

## **Foreign Trained Doctors in Canada: Cultural Contingency and Cultural Democracy in the Medical Profession**

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### **Abstract**

In recent years, the media have highlighted the baffling exclusion of internationally trained physicians in the face of Canada's chronic doctor shortage and exasperating "patient wait times" crisis. Despite the logical role foreign physician could play in resource planning in this country, they still face numerous challenges and institutional barriers in attempting to enter the supply of practicing physicians. This article examines the relationship between culture and power as a critical foundation for understanding the credentials devaluation of foreign-trained doctors, and as a fundamental step toward the advance of inclusive public policy. It argues that the medical profession is culturally regulated to the disadvantage of foreign-born and foreign-trained and predominantly non-European and non-White immigrant practitioners. This paper concludes that the current professional and academic discourse on foreign medical doctors is limited by the lack of an adequate contextual framework, and offers a perspective on a balanced and inclusive approach to social policy.

### **Introduction**

The greatest social control power comes from having the authority to define certain behaviours, persons and things.

Conrad and Schneider (Deviance and Medicalization)

An article in Reader's Digest entitled "*Why Is Canada Shutting Out Doctors?*" acknowledged a fundamental immigration paradox in the field of medicine: While millions of Canadians can't find a doctor, thousands of foreign physicians can't get a licence to practice in Canada.<sup>1</sup> There is a growing consensus among the public, health professionals and administrators across the country that Canada is facing a doctor shortage of unprecedented magnitude,<sup>2</sup> yet a complicated self-regulating bureaucracy seems intent on shutting out foreign-trained physicians. Long wait periods have underscored shortages in certain medical specialties, while ample supplies of trained physicians from other countries seek access to practice medicine within the same specialties.<sup>3</sup> Meanwhile, medical associations across the country report doctor burnout from overwork, threats of job action, and potential cuts to existing services.

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Canada's healthcare system, commonly known as Medicare, took shape in the 1950s and '60s, and is designed to ensure that all residents have reasonable access to medically necessary hospital and physician services, on a prepaid basis. Founded on the liberal democratic principles of universality, accessibility, comprehensiveness, portability, and public administration, the system was considered the crown jewel of Canadian social programming and enjoyed both massive public support and international admiration (Grant 1993:401). However, a decade of turbulence has transformed Medicare from icon of social rights and organizational know-how to an apparent state of crisis and public consternation (Lewis et al., 2001:926). A further blow to an already shaken collective psyche was the publication of the international report from the Organization for Economic Co-operation and Development (OECD) that rated Canada's healthcare system 30th in the world in terms of achievement relative to potential. Canada now has one of the lowest ratios of doctors to population in the Western world.<sup>4</sup>

By 2003, Canada had 2.1 practicing physicians for every 1,000 residents, less than half as many as Greece which came in at the top of the scale at 4.4. The list of countries that out-doctor Canada includes the Slovak Republic (3.6), Hungary and Switzerland (both at 3.5) and the Czech Republic (3.4). France, Germany and the Netherlands all had 3.3 doctors per 100,000, roughly a third more than Canada. In 1999, the United States figure was 2.7 for each 100,000 and the United Kingdom figure was 2.0. Despite a significant increase in health spending since the 1990s, Canada's physician workforce remains far below the OECD average for doctors which was 2.9 for each 100,000 of population, and the only countries with a lower number than Canada in 2001 were Mexico (1.5), Korea (1.4) and Turkey (1.3).

Today, an estimated five million Canadians are without a family doctor, and numbers appear to be growing. At present, just 23 per cent of Canadians are able to see a physician the same day they needed one placing this country dead last among the G8 countries when it comes to physician supply (Gulli and Lunau, 2008). Meanwhile, statistics projected for the coming years are not encouraging. The Canadian Medical Association has said that more than one third of this country's doctors are now 55 or older. As a result, further decreases in the number of family physicians and specialists are anticipated over the next decade, as significant numbers have limited or closed their doors entirely to new patients, and many more are on the verge of retirement.<sup>5</sup>

To date, government policy has been limited to simply given more resources to the system, while largely ignoring calls to enhance its comprehensiveness and accessibility (Lewis, et al., 2001). In the emerging knowledge-based-global economy and society, one of the most logical ways to attempt to relieve physician shortages and improve the comprehensiveness and accessibility of the system is by licensing more international medical graduates (IMGs)<sup>6</sup>. Historically, Canada's reliance on IMGs has been in the 20 to 30 per cent range, and it is recurrently acknowledged that the substantial and longstanding contribution of IMGs to the national physician supply has been of significant benefit to Canada.<sup>7</sup> Still, the physician to population ratio continues to expand due to ever-widening gaps in the labour market in relation to the demographic pressures of an aging population and the graying physician pool. As a result, concern over physician shortages across Canada are projected to continue for many years to come, and present a formative "human capital" (Becker, 1975) and resource planning challenge for Canada's healthcare system.<sup>8</sup>

Despite the important role of IMGs for physician resource planning in this country, they still face numerous challenges and institutional barriers in attempting to enter the supply of practicing physicians.<sup>9</sup> Many foreign-trained doctors are unable to obtain jurisdictional licenses to practice in Canada. While some are considered to lack the required preparation, knowledge and skill, others have been unable to confirm or demonstrate their skill levels due to prohibitive workforce policies, limited access to assessment and/or training opportunities, and lack of support to understand the licensure requirements in Canada. Unfortunately, for foreign doctors who have had their credentials devaluated or discounted, and often lack financial resources of Canadian-born residents, the certification processes in the medical specializations are often long and costly. Frequently, these requirements are a duplication of previous training and assessments (Scott, 1996:276). Consequently, a sizable number of individuals with internationally obtained medical training choose instead to leave the medical profession. With the Canadian health-care system strained by financial pressures and growing doctor shortages, it is indeed

frustrating to many medical doctors, and the public who are the stakeholders in the system, that few steps have been taken to effectively address these daunting challenges.

### **The Link Between Culture and Power**

The Reader's Digest question—*Why Is Canada Shutting Out Doctors?*—continues to resonate with increasing urgency and mystification. This paper will engage the question by exploring how it is possible for foreign education and learning to go unrecognized in the first place—that is, by interrogating the assumptive reality of the medical profession. The key objective in this regard is to examine the relationship between culture and power as a critical foundation for understanding the credentials devaluation of foreign-trained workers, and as a fundamental step toward the development of social justice perspectives and practice in Canada. Through the understanding of the nature of culture and power in Canadian society, we can begin to examine the differential relationship between foreign-born doctors and the Canadian medical establishment; and begin to see how the medical profession can be understood as a feature of a cultural-based power system that ideologically supports White male privilege. In this respect, the medical profession presents an ideal laboratory to begin to see “the how and the why” of a labour market that is culturally regulated to the disadvantage of foreign-born and foreign-trained and predominantly non-European and non-White immigrant practitioners.

Ghassan Hage's interpretation and use of Bourdieu's (1986) theory of “cultural capital” to explore multiculturalism and race relations in Australia is instructive here. In the book, *White Nation*, Hage (1998: 19) defines the term “White” as standing for people of European origin while the term “Third World-looking” people denote most of the rest. For Hage, nationality in Australia is played out as in a White fantasy, a fantasy of belongingness as well as control over a territorial space that is identified as an extension of selfhood. I not only belong to the place, but the place belongs to me. The content of this place is its Whiteness, white in the sense of White culture, a culture of (northern) European origins but clearly kin related to Southern Europe as well. The emphasis on ‘the look’ is important in tracking Whiteness as an organising principle that controls and positions ‘ethnics’ within the Australian social space. Hage argues that ‘White’ is not a stable, biologically determined trait, but a “shifting set of social practices” (Dolby, 2000:49). In this respect, the nation (of Australia) represents a circular field, with the hierarchy moving from the powerful centre (composed of ‘White’ Australians) to the less powerful periphery (composed of the ‘others’). The ‘others’ however are not simply dominated, but are forced to compete with each other for a place closer to the centre.

