to gain access into the profession. Now, that some of the barriers have been lifted and they are able to gain access, studies have revealed that are usually over-represented in roles that are usually supporting men's role. Within medicine in Canada, previous studies

acknowledge that when women do gain access to the medical professional practice, they tend to be over-represented in 'lower status' specialties such as family medicine (Canadian Institution for Health information, 2008). Hence, when female IMGs are discussed, they seem to experience the disadvantage of being a woman combined with that of being non-white/Western. In other words, female IMGs, in Canada, are disadvantaged by both their status as women and as immigrants (Boyd and Kaida, 2005).

When female interviewees in Canada were asked about how they think their gender has affected their professional experiences, seven out of ten female interviewees claimed their gender as female physicians, does not impact negatively on their professional integration experience *per se*. Although, they all say that when it intersects with other factors, it does. According to many of them, there was a structural change in the medical profession in recent years that changed the perception and place of women. However, gender becomes significant when it intersects with other factors such as balancing family and work, childcare, location of work, length of working time and systemic discrimination on the basis of race and country of initial training. A few of them think there is selection bias. They claimed most male dominated specialties such as surgery, still prefer to recruit men because they think women are more suited to specialties with flexible schedules. Evidence from this study suggests some female interviewees experience double negative impacts of sexual and racial discrimination. This finding is consistent with finding about the experiences of professional women and migrant professionals within organisations globally. As mentioned earlier in this Chapter, previous studies on women have found out that ethnic minority women experience 'Double Whammy' Kim (2002) which positions them at the very bottom of the occupational pyramid (Nkomo, 1988). In other words, they experienced double negative impacts of sexual and racial discrimination in the labour market.

Even though, the double whammy experience of discrimination on the basis of race and ethnicity is evident in the experiences of a few interviewees, I want to argue that this term does not completely explicate the experiences of female IMGs. Evidence from the study reveals that their situation is more complex and there is the intersection of more than two variables. For example, a female IMG may be a Muslim, non-native English or French speaker, married with children and Black African. Therefore, the professional integration experience of a female IMG is defined in most cases, by the intersection between several factors such as marital and family status, religion, location of practice, etc.

Another interesting outcome of this study is the similarity of the experiences of female IMGs in Canada with those of Ireland, about bullying, harassment and intimidation from nurses. Although, there is a slight variance with the perceptions of interviewees in Canada about the reason behind

the nurses' attitude. In Canada, unlike in Ireland, some interviewees believe nurses try to rival them. They think nurses are like watchdogs that try to make sure female doctors do not act or behave like men. According to Hinze (1999) female nurses make sure female doctors maintain their feminity. In cases where a female doctor is perceived as too masculine, she is penalised by the nurses. Even though, a female doctor is occupying a professional space that is traditionally filled by men, she is still not expected to take on the normative male role. What a contradiction! In other word, she is expected to work like men, but not behave like men. Therefore, when a female doctor exhibits the normative male role, the female nurse is there to chastise her. This line of thinking is amplified by Cassell (1997) who argues that gender appropriate roles tend to be enforced on female doctors by nurses who work with them. According to Dolisshny (2012), women doctors are penalized when they behave in a way perceived to be the norm for male doctors. However, in order not to oversimplify this argument, it is important to note that, nowadays, it is common for jobs/professions to be constructed with a particular gender/class in mind. However, when others outside of this group take on the roles, the expectations/construction of the role changes, acting dynamically with the changes, For instance, the role of the office clerk and secretary and the para-legal profession in the US has changed over time and the men that got into it are not expected to behave like women, who used to perform the roles. Likewise, a lot has been written on the medical and nursing profession and about the changing structure, roles and gender compositions (Kilminster et al., 2007; O'Lynn, 2004; Sweet and Norman, 1995). Therefore, it is highly problematic to argue that the nursing profession remains static when it comes to roles construction because according to existing literature in that area, there has been changes in roles' construction and expectation and overall gender composition of the nursing profession.

Conclusion

Looking at the perceptions of the majority of interviewees in this research, it is evident that the intersection of race, class and gender impacts negatively on the professional integration experiences of IMGs in Canada, despite the gains made by women in the last two decades with the aid of the Equity Legislation. It is fair to acknowledge the impact of the Equity Legislation on the positions of female IMGs, the effort of many organisations in Canada to increase cultural sensitivity and competence amongst its employee. Nevertheless, evidence from the research still reveals female IMGs tend to be disadvantaged when compared to their male counterparts. Considering the fact that most IMGs are severely disadvantaged at the entry point to professional practice, it means, a female IMGs can experience two or more forms of disadvantage, depending on her religion, marital status, and location of practice. Conclusively, from the evidence gathered in this study, I can say, even though, there is a legislation in place to address racism, sexism and gender discrimination, many female IMGs think their professional integration experience is shaped negatively by their gender, especially, when it intersects with other factors such as religion, lack of supporting social network, the cost of childcare, long hours of work, work in rural areas and race.

Therefore, after critically examining the professional integration experiences of IMGs in Canada and Ireland from the perspective of all interviewees, it can be concluded that race, class and gender, including other variables such as country of training, location of practice, family and marital status and religion, influence the professional integration experiences of IMGs, both at the entry point and within practice in Ireland and Canada. However, it is important to note that the degree of impact of these factors varies significantly. For example, in Ireland, evidence from the study reveals how negative stereotyping associated with the non-European/Western races such as the black race, could intersect with negative perception about religion, gender, and class to produce disadvantage at both the entry point and within employment for IMGs. Besides, evidence in the research also suggests other factors such as country or training, lack of supporting social networks within and outside employment, high cost of childcare, a temporary, specific term employment contract that requires moving from one town to another and region to another and hospital-rotation system of training all impede the full professional integration of IMGs. Disappointingly, according to the evidence in the research, there appears to be no effort by the government of Ireland to foster the inclusion of IMGs by pursuing and formulating policies that can foster their inclusion. Unlike I Canada, where interviewees mentioned the Equity Legislation and other programmes from both governmental and non-governmental bodies aimed at encouraging professional integration of IMGs into Canadian medicine. Furthermore, interviewees in Canada seem less emphatic on the negative role, race plays within medicine. Although, a few of them mentioned it, it was not emphasised like the emphasis the

majority of interviewees in Ireland laid on race. Eight out of ten interviewees in Ireland claimed race plays a major role in their professional career and they believe race influences their career outcome negatively.

Finally and interestingly, the experiences of female IMGs about their inability to balance family role with that of the professional is similar in both Ireland and Canada. This confirms findings of previous studies on women and employment (Cannon, 2003; Gjerberg, 2003; Crompton and Harris, 1998 and Kelly et al., 1982). For example, Cannon (2003) in her *Study of need/demand for Flexible Training at SHOS (SHO) Level for Mother in Irish Medicine*, argues that training scheme posts, structured so that doctors rotate through different hospitals, childcare needs, the result of long and atypical working hours, and uprooting families with a doctor's change of every job run counter to family values. Likewise, Gjerberg (2003), in her work on *Women doctors in Norway: the challenging balance between career and family life*, claims that family responsibilities impacts on a female doctor differently when compared to a male doctor. She stated that, among female doctors, the chance of rising to the position of a specialist decreases as the number of children increases.

Thesis Conclusion

Having examined the professional integration policies and practices in Ireland and Canada, this study found out that in Ireland, the topic of professional integration of IMGs and critical evaluation of integration policies and practices within the health sectors of Ireland is under-studied. Another gap identified relates to a dearth of studies that analyse the professional integration experiences of IMGs within the medical profession in Ireland. This is especially evident in relation to how IMGs experience the processes of accessing professional practice and how professional structures influence and shape their progression. Lastly, there are also the lacunae on what strategies are used to produce and maintain existing professional structures and cultures and how the IMGs perceive and interpret their experiences of these structures, professional processes and practices.

The central focus of this study was from the perspective of the IMGs, and to explore professional integration experiences of IMGs in Ireland and Canada in relation to access to professional practice and outcome within the medical profession. To do this effectively, I have critically evaluated the present professional structures, policies, processes and cultural practices within medicine in both countries.

As a result, the study has succeeded in presenting an insight into what the profession is, how occupations evolve into professions and how they maintain their professional status. It also went ahead to examine how notions of social closure, difference, otherness, race, class and gender, are used as tools to either include or exclude IMGs in both Ireland and Canada.

To get a better understanding of the experiences of IMGs in the medical professional field in Ireland and Canada, particular attention was paid to the intersection of race, class and gender and how they interact with the ability of IMGs to access and progress within the professions. It examined and analysed how everyday experiences of IMGs are shaped by the notions of difference and otherness. It also analysed and interpreted the processes and practices within the medical profession in Ireland and Canada through the lens of social closure.

In order to buttress my argument, I presented statistics that shows that IMGs, who makes up one third of the total number of registered doctors in Ireland are over-represented in positions that have no career prospects attached to them. As a result, I argued that the first barrier to professional integration of IMGs into the medical workforce in Ireland is the schism of medical posts into: service posts and training posts. Also, the institutional constraints placed on IMGs who acquired their qualifications from outside of Australia, New Zealand, Malaysia, Sudan, South Africa (with internships after 2006) and Pakistan (with internships after 2008) in relation to access to training posts was presented as considerable. Access to training posts was revealed to be limited by country of training of an IMG. This study argues that this limitation is legitimised by the Medical Practitioners Act of 2007.

As discussed earlier, in recent years, increased funding of posts and postgraduate training by the HSE increased the number of specialist training positions available for doctors, which in turn, resulted in increased numbers of IMGs availing of specialist training in Ireland. Nevertheless, many IMGs can still not avail of these opportunities because, they had their initial medical training outside the catchment areas or because they had their internships earlier than the specified years in their countries of training. For example, IMGs from South Africa with internships after than 2006 and from Pakistan, with internships after 2008 are disallowed from applying for training posts. What this means is that many IMGs who come to Ireland are confined to the service posts. In this study, it was unearthed that these constraints ultimately impede the progress of IMGs within the medical profession in Ireland, resulting in disparities of outcomes when they are compared with Irish graduates.

To further understand processes and practices of professional integration in Ireland and Canada, and how they impact on the professional experiences of IMGs, the historical development of medical education and career pathways in Ireland and Canada were examined and forms of medical education, career pathways in both countries were discussed and various access routes to registration and practice scruntinised. For example, after careful scrutiny of the access routes to medical licensure and pathways to career progression within medicine in both countries, evidence from this study suggests licensure requirements are secretly laddened with racial and class bias and androcentricty. It is extremely important to note as I have previously stated, that country of origin play a major role in accessing registration in Ireland and licensure in Canada. Also, in Ireland, many IMGs who are deemed not well suited for training positions are good enough for service positions. What this process and practice suggest is IMGs are only good for positions not desired by locally-trained doctors.