The professionalization of medicine in Canada can similarly be characterized as a circular field where White male privilege is centred as an institutionalized cultural capital attribute and constitutive feature of the normative order. The normalization of privilege manifests itself when all members of a society, as well as potential newcomers, are judged against the characteristics or attributes of those who are privileged. Typically this is seen as a neutral process: the standard is typically invisible to those who do the judging and deeply embedded in every institutional sphere, as well as immigration policy. Society's members and potential newcomers are subject to the hidden rules and unconscious procedures of Whiteness that inadvertently distort the process of recruitment, entry, treatment, promotion, and/or reward allocation in favour of one group rather than another. In this system, when people, usually the most privileged, succeed, it is seen as the result of individual effort or merit, not due to privilege (Wildman and Davis, 2002). This has been called “internalizing dominance,” i.e., all the ways that White people learn they are normal, feel included, and do not think of themselves as “other” or “different” (Sawyer, 1989). White people, particularly males, carry this privilege around with them at all times and everywhere they go and are generally unaware of it. McIntoch (1995: 76-77) describes White Privilege as

an invisible package of unearned assets that I can count on cashing in each day, but about which I was ‘meant’ to remain oblivious. White privilege is like an invisible weightless knapsack of

special provisions, assurances, maps, guides, codebooks, passports, visas, clothes, compass, emergency gear, and blank cheques.

Foreign credentials devaluation in medicine is not a generic phenomenon, but rather, has a disproportionate impact on people of colour. The degree of cultural distance from the dominant White majority is an important factor in labour market returns. In this respect, various interests and perspectives on credentials devaluation in our society must be understood in the context of a political economy where Whiteness is institutionalized as a form of cultural capital. Context, as Daniel Cohn (2006) argued, is often “a minimal concern to scholars trained to apply the scientific method to find the answer to a given problem.” But, “[F]or policy-makers working in a liberal democracy, context must be taken into account and given serious consideration in almost every decision, as it defines the breadth and nature of their opportunity to advance policy” (Cohn 2006:4). Indeed, as Cheung's (2005) recent research suggests, the major limitation of foreign credentials literature in Canada today lies in the categorization of immigrants from an inadequate reference point: either that of the White mainstream, or of an otherwise undifferentiated victim. Rather than establish a theoretical and methodological foundation for sound public discussion of social policy, much foreign credentials literature provides a generalized, multi-purpose body of knowledge. But, in attempting to provide knowledge that is applicable to all, it provides a body of knowledge that is, in actuality, applicable to none.

In the following sections of this chapter we will trace the culturally contingent dynamics of the medical profession in Canada, and critically examine how it evolved over the years into a self-regulating institution and a site of social reproduction for elite White males. We will then discuss the integration and settlement patterns of foreign-trained doctors from traditional (European) and non-traditional (non-European) source countries, the cultural matrix for the professionalization of medicine, and the social consequences of “credentialism” manifested in unrecognized education and learning in a diversified labour market. This information provides a glimpse of the theoretical and methodological possibilities for minimizing unnecessary barriers in the medical profession, accelerating the integration of immigrant professionals into the national economy, and facilitating the transfer of skilled immigrant doctors to under-served communities. This in turn might eventually contribute to the development of a consistent and fair system that meets the physician human resource needs of the Canadian public and considers the interests of both international and Canadian medical graduates.

### **The Dialectic of Culture and Power as Methodology**

The dialectical relationship between cultural and power has received widespread attention all around the world from theorists and researchers alike. However, it is generally acknowledged that John Porter's (1965) seminal analysis of Canada's “vertical mosaic” kick-started the dialectical view of culture and its link to social power as essential to understanding the logic that supports dominant and subdominant relationships in Canadian society. Inherent in this view is the notion that culture does not function in a social vacuum, but rather as a system that is characterized by social stratification and group tensions. This perception of culture, as Porter argued, provides an excellent starting point for conceptualizing ethno-racial issues related to dominant and subdominant cultures in terms of relations of power.

This dialectical view of culture, as Richard Johnson (1983:11) argued, incorporates the following three principles

The first is that cultural processes are intimately connected with social relations, especially with class relations and class formations, with sexual divisions, with the racial structuring of social relations, and with age oppression as a form of dependency. The second is that culture involves power and helps to produce asymmetries in the abilities of individuals and social groups to define and realize their needs. And the third ... is that culture is neither autonomous nor an externally determined field, but a site of social differences and struggles.

Culture in this view—in contrast to the conventional anthropology concept of culture defined as an all-embracing neutral category or artifact that contains the traditions and values of diverse groups (see Mead, 1964; Boas, 1982)—provides a sociological method for looking at the dynamics of subdominant cultures and how relations of power and culture directly impact on the lives of differentiated groups, played out in major social institutions and in the workplace. Generally speaking, the dominant culture refers to ideologies, social practices, and structures that affirm the central values, interests, and concerns of those who are in control of the material and symbolic wealth of society. Subdominant cultures are maintained in exploitative conditions and relations not only through the dominant culture's function to legitimate the interests and values of the dominant groups, but also through an ideology that functions to marginalize and invalidate cultural values, heritage, language, knowledge, and lived experiences, all of which constitute essential elements for the survival of subdominant cultures. Keeping this in mind, it is also important to note that subdominant cultures are situated and recreated within life processes of society that are strongly informed by relations of domination, resistance and affirmation.

In this respect, culture is understood as the shared and lived principles of life, characteristic of different groups as these emerge within asymmetrical relations of power and fields of struggle. The meaning and nature of culture, as such, is derived out of the lived experiences of different social groups and the practical activities of ownership, control, and the maintenance of institutions. From this perspective, the structures, material practices, and lived relations of a given society are not in themselves a unified culture, but rather a complex combination of dominant and subordinate cultures that serve the function of the society itself. A phenomenon that is forged, reproduced and contested under conditions of power and dependency that primarily serve the dominant culture (Giroux, 1983).

A dialectical view of culture is present to the issue of power and to the nature in which cultural relationships are structured and perpetuated within and between groups. Hence, dialectical discourse is located in a multidimensional approach to understanding the conflict-based complexity of social stratification and ethno-racial hierarchy. An implicit but important assumption drawn from this dialectic of culture is that if the workplace is to move toward a context of “cultural democracy” (Ramirez and Castaneda, 1974; Darder, 1991; Marri, 2003),<sup>10</sup> then it must be recognized that the ability of individuals from different cultural groups to integrate into the workplace is related to the power that certain groups are able to wield in the social order.

### **The Professionalization of Medicine**

In contemporary society the profession of medicine has consistently maintained a labour force status as one of the highest paid and most respected occupations in Canada. In 2005, for instance, a national level study of occupational prestige in Canada was collected by telephone interviews. The survey included prestige ratings of the 26 major groups in Canada's National Occupations Classification (NOC).<sup>11</sup> Specialized Physicians rank first on the list of top jobs in Canada, while General Practitioners and Family Physicians rank third just behind Judges.

The term profession and professional signal a special position in the political economy which truly distinguishes them and the problems they have at work from those in other occupations. It is in this connection that Friedson (2001) calls a “profession” any occupation that seeks to fully control its own work. We now live in a world that is profoundly dependent on organized bodies of specialized knowledge and technique. As sociologists Dingwall and Fenn (1987: 53) point out, professional licensure is a theoretical solution to certain organizational problems which are intrinsic to any complex society. In this respect, “credentialism” can be understood as the modern occupational device that sustains monopolies and cultural closure in the professional labour market (Freidson, 2001: 204). Credentials are an institutionalized form of cultural capital associated with the emergence of the professionalization of work, which is ideological grounded in evolving traditions of capitalism, liberalism and modernity (Visano, 2006).

Roy Porter's (1997) famous analysis of the history of healthcare in advanced capitalism as a binary between the "professionalization of medicine" and the "medicalization of society" is relevant here. Traditionally, the physician simply patched up sick people. But over the past two centuries, Porter notes, medicine has gradually asserted a more central role in the ordering of society, staking claims for a mission in the home, the workplace and the law courts. Medicine transformed from being a negative enterprise of healing the sick to being a positive project of health promotion, i.e., keeping an eye on the apparently healthy to ensure that they do not succumb to sickness through poverty, ignorance, or inappropriate behaviour. The success of medicine, Porter argues, has allowed it to expand its empire and create a self-regulating and self-perpetuating professional aristocracy; but also, has led to ever 'inflated expectations' of medicine which, when unfulfilled, has created increasing disenchantment and public scrutiny. The result, he argues, has been the creation of a 'therapeutic state.'

This historical narrative on the professionalization of medicine and the medicalization of society, also involves the institutionalization of a medical establishment dominated by a White male elite that maintains ownership of skill or credential assets and control of high positions. As Erik Olin Wright (1985) argued, in advanced capitalist society, exploitation of one group by another does not only occur through control of property or the means of production (as Marx had insisted), but through ownership of skill or credential assets and control of high positions within organizations as well (Krahn, 1998: 167). This medical elite approach the Foucauldian notion of governmentality or the processes whereby a particular section of a population assumes the role of self governance as well as the governance of others. The definition of elites by Wodak and Matouschek (1993:226) identifies elites in the following ways

Elites . . . may be seen to comprise those who in one form or another dominate public discourse . . .  
. . . Elites are those who initially formulate and evaluate the various issues regarding minority groups. By virtue of their ability to determine an initial set of public discursive parameters, these elites are thus able to formulate an ethnic (cultural) consensus.

Roy Porter's (1997) work and historical perspective leads him to believe that if contemporary medicine is to continue to be recognized in the patina of Samuel Johnson's original accolade '*the greatest benefit to mankind*', it will have to redefine its limits even as it extends its capacities. Part of this redefinition may come from confronting diversification of the workforce, and moving toward a context of cultural democracy, where individuals from different groups are recognized to have the ability to express their cultural truths. In this discourse on democracy, any occupational theory of workplace relations must challenge how occupational meanings and values are structured and perpetuated in professions like medicine through the social mechanisms of economic and political control found in the society at large.

Professions as they are constituted in advanced capitalist societies, tend to hold a monopoly over the exclusive right to perform a particular kind of work in the marketplace, thus creating a labour market shelter (Freedman, 1976; Freidson, 2001: 198). Here, the institutions of professionalism remain largely intact because complex, esoteric knowledge and skill is difficult to organize in any other way than by some kind of protective monopoly and expert authority (Freidson, 2001: 208). The idea of "professionalism" then, both requires and refers to training of an incumbent by members of an occupational group. Upon completion of their training, they are provided with a *credential* that serves as a qualification for entry into the labour market. The professionalization of medicine and the credentialization of the occupational membership are now routinized features of contemporary Canadian and North America life.

Of course, this was not always the case. In Victorian Canada, when the country was first confederating the nation, there were no such things as medical schools in the fashion of today. Someone in the 1800s who was not feeling particularly well, may have consulted a physician, or with equal conviction they may have elected to rely on a traditional healer in their community, or a midwife, or a person dealing in patent medicines, or a Thomsonian who advocated herbal remedies, or a homoeopath who believed that the more diluted the medicine the greater its potency, or a leech therapist who used bloodsucking or carnivorous aquatic or terrestrial worm for the practice of bloodletting, or a person

dealing in patent medicines, or anyone else reputed to have a special gift for healing. The point is, allopathic medicine in which disease is treated “by methods or drugs antagonistic to the manifestations of the disease being treated” (Edginton 1989:4; Henslin and Nelson, 1996:544) was commonly recognized as one of the many ways of treating illness. As historian Wendy Mitchinson (1993: 394) has noted, few medical schools existed in Canada in the mid-nineteenth century, and “the newly licensed physician had to face an array of competitors.”

The few medical schools that were opened in 1800s were similar to religious sects today: they competed for clients and represented different claims to the truth. That is, they had competing philosophies about what caused illnesses and how to treat them effectively. Often not even a high school diploma was required for admittance to such schools. Training was short, there was no clinical training, and lectures went unchanged from year to year. Until 1823, the only medical training available in Canada was through apprenticeship (Henslin and Nelson, 1996: 544). An aspiring doctor would be indentured, often as a boy, to a practicing physician for three to seven years. The training itself “was a kind of servitude with much drudgery. The pupil learned to draw teeth, to cup, to bleed, and dress minor wounds. He might also have to look after the preceptor’s horse and bring it around, saddled and ready” (MacDermot 1967: 110). There were no course prerequisites, entrance exams, or formal lectures, and the role of physician was often fused with other roles. Although provincial examining bodies slowly developed to control licences, many doctors continued to practice in defiance of the law. Moreover, while medical journals often printed complaints about “quacks and unlicensed practitioners penalties were rarely enforced (Henslin and Nelson, 1996:544). However, by the end of the nineteenth century, training in an allopathic medical school and the receipt of a university degree had become “the normative route accepted by licensing boards across the country” (Mitchinson, 1993: 25).

The founding of the Canadian Medical Association (CMA) in 1867 meant the effective end of pluralism in Canadian medicine, and the primacy of the scientific model of medicine as promoted by the allopaths (Mitchinson, 1991: 23). When physicians began to join forces to challenge their competitors, the medical establishment in Canada started to dominate the division of labour in which it worked by controlling both the provincial institutions which licensed it and related occupations for unlicensed practice. The CMA was able to have laws passed to restrict medical licences to graduates of approved schools, and to ensure that only graduates of those schools could train the next generation of physicians. In short, by controlling the education and licensing of physicians, the CMA silenced most of the competing philosophies of medicine. So, for instance, in 1869 Ontario created its own College of Physicians and Surgeons who could through its board of directors “certify potential candidates for licence, examine candidates (with some exceptions), and most significantly, determine the standard of medical education or training.” By forming societies, physicians could restrict the practice of medicine to those of like training and orientations. As Edginton (1989: 137) has pointed out: “Its motive in restricting entry to the practice of medicine was not to protect the health of the population (by eliminating quacks), but to create a medical monopoly.”

The elimination of competitors not only paved the way for medicine to become big business, but also to be consolidated around a White, male elite. The end of pluralism in medicine was coterminous with the institutionalization of the human capital of the dominant group as the cultural capital for the whole medical field. Only a select group of White men—a “priesthood” of medicine—was allowed to diagnose and treat medical problems (Henslin and Nelson, 1996:546). They were delegated with the exclusive authority to determine what was right for people’s health. As Milner (1956) noted, only they could scribble the secret language (Latin) on special pieces of parchment (prescription forms) for translators (pharmacists) to decipher. Since only physicians could prescribe state-regulated drugs or order the use of diagnostic and treatment technology, both pharmaceutical and medical technology firms, along with hospitals and the insurance industry, were political allies who supported the policy positions of the profession (Freidson: 2001:182). As the legal gatekeepers who controlled the consumption of medical products and the use of facilities, those industries sought primarily to persuade physicians to prescribe their products, use their technologies, and patronize their facilities. This select group of pale males was

able to shape itself into the most lucrative profession in the country. As a consequence, the well-financed medical associations exercised considerable political influence and labour market control.

These important historical developments in the medical labour market have been greatly stimulated by the supportive ideological structure accompanying the professionalization of health practice. In the occupational transformation and establishment of medicine into a profession the ideology of “public safety” has come to dominate policy discourse, supplemented by the ideology of the “credentialed expert.” As Cyril Chantler (1998: 1670), Dean of the Medical and Dental School at King’s College London put it: “The cardinal principles of medical ethics are to protect life and health, to respect autonomy, and to strive for equity and justice.” Part of the ideology of public safety asserts that health professionals are motivated much more by their dedication to serving the public and doing good work than they are their own material self-interest. Yet, the unusually and consistently high incomes of physicians throughout the history of professionalized medicine would seem to belie the occupational ideology, and negate the ideology of the credentialed expert interested only in disinterested service. Aside from that, the economic privilege at the centre of the ideological struggles against competitors of the past, remain at the heart of the struggles today. This privilege consists in creating what Weber (1978) called a “social closure,” or holding a monopoly over the exclusive right to perform a particular kind of work in the marketplace, thereby creating a labour market shelter. Social closure is secured in contemporary society through the institutionalized cultural capital of the credential certification process. The social instrument which sustains the labour market shelter in professions like medicine is a credential testifying to the successful competition of professional controlled training. For the profession of modern medicine, like other regulated professions, monopoly (social closure) and credentialism (cultural currency) became the key elements of economic privilege (Friedson, 2001).

The success of the medical profession has led to what Peter Conrad (2007) called “*The Medicalization of Society*.” Medicalization describes a process by which non-medical problems come to be defined and treated as medical problems, usually in terms of illness and disorder. Ancillary to the increasing medicalization and expanded markets, the medical profession has increased and expanded control over those markets. So, for instance, medicalization studies by sociologists and feminist scholars have shown how women’s problems have also been disproportionately medicalized and then colonized by (White) men. This is manifested in studies of reproduction and birth control, child birth, infertility, premenstrual syndrome, fetal alcohol syndrome, eating disorders, sexuality, menopause, cosmetic surgery, anxiety and depression (Riessman 1983).

Midwifery is a classic historical example of “internal colonization” (Blauener, 1972), that is, how elites use institutions to deny minority groups access to society’s full benefits. It had been the custom in Canada, as elsewhere, for midwives to deliver babies. Pregnancy and childbirth were considered natural events for which women were best equipped to help women. It was also considered indecent for a man to know much about pregnancy, much less see a woman deliver a baby. Some midwives were trained; others were simply neighbourhood women who had experience in childbirth. In many European countries, midwives were licensed by the state; they still are. In both Canada and the United States, physicians came to see midwives as business competitors (Rothman, 1994).