My perspective is further strengthened by the analysis of medical education training and career structures, indicating the hierarchical origins of the professions in both countries and how these hierarchies were embedded in class and gender differentiations. I opine that these hierarchies have the potential to facilitate social reproduction of status. For example, there exists a hierarchy of specialties, posts and hospitals in both countries. In Ireland, the hierarchical ordering of training posts over service posts is glaring and rural/country hospitals over urban ones. Likewise, in Canada, the urban center hospitals and medical practice are perceived as superior to ones in rural area. This hierarchical context, I argue can necessitate the development of training and regulatory institutions to control access to training posts in Ireland and urban center posts in Canada. I further claim that to successfully control access, there is a necessity for training and regulatory institutions to invent some control and regulatory mechanisms to tacitly deny IMGs, perceived as ‘non-eligibles’, access to

popular training posts in Ireland, many of which, coincidentally, are in urban centers and posts in urban Canada. This tacit closure tactic deployed here is akin to what Murphy (1988) refers to as social closure, that is 'the process of subordination within a hierarchy, in which a group closes off 'opportunities to another group of outsiders beneath it which it defines as inferior and ineligible' (p. 8).

More so, the influence of class on access to medical profession and social reproduction of status within the profession that was a part of the profession previously in both Ireland and Canada were discovered to be prevalent. Surprisingly, this perception is found to be common among both local doctors and IMGs. It is important to note that these practices are not new. Weber (1968) wrote of how social or physical group attributes such as race, language, social origin and religion may be utilized for the purpose exclusion. In this case, as deduced from the narrated experiences of many interviewees, the present practices within the profession in Ireland and Canada and professional outcomes of IMGs can be an indication that the intersection of gender, race and class form the basis of exclusion of IMGs from positions at the top of the medical hierarchy.

Another significant outcome of this study is the similarity in the Canadian and Irish process access to medical practice. For example, access route to practice after an IMG has acquired the Licentiate of Canada, the 'return-for service' or 'return for practice' access route compares favourably to the 'service post' route in Ireland. These routes in Canada, like Ireland, are becoming the most used access routes for IMGs to gain full licensure for independent practice. In Ireland, even though, services posts offer IMGs access to practice, they are largely perceived by IMGs as keeping IMGs in practice and servicing the health service, rather than as assisting them to progress towards becoming an independent consultant.

Additionally, this study reveals that the common areas of practice of doctors in both Ireland and Canada are quite similar, except for the general practice specialty. For example, there are equally a high proportion of IMGs practicing in Surgery, Anesthesiology, Emergency Medicine and Psychiatry in Ireland similar to that of Canada. There is a significant dissimilarity when it comes to the proportion of IMGs practicing as GPs in Canada (over 50% of IMGs) compared with about 14% of the total numbers of IMGs practicing in Ireland. This significant dissimilarity may suggest that the Family Medicine specialty may be closed off to IMGs in Ireland.

When it comes to dissimilarity, as this study unearthed, the areas of closure are different. While access appears closed to many IMGs in Canada, it is progression that appears closed in Ireland. IMGs find it a little easy to get jobs as doctors, filling non-training positions in rural Ireland, as opposed to progressing into senior position within the profession. Whereas in Canada, professional closure appears to be at the access point. Access to practice by IMGs in Canada, as described by one

interviewee is like ‘a camel passing through the eye of a needle’. However, as claimed by majority of the interviewees in Canada, if an IMG can cross that hurdle, progression is a little easy.

Another dissimilarity is the coping strategies employed by IMGs in dealing with the challenges they face. It becomes clearer from the study that many IMGs in Ireland cope by using the system as a stepping to move on to places like Canada, Australia and the USA. In some cases, a few of them could get qualifications from the UK, which they were then able to transfer to Ireland. In Canada, because they point of entry is where the barrier exists, it is difficult to circumscribe it.

Finally, a striking picture emanating from this study is that the access routes and progression pathways for IMGs in both Ireland and Canada are quite arduous, sometimes confusing, time consuming and can amount to disadvantage for IMGs in terms of access to practice and in the case of progression, exclusion from the prestigious and desirable medical positions and location of practice. It is submitted that although, IMGs are a very important part of the medical workforce of both Ireland and Canada because of the roles they play, cultural practices of the medical profession in the two countries may be utilised by dominant social groups to restrict access of IMGs to more prestigious and desirable occupational niches within the profession. The mechanisms identified by the experiences and opinions of participants include non-recognition of previous qualifications and experience, making the licensing process lengthy, inadequate provision of information on access and pathways to promotion within the profession, and via legislation, restricting IMGs to medical posts that come without career progression. The narratives of IMGs reveal that professional regulatory bodies in Ireland and Canada, in certain circumstances, regulate and set uniform standards of education and training for doctors, and such regulation presents barriers to access to and progression of IMGs within the profession.

I argue that IMGs are the lifeline of health systems in Ireland and Canada like immigration is the lifeline of developed countries economy. IMGs help sustain health systems because they take up spacialties and posts which seem to be unpopular with local doctors and practice in geographical locations underesired by locals. This finding aligns with the argument of Nigel Harris (2002) who claims immigration is the lifeline of developed countries economy because immigrants facilitate the native workers or their children, with steadily higher educational qualifications, to transfer to well-remunerated and cleaner jobs. He also claims that without the army of semi-skilled and unskilled labourers who are predominantly immigrants in the industrialised countries, the pool of skilled workers would not last for long.

I further argue that IMGs can be viewed as the lifeline of the health systems in Ireland and Canada because without their access to positions and specialties that locally trained doctors would not fill and geographical locations that are less desirable to local doctors, the health systems of both

countries will not last for too long. For example, how will the healthcare system in Ireland fare if IMGs do not fill up positions in rural hospitals where in some cases, as recent reports have revealed, they constitute two third of the staff strength in such hospitals? Or, in Canada, will the heath system of Canada not suffer severely, if IMGs choose to not serve in those rural under-served areas? From this angle, I infer that the healthcare systems of both countries rely heavily on the contribution of IMGs.

I also wish to state that another significant finding in this thesis is that the institutions of medicine in Ireland and Canada may be excluding IMGs. I draw upon features of the profession such as control of access to medical practice via the imposition of rigorous preregistration requirements, control of access to training posts through state legislation and complete autonomy over disciplinary procedure to buttress this argument. These features which seem to be objectively aimed at protecting the public by promoting and better ensuring high standards of professional conduct and professional education, training and competence of all doctors were discovered in this study to have the ability to also be utilised for inclusionary or exclusionary purposes, depending on who is to be included or excluded. Evidence from this study suggests that, more in Ireland than in Canada, there is room for these processes to become strategies of social closure and be utilised by members of the dominant group against doctors who are deemed to be outsiders because of their nationality, gender and even country of training. IMGs from outside the European Union and Western countries are an embodiment of these markers of differences and as a result, may not experience full professional integration because of the utilisation of these closure strategies against them. However, the availability of a more robust legislative framework may close policy and practice gaps that are used for exclusionary purposes. For example, if there is a transparent avenue opened to an aggrieved doctor to seek redress when aggrieved, then there is likelihood that groups who marginalise other minority groups will curtail their exclusionary activities because of the fear of legal sanctions against them.

After examining the educational and certification requirements for licensure in Canada and Ireland, I state that common to both countries are the deskilling and devaluation of previous academic and clinical qualifications acquired by IMGs from outside of the EEA/Western societies. Common to both countries also are the imposition of rigorous academic and certification requirements as prerequisites for registration and licensure. These formal requirements present a barrier to the professional integration of IMGs in both countries. In the case of Ireland, evidence from the study suggests that credentialism, especially, the non-recognition of prior learning and qualifications from countries outside of the EU and old Commonwealth countries, as utilised by the Medical Council and supported by the government, is a rational means of regulating access of IMGs into and progression

within the medical profession. Many participants think this is the basis of their inability to transfer to training posts and subsequently, become consultants. They interpreted this practice as professional closure.

Evidence from the research also suggests the governments of Ireland and Canada are complicit in perpetuating this closure because they legitimise exclusion in their processes of access. For example, in Ireland, the Medical Practitioners Act 2007, legitimised the denial of access to training positions to many IMGs. As a result, even when an IMG, occupying a non-trainee post performs work of equal value with a doctor in training, they are unequally rewarded. The non-accreditation and certification of the clinical work of not-in-training doctors puts them at an automatic disadvantage compared to a trainee doctor, whose training counts towards credentials required for progression into the position of a consultant. Although, in Ireland, the present Taoiseach, who was then Minister for Health, Dr Leo Varadkar, promised to remove such training barriers to IMGs, up to the time of publishing this piece of work, no law has been passed to that effect.

Similarly, in Canada, evidence from this study suggests that the combination of credentialism and licensure, as prerequisites for either provisional or full professional medical practice impacts negatively on the professional integration of IMGs. Evidence from the study also suggests that the government of Canada, similar to that of Ireland, is also complicit in the perpetuation of this professional closure. This finding validates the findings of previous studies in this field in Canada which found the strenuous and cumbersome registration process; lack of residency posts for IMGs and lack of transparency in the procedure for selecting doctors into residency posts to be significant impediments to the integration of IMGs into the medical profession in Canada. This study found these barriers technically disallow IMGs from practicing in Canada. It must be remembered that to practice, an IMG must be licensed. To become licensed, the registration and certification via residency requirements must be satisfied by many IMGs, especially, those from outside Canada, USA and the old Commonwealth countries. Therefore, if an IMG cannot access residency, such an IMG cannot obtain licensure for the purpose of practicing medicine in Canada. Consequently, IMGs find it difficult to commence the journey to practice professionally in Canada and many that commenced, are unable to access residency even when they have passed required provincial based examinations because of limited numbers of residency posts. In many cases, IMGs end up giving up the hope to practice medicine for alternative jobs such as care jobs, paramedics, etc.

Internalisation of credentialism as a closure strategy and its negative impact on the ability of IMGs to fight professional exclusion is another factor I want to point out in this study. A few IMGs see this idea of seeing the long and arduous process as a best practice. Evidence form this study suggests that they see others who could not succeed in the process as villains and successful ones as special. I

therefore, argue here that this type of thinking can be the result of the internalisation of oppression by IMGs. Some IMGs in Canada see themselves through the lens of the popular dominant discourse of the main social group within medicine in Canada. The crucial point of this discourse is that access to medical practice in Canada needs to be controlled to ensure an excellent quality of healthcare service to patients. So, if one can make it into the hallowed field of practice, one must be special. Likewise, in Ireland, some IMGs have internalised the practice of exclusion, in some cases, decided to overlook discrimination, and in other cases convinced themselves that they deserve to be discriminated against. A few IMGs claim they believe it is okay to work twice as hard as some of their mainstream Irish counterparts and not get recognition for it because they are not from Ireland. That is, they are not Irish, and their primary medical degrees are not from Ireland. Therefore, they perceive themselves to be undeserving of the benefits the professional medical field has to offer its practitioners.