As physicians grew more powerful politically, and more expansive in their market outlook, they launched a bitter campaign against midwives, attacking them as “dirty, ignorant, and incompetent” and even calling them a “menace to the health of the community (Henslin and Nelson, 1996:547). For example, even though few knew anything about delivering babies, physicians in the United States used their new organizational clout in persuading many states to pass laws that made it illegal for anyone but a physician to deliver babies. In Canada, the Victorian Order of Nurses, (founded in 1897 by the National Council of Women to assist rural women who otherwise lacked access to medical care), originally included midwifery in its work. However, as Mitchinson (1993:396) observes, “the opposition of the medical establishment in Canada was so great to what it saw as an infringement of its prerogatives that the idea was allowed to die.” The struggle is not yet over, and nurse-midwives and physicians still clash over who has the competency and right to deliver babies.



Political power derived from genetic elitism was central to sanctioning male physicians' success in expanding their domain over what had been women's work. The key to the internal colonization of women's work here was the ability to redefine pregnancy and childbirth as a medical condition rather than a natural event. To eliminate midwives, White male medical professionals launched a campaign of images, stressing that pregnancy and childbirth were not "normal." What is normal here, or "normalized" is the White male privilege of physicians. Their new definitions, which flew in the face of the millennia-old tradition of women helping women to have babies, transformed pregnancy and childbirth from a natural process into a "medical condition" that required the assistance of an able male. As Henslin and Nelson (1996:547) observe, "[W]hen this redefinition made childbirth 'man's work,' not only did the prestige of the work go up – so did the price."

This social biology perspective in early Canadian medicine and its connection to genetic hierarchy, is both an historical and constitutive part of the conventional wisdom and collective consciousness of the Western world. So, the White medical establishment was not unique in its attitudes toward genetic determinants of gender and race. The books of Herbert Spencer, for instance, expounding on what has come to be known as "Social Darwinism" (see Hawkins, 1997), were read by millions of North Americans, and he had many outspoken disciples among writers, scholars, judges, politicians, editors, clergymen and businessmen. The theory was born with Darwin's (1959) *The Origin of Species* where he expounded on the scientific model of evolutionary advance through competition and survival of the fittest. Darwin had hit upon his great organizing principle in biology—i.e., natural selection—while reading Malthus on the dynamics of population. The principle was then crystallized in the social context again by Spencer who argued that through struggle and conflict certain societies and groups came out on top. Any interference with the process of struggle would have an adverse effect on social development, encouraging poorer quality stock to increase at the expense of the superior. Superior races and groups could become polluted by mixing with inferior races and groups, or by social policies which did anything to alleviate the struggle. It was the "Nordic" and "Aryan" races which these doctrines elevated to highest rank among human beings. Through such theories, imperialism and aggression was viewed as serving a principle of general social evolution (Porter, 1965: 62).

Meanwhile, it was not until 1951 that Elinor Black became the first woman head of a Canadian medical school department, Obstetrics and Gynecology, at the University of Manitoba and Winnipeg General Hospital. Similarly, while Anderson Ruffin Abbotts earned his licence from the Medical Board of Upper Canada in 1861 as the first African Canadian doctor (Hill, 1981), historically the representation of people of colour in the medical field in Canada has been negligible. By curtailing entry to the profession and by specifying what other "para-medical" practitioners could and could not do, the White male medical establishment relegated women and people of colour to the periphery of medicine and ensured their own status, prestige, and high incomes (Henslin and Nelson, 1996: 546).

### **From Genetic Determinants to Cultural Determinants**

During the 1930s, scientists began to raise serious doubts not only about Social Darwinism, but also about the scientific validity of the concept of "race" itself (Barkan, 1992). Since the 1950s, the scientific consensus has been that racial classifications of humanity are arbitrary, that genetic differences between groups are small, and that genetic differences are behaviourally insignificant (Montagu, 1972). More and more, ethnoracial boundaries and identities were viewed as flexible, negotiated, and historically variable. In this respect, it is now recognized that "race" is not an inherent characteristic of individuals, but is socially constructed, taking on a particular meaning in each historical and geographical context. This did not lead to the conclusion, however, that race and ethnicity are unimportant aspects of late modern society. Rather, as W.I. Thomas's famous dictum contends, if people define situations as real they are real in their consequences (Thomas and Znaniecki, 1918: 79). Even though critically scrutinized "race" is a hollow biological concept, and even though ethnoracial identities and boundaries are neither fixed nor unchanging, many people believe in the existence of race, and organize their relationships with others on the basis of those beliefs. Therefore, race is an important part of our social reality.

Analytically, however, race is no longer predominately viewed as a biological reality, but rather, a relational reality.

In this connection, Sleeter wrote “that what White people know about the social world is generally correct, but only for understanding White people” (1992:211). She referred to the perspective of most White people about race as “dysconscious racism,” a term she borrowed from Joyce King. King wrote that “[D]ysconscious racism is a form of racism that tacitly accepts dominant White norms and privileges. It is not the absence of consciousness (that is, unconsciousness) but an impaired consciousness or distorted way of thinking about race as compared to, for example, critical consciousness” (1991:135). Dysconsciousness has manifested itself in the distorted mainstream consciousness of the credentialed foreigner. For example, in her analysis of the United States Immigrant Survey for 2003, Joni Hersch, a Professor of Law and Economics at Vanderbilt University Law School, found that new lawful immigrants to the U.S. who have lighter skin color and are taller have higher earnings, controlling for extensive labor market and immigration status information, as well as for education, English language proficiency, outdoor work, occupation, ethnicity, race, and country of birth. Immigrants with the lightest skin color earn on average 8 to 15 percent more than comparable immigrants with the darkest skin tone. Each extra inch of height is associated with a 1 percent increase in wages. The skin color advantage is not due to preferential treatment of those with lighter skin color in country of birth or to interviewer bias. The findings of this paper are consistent with discrimination against new immigrants on the basis of variations of skin color where Whiteness is the qualitative denominator (Hersch, 2007).

In contemporary discourses on gender and race, research suggests that the genetic elitism of the past has given way to a “cultural imperialism” and an attendant dysconsciousness regarding the colour-coded high-status professions like medicine. So the former genetic determinants of social classification have been superceded by cultural determinants of social classification/polarization. Here, bodies are ascribed race and gender identities that are not linked with biological ranking, but rather, are associated with different culturally embodied competencies. So, what is race? The what-ness of a race is a “privilege and classification” discourse that locates and defines social positioning in relations to a White cultural omega point. Today, “race” bridges the gap between public space and cultural space.

Indeed, a critical examination of the contemporary concept of ‘race’ (Winant, 2000) defines it as a cultural, political and economic construct which classifies people according to the phenotype (skin colour and other physical traits). Therefore, race is still an important part of contemporary social reality in that it draws on interactive distinctions between the privileged and the non-privileged, the dominant and the subdominant. Through the control of major social institutions the dominant culture is able to enforce and reproduce its authority. Though science has now shattered the link between genetic determinants and “social classification,” thereby demonstrating that the concept of race is indeterminate, “race” remains embedded in values of the dominant culture and perpetuates privilege and disadvantage in our society (Winant 2006). The dominant culture can manipulate “race” in order to exercise control over and justify the exploitation of subdominant groups (ergo: the “racialized other”).

Or to put it another way, cultural domination is no longer a subset of genetic elitism, but rather, in contemporary society genetic domination is a subset of cultural elitism. Immigrant doctors of colour continue to be colonized and subjected to a “secondary imperialism” (Carroll, 1989; Dua, 1999) in the political economy of medicine. Recent studies have begun to show how ethnoracial identity embodies competencies that signify differentiated cultural capital in the labour force (Bannerji, 1996; Richmond, 1994; Galabuzi, 2006). This is to say, while genetic determination of social categories may have little currency in contemporary science or everyday work-life, the difficulties immigrants of colour encounter in the recognition of their foreign credentials can be understood as a systematic process of labour-market exclusion, facilitating the reproduction and maintenance of a Whitemainstream economics and practice. Those who hold a valued position may have an interest in defining it in such a way that it cannot be occupied by anyone other than the possessors of properties identical to their own (Bourdieu 1984:151; Bauder, 2003:702).

The modern monopoly of professionalism is not directly “over real property, wealth, political power, or even knowledge, but rather over the *practice* of a defined body of intellectualized knowledge and skill, a discipline.” (Friedson 2001:198). The monopoly of professionalism is affected through the ability to define the entry requirements into the practice, and the performance measures of success. While the modern profession of medicine has grown into a high-tech and self-governing enterprise with a special position in the political economy, it is significant to note that the professionalization of medicine and credentialization of occupational membership are also sites of social reproduction and the perpetuation of the status quo. The modern monopoly in field of medicine is the result of a historical-political struggle to define the treatment of “medical conditions” and to relegate the responsibility for “the health of the population” as the province of a White, male elite, and cultural territory controlled by White malestream thought.

Here, as Bauder (2003) argues, institutionalized cultural familiarity in the licensing criteria enforced by regulatory bodies are processes of distinction that undermine immigrants' access to the professions relative to Canadian-born and Canadian-trained applicants. In addition to assessing the value of non-Canadian credentials, the Medical Council of Canada and other medical regulatory authorities in the provinces—supported by federal and provincial legislation—attempt to reproduce the social and cultural integrity of the professional membership by requiring applicants to internalize cultural competency norms specific to the profession as it is practiced in Canada. Credentialism and licensing procedures can thus facilitate the cultural exclusion of immigrant practitioners, circumscribe their identity as high-risk interlopers, and trivialize their skills and potential contributions to society, all without any reference to race. Accordingly, a self-regulating medical elite can enforce the reproduction of themselves through the differential treatment of foreign and mainstream Canadian-educated workers through a rigorous certification system(s) defining “competency” that favours individuals who best fit the mainstream of Canadian education and experience to the disadvantage immigrants (Bauder, 2003). Moreover, this form of credentialism in the medical profession radiates outwards from a cultural hub of Whiteness in such away as the degree of disadvantage and exclusion correlates to an economic geography where foreign immigrants are roughly situated along a scale from the Global North to the Global South.

Indeed, some of the toughest definitional standards affecting cultural closure on the basis of embodied competencies are imposed by the medical profession (Bauder, 2003:702). Physicians interested in a permanent position in Canada will require full licensure. This will involve, as a minimum, writing the Medical Council of Canada (MCC) licensing exams, and, unless your postgraduate training is “approved and accredited” post graduate training it is nearly impossible for a foreign-trained physician to obtain the additional training required once in Canada, as most post graduate training programs admit only graduates from Canadian medical schools. The situation for the specialists is similar. The Royal College of Physicians and Surgeons of Canada (RCPSC) consider acceptable only international postgraduate education from institutions in the UK, Ireland, Australia, New Zealand, South Africa and Singapore. International postgraduate education obtained in other countries either does not meet RCPSC criteria or are deemed “inconclusive”.<sup>12</sup>

Physician licensing also falls under the jurisdiction of the medical regulatory authorities in each province. Forms of licensing vary by province, but there are two general classes: full and provisional. The requirements for a full licence in Canada are nearly uniform, with the standard requirement being the Licentiate of the Medical Council of Canada. The requirement for a physician to have completed postgraduate medical training in Canada is an obstacle for IMGs wishing to obtain a full licence. However, provisional licences allow IMGs to practice without passing the Medical Council examinations (and completing the requisite Canadian postgraduate medical training). Thus, many IMGs start their careers in Canada by practicing under a provisional licence. The nomenclature for provisional licences varies across provinces, with such licences being called “public service,” “restricted,” “defined,” “conditional,” or “temporary.” In remote and underserved regions of Canada, medical services provided by provisionally licensed IMGs are vital. Typically, provisionally licensed IMGs are hired to meet an immediate shortfall of physicians; they obtain a provisional licence to gain entry to practice and tend to fill positions that Canadian medical graduates will not take (Audas, Ross and Vardi, 2005).

The Ontario International Medical Graduate Clearinghouse recently outlined the latest assessment eligibility procedures for medical licensure and contemporary training programs in the province of Ontario (Foster, 2004). The clearinghouse is the primary academic credentials assessment server in the province, and its assessment program is comprised of three pools of candidates allocated according to their medical specialty and immigration status as residents or temporary employment visa holders. All tolled, the program offered 200 entry level positions in 2005, which is comparable to the entry level openings of the largest medical schools (in fact, currently the entry level enrollment of the University of Toronto Medical School is the largest in the world with approximately 214).<sup>13</sup> In addition, the clearinghouse “objective is bringing order to the system” by act as a liaison between governments, regulatory bodies, medical schools and hospitals to streamline the process (Foster, 2004:7). From this assessment server perspective, the goal is to begin looking at the Ontario doctor shortage from a systems-operation approach rather than a plugging-gaps approach, which includes increasing the ability for assessing physicians and a comprehensive physician resource strategy (Foster, 2004).

At present, however, rigorous certification systems throughout the country favour individuals with Canadian education, training and experience, and disadvantage recent immigrant from predominately non-traditional, non-White source countries (Statistics Canada, 2006, 2003a, 2003b). Over the period from 1996 to 2005, “non-traditional,” “visible minority” source regions (namely, Africa and the Middle East, Asia and Pacific, and South and Central America) have accounted, on the average, for close to 80 percent of annual immigration to Canada (Citizenship and Immigration Canada 2006, p. 27). Hence, the result of global credentialism for Canadian medicine is a racialized, two-tiered occupational structure. Due to this segmented labour market, immigrants suffer from occupational downgrading or de-skilling, and are often forced to switch careers and experience loss of social status.

### **The New Institutionalized Cultural Elitism and Cultural Territoriality**

Credentialism and professional licensure has created a ‘competency lens’ in the field of modern medicine that embodies the dynamic tensions between cultural contingency and cultural democracy. The former Executive Director of the Office of Rural Health for Health Canada, John Wootton, alluded to both the cultural contingency of educational credentials and the possibilities of cultural democracy in the medical profession when he acknowledged there is an absence of evidence suggesting a correlation between the quality of care provided with the original location of medical education. “In fact”, he said, “there is likely to be greater inter-practitioner variation independent of location of training than there is variation as a result of training.”<sup>14</sup>

Most international physicians do not feel that they lack the qualifications or competence, but rather, they perceive they are differentially perceived and treated in the application and assessment process through rules and procedures that are culturally biased and arbitrary. Boyd and Schellenberg (2007) note, for instance, that while medical associations require demonstration of language proficiency for reasons of public safety, there can be significant disparities between licensing associations and applicants as to what constitutes acceptable levels of language “proficiency.” Case studies reveal that professional immigrants are told that their language skills are insufficient when in fact they believe their language proficiencies are good. “At issue here may be different perceptions over the number of words that are known or considered to represent a good level of language skills, the knowledge of technical terms used in Canada, and accent” (Boyd and Schellenberg 2007:7).

One ‘performance versus perception’ study in 2005 by the Institute for Clinical Evaluative Sciences found that doctors trained internationally provide the same level of care for heart attack patients as Canadian physicians. The study concluded that this information places the care provided by internationally trained doctors “into perspective” and should reassure patients and policy makers about their ability to deliver high quality heart attack care. Researchers tracked more than 127,000 Ontario heart attack patients admitted between 1992 and 2000 to acute care hospitals. They compared the mortality rates, and use of secondary prevention medications and invasive cardiac procedures of patients treated by international medical graduates versus Canadian medical graduates. The mortality rates of

IMG-treated and CMG-treated patients were not significantly different at both 30 days (13.3% versus 13.4%) and one year (21.8% versus 21.9%) following their heart attack. Patients treated by both groups also had similar likelihoods of receiving secondary prevention medications at 90 days following hospital discharge, and invasive cardiac procedures at one year. The report concludes that these similarities are likely a testament to the careful screening and training process before a licence is granted. The findings also speak to the ability of internationally trained physicians to become familiar with Canadian standards (Ko et. al., 2005).

In another study, researchers at the College of Family Physicians (Szafran et. al., 2005) compared the demographic and educational characteristics of Canadian international medical graduates (who studied abroad) and immigrant international medical graduates. The research study was drawn from a web-based questionnaire survey conducted during the second-iteration CaRMS match in Canada (see Tables 1). The sampling frame included the entire population of IMG registrants for the 2002 CaRMS match in Canada who expressed interest in applying for a ministry-funded residency position in the 13 English-speaking Canadian medical schools. Those who immigrated to Canada with medical degrees were categorized as immigrant IMGs. Canadian citizens and landed immigrants or permanent residents who left Canada to obtain a medical degree in another country were defined as Canadian IMGs. The researchers compared demographic characteristics, education and training outside Canada, examinations taken, previous applications for a residency position, preferred type of practice, and barriers and supports. Out of 446 respondents who indicated their immigration status and education, 396 (88.8%) were immigrant IMGs and 50 (11.2%) were Canadian IMGs.