Another theme that came up in this research is that of 'gratitude'. In the context of this study, many interviewees, especiallin in Ireland, statetd that mainstream Irish doctors expect them to be grateful for even, having access to service posts. A few participants recounted incidences where they were told by coleagues to be grateful to the Irish for allowing them to work in service posts.

Summing up these evidences, it is suggestive that credentialism and licensure requirements in Ireland and Canada may not be as objective as they claim to be and in fact, they can be mechanisms of professional closure against IMGs.

Having established that the licensure processes in Ireland and Canada may not be as neutral as they are claimed to be by the institutions, evidence from this study also suggests that even though a formal selection process that relies on merit exists within medicine in both Ireland and Canada, an informal process that relies on informal networks, sponsorship and patronage also exists. For example, in Ireland, sponsorship and patronage in the form of formal and informal face-to-face recommendations from more senior and eminent consultants are perceived by many participants as crucial to the career success of an IMG. Although, a few participants believe that merit, dedication to one's work and careful career planning are more crucial than recommendations from a consultant. As for Canada, all participants believe the system is biased at the entry point against IMGs, but fair and meritorious post-licensure. A few participants dissented with this perception. They claimed 'godfatherism', favouritism and cronyism may not be as pervasive within medicine in Canada, as it is in Ireland. However, there consider that there are still elements of sponsorship and patronage, especially in academic medicine in Canada. They argued that even though what an IMG knows matters, who an IMG knows and the information an IMG has about specialties, available funding, job postings, etc. are also crucial if an IMG is going to fully integrate and have similar outcomes

comparable to that of a Canadian graduate, within medicine in Canada. Therefore, the central roles, access to informal networks, sponsorship and patronage play in determining career success of IMGs make these notions valuable as strategies of either professional inclusion or closure. In other words, these processes can be utilised by the dominant social group within medicine in Ireland and Canada to close off opportunities to IMGs who are deemed to be outsiders.

Finally, looking at the perceptions of many participants in this research, it is evident that race, class and gender are perceived to impact negatively on professional integration experiences. Despite the gains made by women and other minority groups in Canada in the last two decades, evidence from the research reveals that female IMGs tend to be disadvantaged when compared to their male counterparts. Considering the fact that most IMGs are severely disadvantaged at the entry point to professional practice, it means, a female IMGs can experience two or more forms of disadvantage, depending on her race, religion and marital status. Conclusively, from the evidence gathered in this study, even though, there is a legislation in place to address racism, sexism and gender discrimination, many female IMGs consider their professional integration experiences are shaped negatively by their gender, especially, when it intersects with other factors such as religion, lack of supporting social networks, costs of childcare, long hours of work, work in rural areas and race.

After critically examining the professional integration experiences of IMGs in Canada and Ireland from the perspective of all participants, it can be concluded that race, class and gender, including other variables such as country of training, location of practice, family and marital status and religion, influence the professional integration experiences of IMGs, both at the entry point and within practice. However, it is important to note that the degree of impact of these factors varies significantly. For example, in Ireland, evidence from the study reveals how negative stereotyping associated based on physical features and cultural assumptions can intersect with negative perceptions about religion, gender, and class to produce disadvantage at both the entry point and within employment for IMGs. Besides, evidence in the research also suggests other factors such as country of training, lack of supporting social networks within and outside employment, prohibitive costs of childcare, temporary, specific term employment contracts that require moving from one region to another and the hospital-rotation system of training, all impede the full professional integration of IMGs. Disappointingly, according to the evidence in the research, there appears to be no effort by the government of Ireland to foster the inclusion of IMGs by pursuing and formulating policies that can foster their inclusion.

Unlike in Canada, where interviewees mentioned programmes by both governmental and non-governmental bodies aimed at encouraging professional integration of IMGs into Canadian medicine. There was a mention of cultural competence training within medicine in several provinces

which aims to increase cultural sensitivity and competence amongst healthcare employees. I also attended a round-table conference on the recognition of foreign qualification of IMGs as a means of reducing the barriers facing IMGs who wish to practice in Canada.

Furthermore, interviewees in Canada seem less emphatic on the negative role race plays within medicine. Although, a few of them mentioned it, it was not emphasised like the emphasis the majority of interviewees in Ireland laid on race. Eight out of ten interviewees in Ireland claimed race plays a major role in their professional career and they believe race influences their career outcome negatively. Does this mean that racism is less rife in Canada compared to Ireland?

Finally, and interestingly, the experiences of female IMGs about their inability to balance family roles with professional ones is similar in both Ireland and Canada. This confirms findings of previous studies on women and employment that argue that training scheme posts, structured so that doctors rotate through different hospitals, childcare needs, the result of long and atypical working hours, and uprooting families with a doctor's change of job, make meeting family obligations and responsibilities difficult.

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Appendix I

Medical Council of Ireland Council Members 2013 - 2018

	Professor Freddie Wood	Medical Member, President
	Dr Audrey Dillon	Medical Member, Vice President
	Dr John Barragry	Medical Member
	Dr Anthony Breslin	Medical Member
	Ms Katharine Bulbulia	Non Medical Member
	Mr Declan Carey P.C.	Non Medical Member

	Ms Anne Carrigy	Non Medical Member
	Mr Fergus Clancy	Non Medical Member
	Dr Sean Curran	Medical Member
	Dr Rita Doyle	Medical Member
	Ms Mary Duff	Non Medical Member
	Professor Fidelma Dunne	Medical Member
	Dr Bairbre Golden	Medical Member

	Dr Ruairi Hanley	Medical Member
	Mr Sean Hurley	Non Medical Member
	Professor Alan Johnson	Non Medical Member
	Ms Marie Kehoe-O'Sullivan	Non Medical Member
	Professor Mary Leader	Medical Member
	Ms Margaret Murphy	Non Medical Member
	Mr John Nisbet	Non Medical Member

	Professor Colm O'Herlihy	Medical Member
	Mr Tom O' Higgins	Non Medical Member
	Dr Michael Ryan	Non Medical Member
	Ms Cornelia Stuart	Non Medical Member
	Dr Consilia Walsh	Medical Member

Source: http://www.medicalcouncil.ie/About-Us/The-Medical-Council/Council-Members-2013-2018/

Appendix II

Royal College of Physicians of Ireland President and Council Members

Professor Frank Murray

President

Tel: 01 863 9763

PRESIDENT@RCPI.IE

Professor Frank Murray is the 141st President of the Royal College of Physicians of Ireland. His term of office is for a three year period to October 2017. Prof Frank Murray is a Consultant Physician/Gastroenterologist at Beaumont Hospital, Dublin and Associate Professor of Medicine at the Royal College of Surgeons in Ireland. Professor Murray graduated from University College Dublin in 1980 and trained in Dublin, Boston USA, and Nottingham, England. He was a Consultant Gastroenterologist in Ninewells Hospital and Medical School, Dundee, Scotland. He has been a Fellow of RCPI since 1994 and a member of RCPI Council since 2002, serving as Registrar from 2007 until he took up the office of the President. As President, Prof Murray chairs the RCPI Executive and Council. He is actively involved in many other areas of College activities both within Ireland and internationally, as chair of the RCPI Policy Group on Alcohol and as a member of the RCPI EQUALS Initiative, a group which sources decommissioned medical equipment in Irish hospitals to send to hospitals in less developed countries. Prof Murray is the former chair of both the Basic Specialist Training Committee and the Irish Committee on Higher Medical Training.

Meet Our Council

Dr John Barragry

Member of Council

Tel: 01 863 9700

COLLEGE@RCPI.IE

Dr John Barragry is a member of Council of the Royal College of Physicians of Ireland and represents RCPI on the Board of the Irish Medical Council. John Barragry graduated from the National University of Ireland. He is Clinical Director of Medical Services at the Adelaide and Meath Hospital.

Dr Ray Barry

Dean, Faculty of Paediatrics

Tel: +353 1 863 9738

PAEDIATRICS@RCPI.IE

Dr Ray Barry is a member of Council and the Dean of the Faculty of Paediatrics, having taken up this role in October 2014. He is the former Vice-Dean of the Faculty and a Consultant Paediatrician in the Mercy University Hospital, Cork.

Professor Colm Bergin

Vice President of the Royal College of Physicians of Ireland and Censor

Tel: 01 863 9700

COLLEGE@RCPI.IE

Professor Colm Bergin is a member of Council as Vice President of the Royal College of Physicians of Ireland. Colm Bergin qualified from Trinity College Dublin in 1989. He is currently Consultant Physician in Infectious Diseases, St James's Hospital, Dublin and Clinical Professor of Medicine at Trinity College Dublin (TCD). He is the Associate Director of the Wellcome-Health Research Board (HRB), Clinical Research Facility, St. James's Hospital Dublin.

Dr Peter Boylan

Chair of the Institute of Obstetricians and Gynaecologists

Tel: +353 1 863 9728

IOG@RCPI.IE

Dr Peter Boylan is Chair of the Institute of Obstetricians and Gynaecologists at the Royal College of Physicians of Ireland. Dr Boylan is a Consultant Obstetrician/Gynaecologist in the National Maternity Hospital. He qualified from UCD 1974 and completed his training in the National Maternity Hospital, Queen Charlotte's Hospital for Women, London, and Chelsea Hospital for Women, London. As Chair, Dr Boylan is responsible for overseeing all matters of the Institute with the support of the Executive Council and all of the Institute Committees. He represents the Institute on the RCPI Council and also on other national and international bodies.

David Byrne

Lay Member of Council

Tel: 01 8639 700

COLLEGE@RCPI.IE

David Byrne is a lay member of Council of the Royal College of Physicians of Ireland. David Byrne graduated from University College Dublin and King's Inns, Dublin. David Byrne is a senior counsel, former Attorney General of Ireland and former EU Commissioner for Health and Consumer Protection. He is Chancellor emeritus of Dublin City University, an Honorary Fellow of the Royal College of Physicians (London) and the Royal College of Physicians of Ireland. He is also patron of Health First Europe and is founder member and co-Chair of the European Alliance for Personalised Medicine (EAPM).

Professor Des Carney

Chair of the Irish Committee on Higher Medical Training

Tel: +353 1 863 9700

MEDICALTRAINING@RCPI.IE

Professor Carney is a member of Council and Chair of the Irish Committee on Higher Medical Training. Professor Carney is a Consultant Medical Oncologist in the Mater Hospital and has also previously held the position of National Specialty Director for the speciality of Medical Oncology.