Immigrant IMGs tended to be older, be married, and have dependent children. Immigrant IMGs most frequently obtained their medical education in Asia, Eastern Europe, the Middle East, or Africa, whereas Canadian IMGs most frequently obtained their medical degrees in Asia, the Caribbean, or Europe. This study found that immigrant IMGs tended to have more years of postgraduate training and clinical experience. Yet a significantly greater proportion of immigrant medical graduates perceived that there were insufficient opportunities for assessment, financial barriers to training, and licensing barriers to practice. In this study, this perception was corroborated by the fact that relatively more Canadian IMGs were successful at obtaining residency positions post-licensure. ([see Tables 2 and 4] Szafran et. al., 2005).

It is also significant to note the historical profile of International Medical Graduates entering Canada, and to examine the correlation between the immigration patterns and the distribution of IMGs nationwide. Historically, most IMGs immigrating to Canada were from Commonwealth countries and as a consequence of the long-established professional and licensure connections, integrated with ease into the Canadian physician workforce. Immigration and physician supply policies of the 1980s to the mid-90s in Canada made it difficult for potential immigrants who declared themselves as physicians to immigrate to Canada. Under previous Citizenship and Immigration Canada (CIC) policies, many alternative approaches existed by which individual MDs could immigrate to Canada, for example, as refugees, on spousal visas or with their occupation listed as "other" than physician. This indicates that the policies may have driven some MDs "underground" by not declaring that they were MDs, yet wishing to be once here. It is believed that only a small proportion of these individuals are practicing medicine today.<sup>15</sup>

In June 2002, Canada replaced the Immigration Act of 1976 with the new Immigration and Refugee Protection Act. The new legislation concentrates on skills, training and potential for successful integration into the Canadian workforce and society. It is intended to be adaptable and responsive, and to choose workers with flexible, transferable skill sets rather than specific occupational backgrounds. The Act also provides for the creation of a new landing class for certain temporary workers, including international graduates of Canadian schools with Canadian work experience who meet the selection criteria as skilled workers. The legislation has the theoretical potential to ease IMG entry into Canada, and lead to increased numbers of IMGs seeking to establish medical practice in Canada, promoting self-identification as medical professionals during the immigration process, and seeking professional integration upon arrival. Yet, the Taskforce on the Licensure of International Medical Graduates (2004: 9-

10) found that underemployed IMGs still come primarily as landed immigrants with “unintended” consequences. Landed immigrants tend to settle in larger multicultural urban communities, and rarely have prearranged employment, whereas physicians on work permits (from Commonwealth countries with long-established professional and licensure connections) tend to be more broadly distributed across the country, particularly in rural communities or areas of traditional need.

Although recently arriving immigrants of colour from Asia, Eastern Europe, the Middle East, or Africa (Szafran et. al., 2005) may be endowed with the same amount of education and experience as Canadian workers, they are excluded from upper labour-market segments to which Canadian-educated and Commonwealth-educated workers have access because of the differential assessment of their credentials. For the foreign-trained doctor of colour (Hage’s *Third World-looking people*), there are disproportionate returns to foreign education and labour-market experience. Here, the lived experience of credentials devaluation is not merely a human capital glitch or generic market imperfection in matching education to employment. The degree of cultural distance from the dominant White majority is an important factor in the social and economic integration of newcomers.

Canadian And Immigrant International Medical Graduates<sup>16</sup>

**Table 1. Characteristics of IMG groups**

DEMOGRAPHIC CHARACTERISTICS	CANADIAN IMGs N = 50 N (%)	IMMIGRANT IMGs N = 396 N (%)	CHI-SQUARE P VALUE
<b>Sex</b>			<b>.003</b>
• Male	37 (74.0)	197 (49.7)	
• Female	13 (26.0)	193 (48.7)	
• Not recorded	–	6 (1.5)	
<b>Age (y)</b>			<b>10<sup>-6</sup></b>
• 25-29	18 (36.0)	29 (7.3)	
• 30-34	22 (44.0)	135 (34.1)	
• 35-44	8 (16.0)	170 (42.9)	
• ≥45	2 (4.0)	59 (14.9)	
• Not recorded	–	3 (0.8)	
<b>Marital status</b>			<b>10<sup>-6</sup></b>
• Married or common law	22 (44.0)	340 (85.9)	
• Single, separated, or divorced	26 (52.0)	48 (12.1)	
• Not recorded	2 (4.0)	8 (2.0)	
<b>Number of children</b>			<b>10<sup>-4</sup></b>
• None	36 (72.0)	108 (27.3)	
• 1	4 (8.0)	107 (27.0)	
• 2	5 (10.0)	116 (29.3)	
• 3	3 (6.0)	41 (10.4)	
• ≥4	–	11 (2.8)	
• Not recorded	2 (4.0)	13 (3.3)	

**Table 2. Medical training of IMG groups**

MEDICAL TRAINING	CANADIAN IMGs N = 50 N (%)	IMMIGRANT IMGs N = 396 N (%)	CHI-SQUARE P VALUE
<b>Year of medical degree</b>			<b>10<sup>6</sup></b>
• 2000-2002	18 (36.0)	1 (0.3)	
• 1997-1999	25 (50.0)	32 (8.1)	
• 1994-1996	5 (10.0)	80 (20.2)	
• 1991-1993	2 (4.0)	83 (21.0)	
• 1970-1990	--	199 (50.3)	
• Not recorded	--	1 (0.3)	
<b>Location of medical degree</b>			<b>1.7x10<sup>6</sup></b>
• Asia	11 (22.0)	145 (36.6)	
• Eastern Europe	10 (20.0)	89 (22.5)	
• Middle East	5 (10.0)	62 (15.7)	
• Africa	3 (6.0)	60 (15.2)	
• Central or South America	1 (2.0)	18 (4.5)	
• Western Europe	8 (16.0)	7 (1.8)	
• Caribbean	10 (20.0)	3 (0.8)	
• Australia or New Zealand	2 (4.0)	--	
• Other	--	7 (1.8)	
• Not recorded	--	5 (1.3)	
<b>Years in clinical practice</b>			<b>10<sup>6</sup></b>
• None	20 (40.0)	20 (5.1)	
• 1-4	25 (50.0)	126 (31.8)	
• 5-10	--	144 (36.4)	
• 11-20	--	99 (25.0)	
• Not recorded	5 (10.0)	7 (1.8)	

Table	2
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**Table 4. Perceived barriers and supports**

PERCEIVED BARRIERS AND SUPPORTS	CANADIAN IMGs N = 50 N (%)	IMMIGRANT IMGs N = 396 N (%)	FISHER EXACT TEST P VALUE
<b>Perceived barriers to assessment</b>			
- Financial	13 (26.0)	131 (33.1)	.20
- Insufficient assessment opportunities	19 (38.0)	253 (63.9)	4 x 10 <sup>-4</sup>
- Not in preferred language	--	4 (1.0)	.62
- Other	5 (10.0)	30 (7.6)	.35
<b>Perceived barriers to training</b>			
- Financial	3 (6.0)	85 (21.5)	4 x 10 <sup>-3</sup>
- Insufficient training opportunities in your discipline	23 (46.0)	228 (57.6)	.08
- Insufficient training opportunities in any discipline	27 (54.0)	255 (64.4)	.10
- Social	--	28 (7.1)	.03
- Not in preferred language	--	3 (0.8)	.70
- Location	17 (34.0)	128 (32.3)	.46
- Licensing	15 (30.0)	182 (46.0)	.02
- Opportunities in field of practice	10 (20.0)	98 (24.7)	.29
- Other	8 (16.0)	24 (6.1)	.18
<b>Perceived barriers to practice</b>			
- Financial	3 (6.0)	50 (12.6)	.12
- Insufficient practice opportunities	17 (34.0)	179 (45.2)	.19
- Social	1 (2.0)	24 (6.1)	.20
- Not able to practise in preferred discipline	--	9 (2.3)	.34
- Location	8 (16.0)	48 (12.1)	.28
- Licensing	14 (28.0)	242 (61.1)	8x10 <sup>-6</sup>
- Insufficient opportunities in field of practice	7 (14.0)	92 (23.2)	.09
- Other	4 (8.0)	21 (5.3)	.30
<b>Perceived supports</b>			
- Financial	13 (26.0)	156 (39.4)	.04
- Orientation to medical practice in Canada	25 (50.0)	224 (56.6)	.23
- Knowledge of certification and licensing requirements	13 (26.0)	111 (28.0)	.45
- Knowledge of Canadian health care system	18 (36.0)	190 (48.0)	.07
- Assistance in preparation for examination	20 (40.0)	114 (28.8)	.07
- Coach or mentor	27 (54.0)	212 (53.5)	.54
- Other	18 (36.0)	83 (21.0)	.02



Using a multivariate regression analysis, for example, Boyd and Schellenberg (2007:4-5) argue

When all other variables in the model are controlled for, it is clear that those born in some regions have a better chance of finding employment as a physician ... a physician born in Canada, and assumed to have trained in a Canadian institution, would have a 92% predicted probability of working as a doctor. Taking all other variables into account, their internationally educated counterparts born in South Africa or South Asia would also have a very good chance, estimated at 85% and 87% respectively. In contrast, a foreign-trained physician born in other regions of Asia or in Eastern Europe had the lowest hypothetical chances (less than 66 out of 100) of being employed in their chosen profession.

For immigrants of colour, who remain more socially and economically marginalized, the effects and experience of labour force integration are more complicated and compounded by embodied cultural competencies. The degree of social distance of foreign workers from the dominant White mainstream and institutionalized cultural capital is an important (albeit, routinely undifferentiated) factor in the Canadian labour market.

Aydemir and Skuterud (2004) analyzed and evaluate the relative importance of a number of commonsense explanations of why the entry earnings of Canada's immigrants have deteriorated over the past 30 years. Using census data from 1966 to 2000, they argue that only about one-third of the overall decline of the entry earnings of Canada's most recent immigrants can be attributed to the "normal" economic cycle, or general labour market trends across the board, that have similarly affected immigrants and recent Canadian-born labour market entrants. They suggest that roughly two-thirds of the precipitous deterioration in the value of a foreign university degree and work experience in the past 30 years coincides with the ending of preferred country policies (targeting immigrants in traditional source countries in Western Europe), and the universalization of Canada's immigration programs that increased newcomer in-take from "non-traditional" source countries in Africa and Asia.

The study further found that among immigrants who arrived in Canada during the late 1960s, an additional year of foreign experience raised their earnings by an estimated 1.5%. However, immigrants of the late 1990s obtained a return of only 0.3% on average for each additional year of foreign experience. This decline occurred almost exclusively among men from Eastern Europe, Africa and Asia. Immigrants from Northern, Western and Southern Europe, as well as those from the United States, saw essentially no change in the returns to their foreign experience. Immigrants from Eastern Europe, Africa and Asia who arrived in the late 1960s obtained, on average, a return of 1.1%. The return to foreign work experience for immigrants of the 1990s from these regions appears to have fallen to essentially zero (Aydemir and Skuterud, 2004).

The issues surrounding foreign educational credentials in Canadian medicine are connected to cultural codes and competencies of a professional elite that can be at the expense of cultural democracy. Sentiments in favour of credentialism and maintenance of standards of achievement have often been advanced as an occupational quality-control mechanism in the service of the public good (Scott, 2006:276). Yet, from a dialectical perspective, credentialism is inhabited cultural territory. For questions of power and ideology are central to the determination of status and achievement. Here, the encroachment of the "other" on what a group of like individuals have claimed as their territory has mainly provoked what Robert Ardrey (1966) called the territorial imperative: the group's fierce attachment to that territory, often giving rise to resentment, fear, exclusion, and aggression.

An article in Labour Law Talk (2004) entitled "*Are international medical graduates the solution to Canada's doctors' shortage?*" is illuminating in regard to mechanisms of cultural territory and cultural closer in the medical profession

The Medical Council of Canada's website ([www.mcc.ca](http://www.mcc.ca)) does have some information targeted to foreign doctors about the three medical exams they must take in

Canada, which the council administers. But those exams, which can cost thousands of dollars, are just the first step to being able to practice in Canada.

Excluding those doctors who come from commonwealth countries like Australia, Britain, New Zealand and South Africa—they can practice medicine immediately upon arriving—it can take years for immigrant doctors from other countries to begin practising medicine in their new home—if at all. In addition to passing the medical exams and an English language exam, they also have to complete a two-year residency program before they can be licensed as doctors in Canada ...

Although many immigrant doctors in Canada would be thrilled to just do their two years of residency and get it over with, the kicker is that residencies are extremely hard to get, particularly in B.C. Only six foreign-trained doctors in B.C. are eligible for family practice residencies a year, through St. Paul's Hospital. But there's probably 100 to 200 immigrant doctors wanting to practice here. In Ontario, there are 200 foreign residency spots (family practice and specialist residencies); in Alberta, 28.

Although there's also the possibility of getting a residency through the Canadian Resident Matching Service (CARMS), which matches medical graduates with residency positions, Canadian medical graduates get priority. Foreign doctors can try for whatever is left over in a second matching process. Of 657 international medical school graduates registered with CARMS in 2004, only 87 got matched—that's only 13.2 per cent.

With the competition so high, the few residency spots available to immigrant doctors in B.C. go to those doctors who have high levels of English, have reference letters from Canadian doctors as well as some knowledge and experience in Canadian medical settings. So how does a doctor get those reference letters and experience without a Canadian licence?<sup>17</sup>

Despite the theoretical potential for cultural democracy embedded in liberalized immigration policy, culturally acceptable IMGs still come from Commonwealth countries on work permits with offers of employment. Others immigrate through family reunification program or refugee programs primarily from countries in the Global South, and although they wish to practice medicine in Canada, they are often unable to become licensed. Because many of these individuals are inhibited from declaring their profession upon entering Canada, the actual number of IMGs living in Canada and working in other fields is unknown. Similarly, the precise number of Canadian immigrants who fail the assessment of their credential after arrival in Canada is not known. Individual studies in different provinces suggest that less than half of the immigrants in regulated occupation manage to obtain Canadian accreditation, and among foreign-educated medical doctors the proportion is as low as 5%.<sup>18</sup> In the latter case, the unavailability of required internship positions is a major contributing factor (Basran and Zong 1998).

One thing that is known is that in the Human Rights Commission of British Columbia recently ruled in favour of 5 International Medical Graduates from non-Commonwealth, non-White countries who felt they were discriminated against. The commission stated that no individual could be prevented from having access to the training required to obtain a medical licence on the basis of his or her country of origin (*Bitonti v. College of Physicians & Surgeons of British Columbia* [1999]. B.C.H.R.T.D. No. 60).

### Conclusion

The tension between cultural contingency and cultural democracy in Canada is slowly transforming the medical profession into a contested site. From the perspective of the “competence lens” of regulatory bodies in Canada, while internationally trained physicians have an important role to play, it is critical that practice standards are maintained at a level acceptable to the Canadian public.<sup>19</sup> Medical education varies widely around the world, and there is no uniform international assessment process. Hence, the question is, as Rocco Gerace, the former Registrar of the College of Physicians and Surgeons of Ontario framed it, “how to deal with the shortages of physicians without compromising performance standards.”<sup>20</sup> From the view of regulatory authorities in Canada, the fundamental criteria for determining qualified physicians includes knowledge skills or competence and clinical judgment as measured during

interaction with patients (Foster, 2004). Or, as the Report of the Task Force on Licensure of International Medical Graduates states

Ideally one would want to measure performance of physicians as many of these have had discipline-specific training and practice experience in their country of origin. These physicians, however, have never practiced in Canada, and their scope of practice may have been very different. Performance is logistically more complex to evaluate than competence. A lack of reliability of currently available tools has often been cited as a limiting factor in performance assessment. It is reasonable to say that current examination tools measure a mixture of competence and performance, with competence being the greater component. Most assessment programs across the country combine competence assessment with a period of evaluation in a clinical setting, which in turn provides a measure of performance.<sup>21</sup>

On the other hand, from the perspective of the foreign-trained doctor forced to drive a taxicab or do other menial “survival” jobs in the midst of a chronic doctor shortage and health care crisis, credentials devaluation is not experienced as simply a performance/competence equation. On the contrary, since foreign doctors are predominately non-White (reflecting current immigration flows), many feel that they have been tricked into this situation by Canadian immigration policies and labour-market regulations that do not disclose to immigrants of colour that their credentials will be devaluated. So, they often see themselves as victims of the cultural bias of a “pale male” mandate where immigrants of colour experience unequal treatment, and are regularly subject to an unnecessary duplication of previous medical training. In this respect, Joan Atlin, the former Executive Director for the Association of International Physicians and Surgeons of Ontario, has emphasized the importance of focusing on the doctor shortage in Ontario through a lens of competence *and* a lens of rights—human rights and the Charter of Rights. The question is, as Atlin put it, Why is medical licensure a right for Canadians and a privilege for internationally trained physicians?<sup>22</sup>

At present, internationally trained physicians have to compete with each other for the limited assessment and training positions available, and only typically about 10 to 15 percent of the talent pool find a placement. At the end of the process, those who do succeed in obtaining a licence to practice also have to fulfill a five-year return of service contract with the government. This means that the present licensure system is creating two classes of Canadians: one class with full access and another which has to compromise and compete before it can gain access to the steps to prove competency. In this respect, Canada’s doctor shortage is not only a regulatory and assessment problem but an equity problem as well, which requires a “paradigm shift” to eliminate the double standards that are embedded in the medical profession and society.<sup>23</sup> In the new political economy of race and immigration, internationally trained physicians are “treated like labour market commodities and not like citizens with equality rights.”<sup>24</sup> Yet, the possibility of a self-sufficient system that can provide adequate service to all Canadians lies precisely in organizing social policy principles around equity and fair practice, actualizing our already existing human capital resources.