Dr Áine Caroll

Junior Fellow on Council

Tel: 01 863 9700

COLLEGE@RCPI.IE

Dr Áine Carroll Studied Medicine in Queens University in Belfast and did a postgraduate MD in Newcastle University, Newcastle upon Tyne. She completed higher specialist training in Rehabilitation Medicine in Newcastle upon Tyne and came to work in Dublin in 2005 and is currently the National Director of Clinical Strategy and Programmes Division of the Health Service Executive, Ireland. Dr. Carroll is a Consultant in Rehabilitation Medicine at the National Rehabilitation Hospital and Senior Clinical Lecturer in the University College Dublin. She is past chair of the Medical Board of the National Rehabilitation Hospital and past President of the Irish Association of Rehabilitation Medicine. She is a Junior Fellow on Council and is a previous NSD for Rehabilitation Medicine. Dr. Carroll has published on a wide variety of topics including clinical leadership, life expectancy determination in disability, the use of botulinum toxin in spinal pain, osteoporosis in disability, whiplash injury and has presented at many national and international

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Dr Geoffrey Chadwick

Senior Fellow on Council

Tel: 01 863 9700

MEDICALTRAINING@RCPI.IE

Dr Geoffrey Chadwick is a Senior Fellow on Council. Geoffrey Chadwick graduated from Trinity College Dublin in 1978. He trained in general internal medicine and respiratory medicine in Dublin and Oxford. He is Consultant in *St. Columcille's Hospital Loughlinstown*. His special interests are in medical education and health services management.

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Professor Richard Costello

Director of Research

Tel: 01 863 9700

RESEARCH@RCPI.IE

Professor Richard Costello is a member of Council as Director of Research at the Royal College of Physicians of Ireland. Richard Costello graduated the Royal College of Surgeons in Ireland in 1988 and is currently Consultant Physician in Respiratory Medicine at Beaumont Hospital Dublin and Associate Professor of Medicine at the Royal College of Surgeons in Ireland. He serves on numerous committees and is a member of the Allergy and Immunology Assembly of the American Thoracic Society and the Health Research Board's pharmacology panel. He was involved in the establishment of the Irish Sleep Association. He has authored over 40 publications. His current research interests are lung immunology, neuro-immune interaction in allergic rhinitis and laser capture microdissection.

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Professor John Crowe

Immediate Past President

Tel: + 353 1 863 9763

COLLEGE@RCPI.IE

Professor John Crowe is the immediate past President of the Royal College of Physicians of Ireland, having completed his three year term of office in October 2014. Professor Crowe qualified in medicine from University College Dublin and from Trinity College with a PhD in physiology. He was appointed consultant gastroenterologist at the Mater Hospital in 1978 where he worked until 2011 in Gastroenterology and as director of the Centre for Liver Disease. He has a Newman chair from UCD and is a past president of the Irish Society of Gastroenterology. He served as Censor, Vice President and Treasurer of RCPI until he was elected President in 2011.

Dr Philip Crowley

Co-opted Fellow on Council

Tel: 018639763

COLLEGE@RCPI.IE

Dr. Philip Crowley is National Director of Quality Improvement with the HSE since January 2011. Philip is a fellow of the Faculty of Public Health at RCPI. He works in collaboration with the College on quality improvement initiatives. Philip trained in general practice and in public health medicine

and has worked with the Institute of Public Health in Ireland, with the Irish College of General Practitioners on refugee and asylum seeker health and as a general practitioner in the North inner city of Dublin. Philip worked for 6 years as Deputy Chief Medical Officer with the Department of Health and Children until taking up his current post. Philip continues to work as a GP part-time in an inner city Dublin practice.

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Dr Paul Darragh

Duns' Librarian

Tel: 01 6698817

HERITAGECENTRE@RCPI.IE

Dr Paul Darragh is the Dun's Librarian at the Royal College of Physicians of Ireland. Paul Darragh qualified in medicine from Queen's University Belfast and has an MD and a PhD from the same institution. He was appointed a Lecturer/Consultant in the Department of Epidemiology and Public Health of Queen's University in 1980. He now works in the Public Health Agency in Northern Ireland and leads the review of learning from serious adverse incidents, commissioning for Older People and Adult Safeguarding. His research has been in the field of Learning Disability and Contagious Psychogenic Illness.

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Dr John Donohoe

Past- President

Tel: 01 863 9763

COLLEGE@RCPI.IE

Dr John F. Donohoe is a member of the Council and Past-President of the Royal College of Physicians of Ireland. He also chairs the Institute of Medicine. John Donohoe graduated from St. Vincent's University Hospital-University College Dublin Medical School in 1967. He has also been the Director and Senior Consultant Nephrologist - Transplant Physician at the National Renal and Transplant Centre, Beaumont Hospital and Consultant Nephrologist at the Mater Misericordiae University Hospital in Dublin. He was also Clinical Lecturer in Nephrology at University College Dublin and the Royal College of Surgeons in Ireland. He has had over 80 works published in peer-reviewed journals in the areas of experimental acute renal failure and electrolyte and metabolic disturbances as well as clinical papers. He has contributed book chapters on diverse clinical conditions including acute renal injury, aluminium toxicity and bilateral renal cortical necrosis.

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Dr Una Fallon

Chair of Ethics Committee

Tel: 01 863 9700

COLLEGE@RCPI.IE

Dr Fallon is a member of Council as Chair of the Research Ethics Committee.

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Dr Catherine Fleming

Censor

Tel: 01 863 9700

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Dr Catherine Fleming is a Censor on the Council of the Royal College of Physicians of Ireland. Catherine Fleming graduated from University College Dublin in 1990. She is Consultant in Infectious Disease in Galway University Hospital.

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Professor Hilary Hoey

Director of Professional Competence, Senior Fellow and Censor

Tel: 01 863 9700

DIRECTOROFPROFESSIONALCOMPETENCE@RCPI.IE

Professor Hilary Hoey is the Director of Professional Competence, and a Censor of the Royal College of Physicians of Ireland. She is a former Dean of the Faculty of Paediatrics and the is the Faculty's Clinical Lead for the Qatar Revalidation Programme. Hilary Hoey graduated from University College Dublin and the University of Dundee. She was awarded an MD Degree at Trinity College Dublin for research on growth in childhood and for the construction of The National Growth Standards for Irish Children. She is a specialist reviewer of many international academic publications and editorial boards and has been External Examiner in Paediatrics at the University of Cambridge, University of Nottingham, the Royal College of Surgeons in Ireland, University College Dublin, University of Kuwait and the University of Cairo. She is Chairman of Diabetes Ireland, and President-Elect of the European Society for Paediatric Endocrinology.

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Dr Mary Holohan

Director of Examinations

Tel: 01 863 9700

EXAMINATIONS@RCPI.IE

Dr Mary Holohan is a member of Council and the Dean of Examinations and Chairperson of the Examinations Committee of the Royal College of Physicians of Ireland. Mary Holohan is a consultant obstetrician and gynaecologist at The Rotunda Maternity Hospital, Dublin. Her special interests are post-term pregnancies, urinary incontinence, continuing professional development (CPD) and the medical care of the adult victim of sexual crime. She is on the RCOG curriculum committee for the Advanced Training Skills Module for Forensic Gynaecology.

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Professor Mary Horgan

Director of Development and Planning

Tel: 01 863 9700

COLLEGE@RCPI.IE

Dr Mary Horgan is a member of the Council and Director of Development of the Royal College of Physicians of Ireland. She also chairs the Steering Committee on Acute Medicine (training). Mary Horgan graduated from University College Dublin in 1986. She is Consultant Physician in Cork University Hospital and Professor in the School of Medicine, University College Cork. She served as Chair of the Consultant Medical Staff Committee and the Executive Management Board in CUH. Professor Horgan has served as a Board member of IBTS and is currently a Board Member of the Irish Medicines Board where she chairs the National Advisory Committee on Human Medicine. She is President of the Infectious Diseases Society of Ireland.

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Professor Hilary Humphreys

Dean, Faculty of Pathology

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PATHOLOGY@RCPI.IE

Dr Hilary Humphreys is Dean of the Faculty of Pathology. He is also a Senior Fellow on Council, and has previously served as Vice President and Censor of the Royal College of Physicians of Ireland. Hilary Humphreys is Professor of Clinical Microbiology at the Royal College of Surgeons in Ireland and Consultant Microbiologist in Beaumont Hospital, Dublin. Hilary Humphreys has a long standing research interest in hospital infection prevention and control and antibiotic resistance, including MRSA. He has chaired expert groups, including the Strategy for the control of Antimicrobial Resistance in Ireland (SARI) and working parties that have produced guidelines on MRSA in the UK and Ireland. More recently, he has received a major research grant to determine amongst other things the benefits of universal MRSA screening and enhanced environmental decontamination. He is a member of the editorial board of the Journal of Hospital Infection and Clinical Microbiology and Infection.

Professor Michael Keane

Junior Fellow on Council

Tel: 01 863 9700

COLLEGE@RCPI.IE

Professor Michael Keane is a Junior Fellow on Council and has also served as a Censor of the Royal College of Physicians of Ireland. He graduated from UCD in 1989 and is currently Professor of Medicine and Therapeutics at UCD and Consultant Respiratory Physician at St Vincent's University Hospital. Michael Keane is Chairman of the Medicine Division, Chair of the SVHG Medical Executive and a member of the hospital Board of Directors. He is Clinical Director of the UCD Clinical Research Centre and a member of the Molecular Medicine Ireland Board of Directors. His research interest's centre on molecular investigation into, and treatment of, inflammatory lung diseases; particularly pulmonary fibrosis.

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Professor Elizabeth Keane

Dean of the Faculty of Public Health Medicine

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FPHM@RCPI.IE

Prof Elizabeth Keane is a member of Council and the Dean of the Faculty of Public Health Medicine. Prof Keane is a graduate of University College Cork. She was Director of Public Health in HSE South (Cork and Kerry) from 1995 until 2014. She has lectured in the Department of Epidemiology and Public Health in University College Cork since 1990 and was appointed Adjunct Professor in 2012. As

Dean, she is responsible for overseeing all matters of the Faculty with the support of the Board and the Faculty Committees. She represents the Faculty on RCPI Council and also on other national and international bodies.

Leo Kearns

Chief Executive Officer, Royal College of Physicians of Ireland

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Leo Kearns is the Chief Executive Officer of the Royal College of Physicians of Ireland. He joined us as CEO in 2006, and since then has led a major programme of transformation. Under his leadership, RCPI has adopted a proactive and progressive role in the improvement of patient care in the Irish health system. Leo has played a national leadership role in the development of the National Clinical Programmes, of which there are now over 35. He has also been centrally involved in the development of Clinical Directors within the Irish health sector, and in the introduction of Professional Competence. In addition to his role of CEO of RCPI, Leo served as National Lead for Transformation and Change in the office of the Director General HSE from 2013-2015. He is also Chair of the Strategic Advisory Group for the Implementation of Hospital Groups, a member of the National Patient Safety Advisory Board, the National Clinical Effectiveness Committee, the National Committee on Quality Indicators, and the National Steering Group on Clinical Programmes.

Dr John McDermott

Associate Director of Basic Specialist Training in General Internal Medicine

Tel: 01 863 9700

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Dr John McDermott is Associate Director of Basic Specialist Training in General Internal Medicine in the Royal College of Physicians of Ireland and a Junior Fellow on Council. Dr McDermott graduated from NUI Galway (then UCG) in 1998. He is a Consultant Endocrinologist and Dean of Postgraduate Studies in Connolly Hospital Blanchardstown, and Module Coordinator for the RCSI Graduate Entry Medicine Programme in Connolly Hospital.

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Dr Kathleen McGarry

Associate Director of Training Site Accreditation

Tel: 01 863 9763

COLLEGE@RCPI.IE

Dr Kathleen McGarry is Associate Director of Training Site Accreditation and a Senior Fellow on Council of the Royal College of Physicians of Ireland. She has previously served as Censor and Vice President. Kathleen McGarry qualified in medicine from University College Dublin in 1972. She is Consultant Physician in Navan Hospital, Co Meath. She has served in various capacities on the Irish Medicines Board and the Irish Heart Foundation where she has been chair of the Council for Women's Heart Disease and is a current member of the board. She has over thirty international publications and has been involved in the discovery of a new genetic abnormality in an Irish family with hypertrophic cardiomyopathy.

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Dr T. Joseph McKenna

Co-opted Fellow on Council and Associate Dean of Assessments for Specialist Division of the Register of the Royal College of Physicians of Ireland

Tel: 01 863 9700

COLLEGE@RCPI.IE

Dr T. Joseph McKenna is a Co-opted Fellow on Council and Associate Dean of Assessments for Specialist Division of the Register of the Royal College of Physicians of Ireland. He is also Clinical Lead on the Qatar Revalidation Programme for RCPI. He previously served as Registrar and President of RCPI and was Chairman of the Irish Committee for Higher Medical Training and immediate past Chairman of the Forum of Irish Medical Training Bodies. He practiced as Consultant/Endocrinologist/Diabetologist/General Physician in St. Vincent's University Hospital, Dublin from l978 to 2007. He continued in private practice until 2012. He serves on Medical Council and Health Service Executive committees. Amongst other posts he has held are President of the Irish Endocrine Society and Chairman, Section of Medicine, Royal Academy of Medicine of Ireland, and he served on the Editorial Boards of The Journal of Clinical Endocrinology and Metabolism(US), The Endocrinologist(US) and Clinical Endocrinology(UK). He has published over 200 scientific papers in national and international scientific journals and co-authored a textbook on Endocrinology and Metabolism.

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Dr Sinead Murphy

Director of Education and Professional Development

Tel: 01 863 9718

COLLEGE@RCPI.IE

Dr Sinead Murphy was appointed to the role of Director of Education in 2014. Dr Murphy's primary role is as an educator and has most recently held the position of Director of Paediatric Education at the UCD School of Medicine and Medical Sciences. Dr Murphy is also a Consultant Paediatrician at Children's University Hospital, Temple St. She has consistently combined her role as a clinician educator with clinical positions at every level allowing for seamless integration of these two

interconnected roles. Dr Murphy studied undergraduate medicine in Trinity College Dublin in 1994 and went into Paediatrics straight from internship. She continued her clinical training at Great Ormond Street Hospital in London and at University College London returning to Ireland in 2001. She has a special interest in childhood obesity and has carried out extensive research on this subject. More recently, she has been in the role of clinical lead on the paediatric childhood obesity service which was developed and is run by a multidisciplinary team in Temple Street. Dr Murphy received Fellowship of the Royal College of Physicians of Ireland in 2012.

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Dr Jane O'Halloran

Past Chair of Collegiate Members Committee

Tel: 01 863 9710

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Professor Conor O'Keane

Treasurer of the Royal College of Physicians of Ireland

Tel: 01 863 9763

TREASURER@RCPI.IE

Professor Conor O'Keane is a member of Council and the Treasurer of the Royal College of Physicians of Ireland, he is Chair of the RCPI Centre for Leadership and Quality and Leadership in Healthcare and serves as a member of Council. He also chairs a number of Committees of the College including the Investment Committee. He has also served as Dean of the Faculty of Pathology and is a Fellow of the Faculty of Pathology. Conor O'Keane is a Consultant Histopathologist at the Department of Histopathology, Mater Misericordiae University Hospital, Dublin. He is currently an Associate Clinical Professor of Pathology at University College Dublin, Chairman of the Medical Board, Mater Misericordiae University Hospital and an ex-officio member of that hospital's Executive Management Committee. He also serves as a Director of Bone Bank at Cappagh Orthopaedic Hospital.

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Professor Desmond O'Neill

Senior Fellow on Council and Programme Director, National Programme Office for Traffic Medicine

Tel: +353 1 863 9788

DIRECTORTRAFFICMEDICINE@RCPI.IE

Professor Desmond O'Neill is the Programme Director of the National Programme Office for Traffic Medicine, which was established jointly by the Royal College of Physicians of Ireland and the Road Safety Authority in 2011. Professor O'Neill was elected to the RCPI Council as a Senior Fellow in October 2014 and will serve a two year term. He is a Consultant Physician in Geriatric and Stroke Medicine at Tallaght Hospital Dublin and Professor of Medical Gerontology at Trinity College Dublin.

Professor Anthony O'Regan

Dean of Postgraduate Specialist Training

Tel: 01 863 9700

MEDICALTRAINING@RCPI.IE

Professor Anthony O'Regan is Dean of Postgraduate Specialist Training at RCPI. He is a consultant in respiratory and internal medicine in Galway University Hospitals and Professor (personal) of Medicine at the National University of Ireland, Galway. He is Chief Academic Officer for the Saolta University Health Care Group, President of the Irish Thoracic Society. Professor O'Regan graduated from University College Dublin in 1990, completed postgraduate training at the Medical College of Wisconsin and Boston University School of Medicine and served as the first Irish Chief Medical Resident at the Medical College of Wisconsin. He is a fellow of the Royal College of Physicians of Ireland, is American board certified in internal Medicine, Pulmonary Medicine, Critical Care Medicine, and Allergy and Immunology, and is a fellow of the American College of Chest Physicians. He was conferred with a MD doctorate from UCD in 2003. Prof O'Regan has received research funding from the National Institutes of Health, the American Lung Foundation, and the Irish Lung Foundation. He has over 40 peer reviewed publications. He has received several distinguished teaching awards in USA and Ireland.

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Dr Michael O'Connell

Censor

Tel: 01 863 9763

COLLEGE@RCPI.IE

Dr Michael O'Connell is an elected Junior Fellow and Censor on the Royal College of Physicians of Ireland. He is currently National Specialty Director for Obstetrics and Gynaecology and Chairs the Specialty Training Committee for the Institute of Obstetricians and Gynaecologists. He sits on the standing executive and examinations committee of IOG and is a member of credentials and examination committee RCPI. He has previously held the role of Vice President of the College, Associate Dean of the Institute of Obstetricians and Gynaecologists and for IOG convenor of meetings and honorary secretary. Michael O'Connell qualified from University College Cork in 1989. He is a consultant Obstetrician/Gynaecologist in Coombe Women and Infants University Hospital, Dublin. His interests are in high risk pregnancy (infectious disease and addiction) and postgraduate education.

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Dr Diarmuid O'Shea

Registrar of the Royal College of Physicians of Ireland

Tel: 01 863 9763

REGISTRAR@RCPI.IE

Dr Diarmuid O'Shea is the Registrar of the Royal College of Physicians of Ireland. On taking up this role he stepped down as Vice-President of Education and Professional Development, a role he held for 8 years. He acted as the Masterclass Series Convenor in the RCPI since its inception in 2007. He was National Specialty Director in Geriatric Medicine from 2000 – 2004 and served as a member of the Irish Committee on Higher Medical Training during this time. Diarmuid O'Shea is a medical graduate of University College Dublin. He is a Consultant of Medicine for the Elderly at St Vincent's University Hospital, Dublin. He is a fellow of the Royal College of Physicians of Ireland and UK.

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Dr Donal Reddan

Censor

Tel: 01 863 9700

COLLEGE@RCPI.IE

Dr Donal Reddan is a Junior Fellow on Council. He is also a recent Vice President and Censor of the Royal College of Physicians of Ireland. Donal Reddan graduated from University College Dublin in 1992. He is a Consultant Nephrologist, General Physician and clinical lecturer at University College Galway Hospital. He is Clinical Director for Medicine for the Galway Roscommon University Hospital (GRUHG) group and regional lead for Nephrology in the west. He has been involved in the design and implementation of a number of pivotal clinical trials, in chronic kidney disease and he has published extensively in the area of CKD associated anemia, CKD associated cardiovascular risk and contrast induced acute kidney injury. He has over 70 peer reviewed publications.

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Patricia Rickard-Clarke

Lay Member of Council

Tel: 01 863 9700

COLLEGE@RCPI.IE

Patricia Rickard-Clarke is a lay member of Council of the Royal College of Physicians of Ireland. Patricia Rickard-Clarke is a solicitor. In 2012 she retired as a Commissioner of the Law Reform Commission and was the lead Commissioner with regard to the Commission's work on Vulnerable Adults and the Law (which includes the reform of the law on Capacity). She is Chair of the Law Society's Mental Health and Capacity Task Force. She is a member of: the Council of the Hospice Foundation and a member of its Think Ahead Project Advisory Group of the Forum on End of Life, the HSE's National Financial Abuse of Older People Working Group and the User Group of National Centre for the Protection of Older People (NCPOP) at University College Dublin.

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Dr Maeve Skelly

Junior Fellow on Council

Tel: 01 863 9700

COLLEGE@RCPI.IE

Dr Maeve Skelly is a Junior Fellow on Council of the Royal College of Physicians of Ireland. She is interim Programme Director for BST in the Mid West. Maeve Skelly graduated from University College Dublin in 1989. She is Consultant Gastroenterologist and Physician in Mid Western Regional hospital Limerick. She is Clinical Lead for Endoscopy in the Mid West and a member of the Clinical Programme for Quality in Endoscopy. She is a board member and Treasurer of the Irish Society of Gastroenterology.

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Dr Declan Whelan

Dean of Faculty of Occupational Medicine

Tel: +353 1 863 9794

FOM@RCPI.IE

Dr Declan Whelan is a member of Council and the Dean of the Faculty of Occupational Medicine of the Royal College of Physicians of Ireland. As Dean, he is responsible for supervising all matters of the Faculty with the help of the Board and the Faculty Committees. He has experience of a wide range of Faculty activities and has previously held the positions of Treasurer and Vice Dean of the Faculty. Dr Whelan's main area of interest is in the interface between Traffic Medicine and Occupational Medicine. As chairman of the multidisciplinary RCPI Working Group in Traffic Medicine he oversaw the publication of the Medical Fitness to Drive Guidelines, for Healthcare Professionals, a collaborative project between the Road Safety Authority of Ireland and the Royal College of Physicians of Ireland. Currently Dr Whelan is the Chief Medical Officer to the C.I.E. Group, the National Transport Company of Ireland. This role involves the provision of a comprehensive Occupational Health Service to some 11,000 employees. He has also held the position of Secretary to

the International Union of Railway Medical Services (U.I.M.C.) based in Paris. Dr Whelan is a member of the International Commission on Occupational Health (ICOH) and is currently a member of the ICOH Congress 2018 organising committee which will bring some 4,000 delegates and accompanying persons to Dublin in 2018 for an International Congress on Occupational Medicine and allied disciplines.

Dr Barry White

Director of Quality and Clinical Care

Tel: 01 863 9700

COLLEGE@RCPI.IE

Dr Barry White is a member of Council and Director of Quality and Clinical Care at the Royal College of Physicians of Ireland. He graduated from University College Dublin and is currently Consultant Haematologist and National Haemophilia Director at St James's Hospital. He is widely published with over 50 peer reviewed publications.

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Source: https://www.rcpi.ie/about-us/our-people/our-president-and-council/ (Accessed on the 30/08/2016)

Appendix III

The College of Anaesthetists of Ireland Council Members 2015-2016



Council

College Council 2015-2016

Officers

Dr Kevin Carson	President
Dr Liam Conroy	Vice-President
Dr Brian Kinirons	Honorary Secretary
Dr Kevin Clarkson	Honorary Treasurer

Committee Chairs

Dr Camillus Power	Chair Training & Education

	Committee
Dr Donal Buggy	Chair Professional Development Committee
Dr Anne Hennessy	Chair Examinations Committee
Dr Ehtesham Khan	Deputy Chair of Examinations Committee
Dr Gerry Fitzpatrick	Chair Quality & Safety Committee (incorporating PCS)
Dr David Honan	Professional Competence Scheme
Dr John O'Dea	Chair Credentials Committee
Dr Padraig Sheeran	Chair Hospital Accreditation Committee
Dr George Ghaly	Chair Academic Committee
Dr Miriam Langdon	Chair IT & Communications Committee
Dr Damian Murphy	Membershi

	p Secretary

Ex-Officio

Mr Fintan Foy	Chief Executive Officer
Dr Ellen O'Sulivan	NCPA

New Members 2015

Dr John O'Dea

Dr George Ghaly

Dr Miriam Langdon

Co-opted Members

Dr Connail McCrory	Dean Faculty of Pain Medicine
Dr Jeanne Moriarty	JFICMI
Ms Anne Maher	Lay Representative
Dr Patrick Nolan	Lay Representative
Dr Geraldine Moloney	AAGBI Representative

Source: https://www.anaesthesia.ie/index.php/college-council (Accessed on the 18/08/2016)

Appendix IV

Irish College of General Practitioners (ICGP) Board 2016-2017

The Board has replaced the Council as the primary decision-making body in the ICGP. It assumes responsibility and accountability for decision-making and the delivery of the ICGP's strategic objectives.

Members of the Board include the ICGP president and chair, and the Committee chairs.

Click on the links below for information on our Board members.

President Dr Gerry Cummins	**Vice President** Dr Richard Brennan
Immediate Past President Prof Fergus O'Kelly	**Chair** Dr John Gillman
Hon Secretary Dr John O'Brien	**Hon Treasurer** Dr Joseph Martin
Chair of Postgraduate Training (PGTC) Prof Fergus O'Kelly	**Vice Chair of Postgraduate Training (PGTC)** Dr Sheila Rochford
Chair of Research Prof Andrew Murphy	**Chair of Communications** Dr Mark Murphy
Chair of Membership Services Dr Sarah Maguire	**Chair of Quality & Standards** Dr Velma Harkins
Chair of Education Governance Dr John Cox	**External Board Member/Chair of Audit Committee** Ms Mary Donovan
External Board Member Ms Susan Gilvarry	



Dr Gerry Cummins, President


Dr Gerry Cummins is a member of the Meath Faculty. He graduated from UCD in 1977, and completed his three years of GP training in Stoke on Trent in 1981. In the same year , Dr Cummins became a member of the RCGP (MRCGP) and returned to Ireland. » read more

Dr Richard Brennan, Vice President


Dr Richard Brennan is a member of the Carlow / Kilkenny Faculty. He graduated from the RCSI in 1978, has been a member of the ICGP since 1987, and received his Fellowship of the RCGP in 2006. » read more

Prof Fergus O'Kelly, Immediate Past President, Chair of PGTC

 Professor Fergus O'Kelly is clinical professor at Trinity College Dublin and past director of the TCD/HSE Specialist Training Scheme in General Practice. He has addressed the problem of drug use/HIV in his local area and served on the National HIV/AIDS Committee. » read more

Dr John Gillman, Chair

 Dr John Gillman is a member of the South Tipperary Faculty. His areas of interest are doctor and patient welfare, clinical and corporate governance, health economics and social media. » read more

Dr John O'Brien, Honorary Secretary

 Dr John O'Brien is a member of the West Dublin Faculty. He is a foundation member of the College. He has been chair of the Membership Committee, a CME tutor and a trainer, and is currently chair of the Substance Misuse Audit Review Group. » read more

Dr Joseph Martin, Hon Treasurer / Chair of Finance Committee

 Dr Joseph Martin is a founder member of the Merrion Faculty in South Dublin, and has been one of its faculty representatives on the ICGP Council since the first elected Council in 1985. He was instrumental in setting up the Liberties Primary Care Team as one of the 10 pilot PCT projects.» read more

Dr Sheila Rochford, Vice Chair of PGTC

 Dr Sheila Rochford is a member of the Cork City Faculty. She is an

assistant programme director on the Cork GP Training Programme, and has an interest in medical education, care of the elderly and infection prevention and control in general practice. » read more

Prof Andrew Murphy, Chair of Research



Professor Andrew W Murphy was appointed in 1997 as the foundation professor of general practice at the National University of Ireland Galway. He has published over 130 papers on his interests of chronic disease management in the community, professional practice and medical education. » read more

Dr Mark Murphy, Chair of Communications



Dr Mark Murphy works in an urban practice in South Dublin. From Dublin originally, he qualified from UCD in 2005 and completed his GP training with the Sligo Specialist Training Scheme in General Practice in 2013. » read more

Dr Sarah Maguire, Chair of Membership Services



Dr Sarah Maguire is a member of the ICGP Donegal Faculty. Sarah is an assistant programme director on the Donegal GP Training Scheme. She has an interest in care for people with complex health needs and how this is taught to trainees. » read more

Dr Velma Harkins, Chair of Quality & Standards



Dr Velma Harkins is a member of the Westmidlands Faculty. She is an under-graduate and post-graduate trainer, GP unit doctor for Offaly, Chair of Offaly MIDOC Out-of-Hours Co-op, and Chair of the National Association of Trainers in General Practice. Dr Harkins has a special interest in structured diabetes care. » read more

Dr John Cox, Chair of Education Governance

 Dr John Cox is a member of the ICGP Wexford Faculty. He has a special interest in cardiovascular risk factor assessment and management in general practice. He is also interested in information technology as applied to software systems in use in general practice. » read more

Ms Susan Gilvarry, External Board Member

 Ms Susan Gilvarry has a degree in business/law and is a trained mediator, having completed the Mediation Course at the Harvard Negotiation Institute, Boston in 2010. » read more

Ms Mary Donovan, Chair of Audit Committee, External Board Member

 Ms Mary Donovan is a graduate of UCC, a Fellow of the Institute of Chartered Accountants and of the Irish Computer Society, a member of the Board of Guardians & Directors of the Coombe Women & Infants University Hospital, and a Board member of the Bon Secours Health System.» read more

Source: http://www.icgp.ie/go/about/college_structure/executive (Accessed on the 12/08/2016)

Appendix V

Irish College of General Practitioners (ICGP) Council 2016-2017

Contact

Caroline Murtagh, email:caroline.murtagh@icgp.ie

The Council is the core representative body of the College. Its primary roles are to guide the Board on key policy and strategy matters. Each faculty has at least one representative and there are also several places filled by election, co-option and ex-officio appointment.

Council members

B

Colin Bradley
Declan Brennan
John Brennan
Frank Broderick

C

Mairead Cashman
Mary Angela Cowley
Tony Cox

D

Donal Daly
Frank Dobbs
Kieran Doran

E

Kenneth Egan

F

Tom Fahey
Mary Favier
Ronan Fawsitt
Henry Finnegan
Tom Foley

G

Lucia Gannon
Rukshan Goonewardena

H

Lynda Hamilton
Conor Hanrahan
Velma Harkins
Rosarie Harrington-Ryan
David Hurley

J

Naomi Johnson

K

Joseph Keenan
Teresa Kenny

L

John Latham
Noreen Lineen-Curtis

Liam Lynch

M

Niall Maguire
Sarah Maguire
Ivan Martin
Mairead MacEoin
Donal McCafferty
Paul McDonald
Mary Helen McFadden
Clare McNicholas
Monica McWeeney
Iain Morrison
Brenda Murnane

N

Grainne NiGhairbhi
Laura Noonan
Brian Norton

O

Sean O'Callaghan
Darach O'Ciardha
David O'Connell
Bernie O'Connor
Nual O'Connor
Pascal O'Dea
Cian O'Doherty
Hugh O'Donnell
Patrick O'Donovan
Bernadette O'Leary
Conor O'Leary
Kate O'Leary
Christelle Oliver-Dussault
Patrick O'Meara
Daragh O'Neill
Mark O'Sullivan

P

Brendan Payne

R

Brefini Reynolds
George Roberts
Andree Rochfort
Paddy Ryan

S

Eamonn Shanahan
Peter Sloane

W

Gerald White
Yvonne Williams

Source: http://www.icgp.ie/go/about/college_structure/council (Accessed on the 12/08/2016)

Appendix VI

The Irish College of Ophthalmologists Council / Staff / Committee

Honorary Officers of the College

- President Mr William Power
- Vice President Miss Marie Hickey Dwyer
- President Elect Dr Alison Blake
- Honorary Treasurer Mr Mark Cahill
- Honorary Secretary Dr Patricia Quinlan

College Council

The Council of the College are elected for a three year term by the qualifying members of the College

Current members of Council:

- Susan Kelly
- Marc Guerin
- Gerry Fahy
- Michelle Fenton

- John Stokes
- Dara Kilmartin
- Jeremy O Connor
- Iain Harrison

Clinical Lead for National Clinical Programme in Ophthalmology; Peter Barry

Dean of Post Graduate Education: Yvonne Delaney

Programme Director for Surgical Training; Gerry Fahy

College Committees

The College has several committees that address the business of the College incl;

- **Manpower, Education & Training Committee**; Chair Gerry Fahy. Committee members; Marie Hickey-Dwyer, Donal Brosnahan, Ian Flitcroft, Yvonne Delaney, Emily Hughes, Barry Quill, Eamon O'Connell, Billy Power, Deirdre Townley, Ian Harrison, Alison Blake, Kevin Kennelly, Conor Murphy.
- **Medical Ophthalmologists Committee**; Chair Michelle Fenton. Committee members; Alison Blake, Catherine McCrann, Iain Harrison, Garry Treacy, Fiona Kearns, Grace O'Malley, Margaret Morgan, Paddy Condon, John Traynor, John Smith, Susan Mullaney, Geraldine Comer, Sacha Hutchinson.
- **Ethics Committee**; Chair Patricia Quinlan. Committee members; Paddy Condon, Louis Collum, Eamon O Connell, Marc Guerin, Patricia McGettrick
- **Scientific and Continuing Professional Development Committee**; Chair Jeremy O Connor. Committee members; Billy Power, Denise Curtin, Dr Fiona Kearns, Eugene Ng

College Staff

- CEO; Ms Siobhan Kelly 01 402 2777 siobhan.kelly@eyedoctors.ie
- Dean of Postgraduate Education; Yvonne Delaney yvonnedelaney1@gmail.com
- Clinical Lead for National Clinical Prpgramme in Ophthalmology; Peter Barry peterbarryfrcs@eyedoctors.ie
- Administrator; Mrs Marian Scully 01 402 8535 marian.scully@eyedoctors.ie
- Communications Manager; Ms Ciara Keenan 01 402 2777 / 086 369 4427 ciara.keenan@eyedoctors.ie

Source: http://www.eyedoctors.ie/About-The-College-Of-Ophthalmologists/who-we-are.asp (accessed on 21/10/2016)

Appendix VII

Royal College of Surgeons Ireland Council

The governing body of RCSI is its Council, composed of twenty-one surgeons who are Fellows of the College and are elected by the College's Fellows and Members.

Council meets regularly during the year and meetings are chaired by the President. Council delegates a number of its main functions to various boards and committees. The significant activities of these boards and committees are reported to Council on a regular basis. The following are the current members of our Council:

2016 - 2018 Council	
	**Professor John Hyland – President** Consultant Surgeon (General / Colorectal), St. Vincent's University Hospital; Past-President Association of Coloproctology G.B. & I; Regional Director Cancer Services; ECAHB ERHA; Examiner Intercollegiate Fellowship; Chairman Steering Committee South East Dublin Surgery; Council member Irish Society Gastroenterology; Past Chairman HST Committee; Past RCSI rep SAC in General Surgery; Past Chairman BST Committee



Mr. Kenneth Mealy - Vice President
Mr. Kenneth Mealy is a General Surgeon with a special interest in gastrointestinal (GI) surgery and is based at Wexford General Hospital. Mr. Mealy has an active interest in surgical training and held the post of Chairman of the Dublin Region Basic Surgical Training Committee from 2001 until 2006 and has been Chairman of the National Basic Surgical Training Committee since then. He also held the position of President of the Surgical Section of The Royal Academy of Medicine in Ireland (RAMI) in 2008.



Professor Arthur W Tanner
Presently Medical Director, Leinster Rugby; General / Upper GI surgeon (Retired). Vice Dean of the Faculty of Sports and Exercise Medicine. Previously served on Council of RCSI from 1986-2001 and during this time chaired the College Committee and the Intercollegiate Committee for Basic Surgical Training & Exams. Served as a member of the Medical Council. Previously held position of Director of Surgical Affairs, RCSI.



Mr Declan Magee
Consultant Surgeon (Gen) Blackrock Clinic,(late St Columcille's Hospital); Member of Council RCSI, 1993 to date.
Recent: Chairman, Finance C/T RCSI; Chairman, RCSI OUTREACH, C/T for Intl' Cooperation. Previous: Chairman, Irish Surgical Postgraduate Training C/T; RCSI rep, SAC in General Surgery; Member Performance in Practice C/T, Medical Council. Past: Examiner Part B Fellowship; Chairman, Sen. Reg. Group; Council, Surgical Section RAMI; 'Kennedy' Dublin Hospital Initiative Group



Professor Patrick Broe
Consultant Surgeon (General & Upper G.I. Surgeon), Beaumont Hospital 1986 Lead Clinical Director, Beaumont Hospital, June 2010-2012 Medical Board, Beaumont Hospital and Surgical Division Beaumont Hospital Past Member of Council of Association of Surgeons GB& I Past President, RCSI (2012 – 2014) Past Chairman, College Committee RCSI Past President, Surgical Section, RAMI Past Chair of Clinical Governance, Beaumont Hospital CME Committee RCSI Millin Lecturer 1985 Fellow, Johns Hopkins Hospital 1979-81



Mr. Parnell Keeling
Consultant General Surgeon, Bon Secours Hospital. Fellow American College of Surgeons. Clinical & Research Fellow Johns Hopkins '77 to '79. Member Finance C/T RCSI. Chairman House & Property C/T RCSI. Member Faculty of Medicine & Health Sciences Board RCSI. Member Faculty of Nursing & Midwifery RCSI. Faculty Surgical Skills Courses. Intern Co-Ordinator Connolly Hospital. Participating in the Graduate Entry Programme at Connolly Hospital. Past President Surgical Section Academy of Medicine. Past President Association of Graduates RCSI.



Mr. Kevin O'Malley
Consultant Surgeon (Vascular), Mater Hospital; Current Chair of RCSI Committee for Surgical Affairs; Previous Chair Irish Association Vascular Surgery; Previously Senior Lecturer/Consultant Charing Cross Hospital, London 1989-92; Council member European Society for Vascular Surgery; Chairman, Organising Committee ESVS, Dublin 2003; Chairman, Mater Hospital Medical Board; Member of National Blood Users Group; Millin Lecturer 1987.



Mr. James Geraghty
Consultant General Surgeon Qualifications PhD, MCh, FRCSI; Senior Lecturer in Surgery UCD; James IV Association; Surgeons Travelling Fellows; Millin Lecture, RCSI Travelling Fellow; Ainswoth Fellowship UCC. Chairman, National QA Surgical Committee, Breast Screening; Surgical Representative, National Guidelines Breast Cancer, Secretary, South East Dublin Department Surgery; Chairman Cancer Strategy Committee, Tallaght Hospital.



Mr. Paul Burke
Consultant General Surgeon, ,St. John's Hospital & University Hospital Limerick President, Irish Association of Vascular Surgeons 2013 – 2015; Irish Representative on Council of European Society of Vascular Surgery 2011 – 2014; Director of Reconfiguration of Acute Hospital Services Mid-West Region (2008 – 11); Previous Chairman Medical Board and member of Board of Management of St John's Hospital.



Mr. Joseph O'Beirne
Consultant Surgeon (Trauma & Orthopaedic), Waterford Regional; Member of Irish and UK AO Faculties; Chairman, Basic Surgical Training Committee 2003 - 2005; Chairman, Hospital Recognition Sub-Committee 1997-2002; RCSI representative, Intercollegiate Committee for Basic Surgical Training; Vice-Dean, South Eastern BST Programme; Appointed Chairman, ATLS 2005, Examiner Basic Surgical Skills; Examiner for MFRCSI; Founder member, Irish Orthopaedic Trainees' Association 1989-91. Council member, Irish Institute of Trauma & Orthopaedic Surgery, Previous Chairman of Medical Board, Waterford Regional Hospital (2009 -2013).



Professor Patrick Ronan O'Connell
Professor of Surgery UCD and St Vincent's Hospital (since 2007). Consultant Surgeon Mater Misericordiae Hospital (1990-2007); Royal London Hospital (1989-1990). Special interests: IBD, pelvic floor physiology and continence. Editor: BJS (1999-2006); Bailey and Love's Short Practice of Surgery (25th ed). NIH Fogarty Scholar (1984); Council of Europe Scholar (1989). Winner: Patey Prize (1985); Freyer Lecturer and Sir Alan Parks' Visiting Professor (2007). Secretary elect: European Society of Coloproctology; Fellow: ASCRS, Society Pelvic Surgeons, European Surgical Association, International Surgical Group.



Michael E. O'Sullivan
Trauma & Orthopaedic Surgery, University Hospital Galway / Merlin Park Hospital. Irish Institute of Trauma/Orthopaedics Council Member; Irish Intercollegiate representative to exam board for Trauma and Orthopaedics (2008-2013); Examiner, Intercollegiate board for Trauma and Orthopaedics (2001-2013); Secretary: Irish Hand Surgery Society (2004-2007).



Mr. David Quinlan
Consultant Urologist, St Vincent's University Hospital Current President, Irish Society of Urology; Current Council Member, British Association of Urological Surgeons; Current Trustee, The Urology Foundation, London; Current Hon. Secretary, The Urological Club of Great Britain and Ireland. Previous Chairman Dublin Region Pre-Fellowship Training Scheme; Previous Director of Training, Irish Society of Urology Current Chairman, British Journal of Urology International Previous Secretary of Medical Board, St Vincent's University Hospital, Dublin Chair National Prostate Cancer Tumour Group, The National Cancer Control Programme



Professor Kevin Conlon
General Surgery, Trinity College Dublin / St. Vincent's University Hospital / Tallaght Hospital. Member of the General Surgical Subcommittee and Irish Surgical Postgraduate Training Committee, RCSI; Director: Centre for Pancreatocobiliary Diseases, Adelaide and Meath Hospital inc. National Children's Hospital; Head: Department of Surgery, TCD (2006-2009); American College of Surgeons International Relations Committee (2005-2011).



Mr. David Moore
Trauma & Orthopaedic Surgeon, Our Lady's Children's Hosptail Crumlin / Tallaght Hospital Dublin, President of the Irish Institute of Trauma and Orthopaedic Surgery (2007 - 2013). Member of the RCSI College Board, Chairman of the RCSI Academic Council. Member of the RCSI Finance Committee. Member of the RCSI Medicines and Health Sciences Board. Steering Committee of the Irish National Orthopaedic Register. Joint Clinical Lead in the Trauma and Orthopaedic Clinical Programme. Steering Group for the Prospective Funding. Member of the Joint Committee for Intercollegiate Examinations. Member of the Governing Board of the National Office of Clinical Audit. Member of the Steering Committee of the Irish Hip Fracture Database.



Professor K. Simon Cross
Consultant Surgeon (General), Waterford Regional Hospital SER Postgrad.Vice Dean/Director BST Training 2006-13; Tutor SER RCSI FIRST Programme 2006; Lead MRCSI Examination Waterford 2006-12; SpR Trainee Mentor Examiner for Intercollegiate Specialty Board in General Surgery 2008; Hospital based Director of Core Surgical Training 2014.
Chairman SR Group in Surgery 1993-94; SER Representative ISPTC; WRH Representative Gen. Surg. Subcommittee; WRH Representative BST Committee; WRH Representative on Core Surgical Training Committee; RCSI Deputy Representative on Intercollegiate Board in General Surgery; RCSI Representative on Intercollegiate Board in Vascular Surgery



Dr. Laura Viani
Consultant Surgeon (Otolaryngology), Beaumont Hospital and Temple Street Hospital; Director of Cochlear Implant Programme; Member of European and British Cochlear Implant Groups, Past member of Comhairle na nOspideal; past member Honorary Secretary, Medical Board, Beaumont; Higher Surgical Training Committee-Otolaryngology; Member, Finance Committee & Council, RCSI.



Professor Michael Kerin

Professor and Head of Department of Surgery, NUI Galway September 2004-; Lead Surgeon Breast Check/General Surgeon Mater Misericordiae/UCD 1999-2004; Senior Lecturer / Consultant Surgeon, University of Hull 1996-1999; FRCSI, FRCS Ed 1988; MB, NUI Galway 1984; Millin Lecturer RCSI 1996; James IV International Traveller 2002; External Reviewer to British Screening Association Surgical Oncology Group 2004; President Society Irish Breast Surgeons 2006; Organiser of several National & International Surgical Oncology Meetings (Nottingham, Freyer, Mater etc); Regional Director of Basic Surgical Training Programme; Represent General Surgery, Surgical Oncology, Academic and Trainees View.



Ms. Camilla Carroll

Consultant ENT Head and Neck Surgeon and lead Consultant in the Emergency Department at the Royal Victoria Eye and Ear Hospital Dublin. RCSI School of Medicine graduate (Class of 1985); Fellowship in General Surgery (1989); AJCHNS Fellow in Head and Neck Surgery University of Toronto, Canada (1998-2000); Imperial College London Masters Medical Educational programme in Surgical Education 2015 -2017; External Faculty Member for the Department of Surgical Affairs (Human Factors in Patient Safety); Postgraduate examiner in the Court of Examiners for the Royal Colleges; Surgical mentor for the recently formed WISA division of COSECSA; Associated with the RCSI Sayed Hanson Medal in Anatomy and the RCSI Sayed Neurosurgical Research Medal in Neurosurgery. Currently, involved in establishing a postgraduate training programme for GP ENT Specialists; Chairperson Student Services Council; member Academic Council and Professional Development & Practice Committee, RCSI.



Ms. Bridget Egan

Consultant Surgeon (General) The Adelaide and Meath Hospital, Tallaght Secretary General Surgery Subcommittee; Member ATLS Committee; RCSI ATLS Instructor; AMNCH rep National Vascular Training Group; Intercollegiate Membership Examiner ; Intercollegiate Fellowship Examiner (Accepted)

Secretary Irish Association of Vascular Surgeons; IAVS Rep to UEMS Section and Board of Vascular Surgery; Examiner European Board of Vascular Surgery; Reviewer European Journal of Vascular and Endovascular Surgery

Chair Medical Board AMNCH; Member Steering Group Trinity Health Ireland; Member Executive Trinity Health Ireland

	**Ms Deborah McNamara** Consultant Surgeon (General/Colorectal), Beaumont Hospital, Programme Director, Higher Surgical Training; Programme in General Surgery, RCSI 2010-2013; Chairman, General Surgery Sub Committee, RCSI 2010 –2013; Secretary, General Surgery Sub Committee, RCSI 2007-2010; RCSI nominee, National Endoscopy Training Group of the Conjoint Board of the RCPI and RCSI 2009 – present Council Member and Irish Chapter Representative, Association of Coloproctology of Great Britain and Ireland, 2009-present Secretary, Iri

Source: http://www.rcsi.ie/council (Accessed on the 15/03/2016)

Appendix VIII

The 17 faculties of medicine in Canada

Faculty of Medicine, MEMORIAL UNIVERSITY OF NEWFOUNDLAND

Faculty of Medicine, DALHOUSIE UNIVERSITY

Faculty of Medicine, LAVAL UNIVERSITY

Faculty of Medicine and Health Sciences, UNIVERSITY OF SHERBROOKE

Faculty of Medicine, UNIVERSITY OF MONTRÉAL

Faculty of Medicine, MCGILL UNIVERSITY

Faculty of Medicine, UNIVERSITY OF OTTAWA

School of Medicine, QUEEN'S UNIVERSITY

Faculty of Medicine, UNIVERSITY OF TORONTO

Michael G. DeGroote School of Medicine, MCMASTER UNIVERSITY

Schulich School of Medicine & Dentistry, WESTERN UNIVERSITY

Northern Ontario School of Medicine, LAURENTIAN UNIVERSITY / LAKEHEAD UNIVERSITY

Faculty of Medicine, UNIVERSITY OF MANITOBA

College of Medicine, UNIVERSITY OF SASKATCHEWAN

Faculty of Medicine & Dentistry, UNIVERSITY OF ALBERTA

Faculty of Medicine, UNIVERSITY OF CALGARY

Faculty of Medicine, UNIVERSITY OF BRITISH COLUMBIA

Appendix IX

Themes for Interviews with Employer Representatives

1. What is the role of the organisation in hiring, promoting and transferring of migrant doctors around the hospitals in Ireland and the criteria for such practices? I will be looking at the code of ethics in relation to recruitments and promotion (if relevant).
2. What is the total number of foreign doctors in Ireland?
3. What is their nationality and gender breakdown?
4. What are the areas of specializations of these doctors?
5. What are their occupational positions?
6. What are their present places of primary assignment?
7. What specific challenges do the organisation perceives as facing the international medical graduates in practicing successfully in Ireland?
8. How has the organisation tried to combat these barriers? In order words, what are the specific programmes and initiatives put in place by the organisation to facilitate full integration or inclusion of these set of workers?
9. What is the success rate of these programmes and initiatives?
10. General discussions on the recruitment and retention of migrant doctors in Ireland.

Appendix X

Interview guide for IMGs

11. Your Nationality
12. Your Profession
13. Your Age
14. Year of graduation
15. Country of graduation
16. Year of registration in country
17. Occupational position on arrival in country
18. Present occupational position
19. What are the perceived professional challenges faced pre and post-employment in Ireland/Canada. Specifically,
    - What are the challenges faced during registration?
    - Are your previous experiences gained practicing outside Ireland, taken into consideration at the point of access?
    - How was your professional competency rated on arrival in Ireland/Canada?
    - How would you describe your experience of progression as an international medical graduate in Ireland/Canada?
20. In relation to professional integration, what are your experiences? Do the HSE/HC and the various training bodies operate on the principle of equality in relation to admissions onto training schemes, rotation around hospitals, etc.?
21. What are the specific inclusion initiatives you could mention, championed by the HSE/HC and the other training bodies in combatting the problem of over-representation of migrant doctors in the grade Non-Consultant Hospital Doctors and their under-representation as Consultants? Or In Canada, inability to access professional practice.
22. Is your professional progression comparable to that of your mainstream European counterparts?
23. Being an internationally trained healthcare professional, how did you become integrated into your professional sphere? What are the challenges to your own integration and how did you navigate around these challenges?
24. Are you aware of any inclusion policy in the country and will you say it is effective in dealing with some of the challenges you faced as a junior doctor?
25. What do you think are the barriers to professional integration of IMGs in relation to the medical profession in Ireland/Canada?
26. How do you think the perceived barriers to the full integration of migrant doctors could be removed?
27. Would you be able to describe your experience with clients as a junior doctor in Ireland/Canada?
28. Would you see your race/ethnicity or gender as a barrier to upward mobility within the medical profession in Ireland?
29. Any other issues I might not have mentioned that you think will be beneficial to producing an original piece of work.

Appendix XI

Purpose of the Research

This research is a part of my requirement to complete a PhD Social Science degree at the University College Cork. It is purely academic and not for commercial purposes. No name or place will be mentioned when the final thesis is being written and this entire document remains confidential and will be destroyed after the submission of the thesis.

The main purposes of this research is to gain an in-depth understanding into the specificities of various challenges faced by foreign trained doctors in relation to access and progression within the public health sector in Ireland and benchmark these experiences in Ireland with those of foreign doctors in Canada. This study also seeks to assess the impact of current employment equality policies and practices of healthcare provision employers in both Ireland and Canada in relation to addressing existing and perceived challenges to migrant doctors' inclusion.

At the heart of this purposes is the desire to acquire knowledge that will help inform the development of tools and resources to support the integration of foreign doctors into all occupational grades within the medical professional fields in both Ireland and Canada and to contribute original knowledge to an academic field that is currently under-researched in Ireland.

Appendix XII

Informed Consent Form for Interview interviewees

Professional Integration Experiences of International Medical Graduates in Ireland and Canada

Consent Form

I _____ agree to participate in the research in the study 'Employment Equality and Workplace Inclusion of Immigrants: Internationally Educated Health Professionals' Experiences in Ireland and Canada'.

The purpose of this study has been explained to me and I understand it.

I am participating voluntarily.

I give permission for my interview with Olaniyi Kolawole (the interviewer) to be recorded on the project recording instrument and any information I have provided to be kept on record as part of the research data.

I understand that I can withdraw from the study, without repercussions, at any time whether before it starts or while I am participating.

I understand I can withdraw my permission to use the data up to the point of submission of the material for publication, in which case the material I have provided will be deleted. Should I wish to withdraw my data from the study, I agree to email the researcher to indicate my decision.

I understand that anonymity will be ensured in the in the write-up by disguising my identity.

Signed_____ Date_____