In recent years, a series of scholarly reports have acknowledged the primary obligation of regulatory medical bodies to protect the public interest with respect to health, safety, and welfare.<sup>25</sup> However, it is also advised that in fulfilling this obligation in fair and balanced way, the medical bodies must also consider the duty to respect an individual's right to equality of opportunity and to equal treatment without unreasonable discrimination.<sup>26</sup> Accordingly, the Council of the College of Physicians and Surgeons of Ontario continue to lead the way by take steps toward tackling Canada’s proverbial health-care problem, including recently forwarding recommendations to the health ministry proposing a new assessment program for foreign-trained physicians created at the province's five medical schools, which includes a new “fast-tracking process” to be coupled with other state initiatives like “location incentives” for under-serviced areas and “medical school tuition subsidies.”<sup>27</sup>

Yet, seeing the issue of immigrant skills utilization through the lens of equity rights as well as the lens of competencies also recommends a new systemic “equity rights” program or action plan as well,

which would include (1) a focus on an adequate number of training opportunities, and (2) a focus on competencies that reflect clear and concise criteria and apply the same standards to all. From this perspective, anybody who can perform to the standard that is accepted by society should have an opportunity to practice medicine. For many internationally trained physicians this was the working assumption about this country before they emigrated. It was only after their arrival that they realized that they had been seduced and abandoned.<sup>28</sup>

The difficulty of striking a balance between well-established standards of professional competence and anti-discriminatory employment practices is Canada's most daunting cultural democracy challenge in the 21<sup>st</sup> century workplace, which requires an exceedingly collective imagination and dexterity. In this regard, cultural democracy theory would advocate the removal of overt and covert discriminatory barriers in a way that preserves human rights and professional standards of medicine through the implementation of systemic programs like a "licensing equity plan" by regulatory and licensing bodies and/or the implementation of an "employment equity plan" by employers, under the coherent supervision of the state's immigration program and a national immigrant-settlement policy (Foster 2004). In any event, the challenge of cultural democracy implies, as the labour force becomes increasingly composed of diversified workers with foreign education and experience, an accurate understanding and evaluation of the skills, knowledge and experience plays a key role in enabling these workers to find jobs in which this preparation can be used to full advantage. It also suggests, until institutions and workplaces are broadened in their scope to embrace diversification in the workforce as essential, the search for political unity, social coherence, economic prosperity, and cultural enrichment will remain elusive.

### Endnotes

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<sup>1</sup> Cornwall, Claudia. 2004. *Why Is Canada Shutting Out Doctors? While millions of Canadians can't find a doctor, thousands of foreign physicians can't get a licence to practice.* <http://www.readersdigest.ca/mag/2004/08/doctors.html>. (accessed 02.08.08).

<sup>2</sup> In recent years the doctors shortage has reached an acute phase, and has drawn such attention from The Globe and Mail, which featured story titles such as, *Canada near crisis over doctors and nurses: report* (January 28, 2005); *Shortage of family doctors contributes to long wait times 2006 study* (November 2, 2006), *Doctors press Ottawa, provinces on wait-time guarantees* (November 26, 2007), *Manitoba spends millions in bid to lure ER doctors* (June 28, 2007), *Wanted: One family doctor. Get in line.* (March 31, 2007) Medical schools are working hard to help cure the doctor shortage (January 29, 2008), *Wait for Surgery Savages Economy* (January 15, 2008).

<sup>3</sup> Statistics from the 2004 indicate that while approximately one-third of Ontarians have had problems finding a doctor or had a relative who experienced difficulty, there are presently three to four thousand passionate but jobless internationally trained physicians in Ontario alone. ("Making the Mosaic Work." 2004. *Second Annual Law and Diversity Conference* held at the University of Toronto, January).

<sup>4</sup> Organization for Economic Co-operation and Development: *Statistics and Indicators for 30 Countries*. OECD Health Data 2005.

<sup>5</sup> The College of Physicians and Surgeons of Ontario. 2004. *Tackling the Doctor Shortage: A discussion paper*. May.

<sup>6</sup> The College of Physicians & Surgeons considers any individual who has attended medical school and completed his/her postgraduate medical training outside of Canada to be an IMG.

<sup>7</sup> Report of the Canadian Task Force of International Medical Graduate Licensure. 2004. *Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources*. Feb. Available: [www.aipso.ca/Task%20Force%20Final%20Report](http://www.aipso.ca/Task%20Force%20Final%20Report.pdf).pdf (accessed 02.11.08).

<sup>8</sup> Report of the Canadian Task Force of International Medical Graduate Licensure. 2004. *Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources*. Feb. Available: [www.aipso.ca/Task%20Force%20Final%20Report](http://www.aipso.ca/Task%20Force%20Final%20Report.pdf).pdf (accessed 02.11.08).

<sup>9</sup> Report of the Canadian Task Force of International Medical Graduate Licensure. 2004. *Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources*. Feb. Available: [www.aipso.ca/Task%20Force%20Final%20Report](http://www.aipso.ca/Task%20Force%20Final%20Report.pdf).pdf (accessed 02.11.08).

<sup>10</sup> “Cultural” or “multicultural” democracy are contiguous concepts in social theory on pluralism that make reference to the protection and promotion of cultural diversity, and the right to culture for everyone in our society and around the world. Ramirez and Castaneda (1974) argue that cultural democracy asserts the basic integrity of one’s cultural upbringing, its strength and positive values. Similarly, Marri (2003:262) argues that “[M]ulticultural democracy incorporates socio-economic, cultural, and political diversity and goes beyond current conceptions of democracy. It begins by asking these critical questions: Who is and is not participating in democracy and on whose terms? And how wide is the path to participation? These questions serve as a foundation for exploring the three tenets of multicultural democracy: democracy as a path, membership in both large and small publics, and diversity as essential.”

<sup>11</sup> The National Occupational Classification for Statistics (NOC-S) 2006 provides a systematic classification structure to identify and categorize the entire range of occupational activity in Canada. This up-to-date classification is based upon, and easily related to, the National Occupational Classification. It consists of 10 broad occupational categories which are subdivided into major groups, minor groups and unit groups. Definitions and occupational titles are provided for each unit group. An alphabetical index of the occupational titles classified to the unit group level is also included. See – Canadian Occupational Projection System (COPS) produced by the federal department of Human Resources Development Canada, 2006.

<sup>12</sup> The Society of Rural Physicians of Canada. 1999-2002. URL: <http://www.srpc.ca/canlocum.html>

<sup>13</sup> Field notes from – “Making the Mosaic Work.” 2004. *Second Annual Law and Diversity Conference* held at the University of Toronto, January.

<sup>14</sup> Field notes from – “Doctor Shortages and the Integration of International Physicians: Opportunities and Solutions. 2001. (Conference hosted by Dr Carolyn Bennett, MP) Sponsored by *The Maytree Foundation*, 171 Bloor Street West, Suite 804, Toronto, Ontario M5S. [www.maytree.com](http://www.maytree.com)

<sup>15</sup> Report of the Task Force on Licensure of International Medical Graduates. 2004. *Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources*. Feb. Available: [www.aipso.ca/Task%20Force%20Final%20Report](http://www.aipso.ca/Task%20Force%20Final%20Report.pdf) .pdf (accessed 02.11.08).

<sup>16</sup> Szafran, Olga Rodney A. Crutcher, Sandra R. Banner, and Mamoru Watanabe. 2005. Canadian and immigrant international medical graduates. *The College of Family Physicians of Canada*. <http://www.cfpc.ca>. Available: <http://www.cfpc.ca/cfp/2005/Sep/vol51-sepresearch-3.asp> Retrieved: March 22, 2008.

<sup>17</sup> Are international medical graduates the solution to Canada's doctors' shortage? *Labour Law Talk*. 10.15.04 <Available: [www.laborlawtalk.com/showthread.php?t=67929](http://www.laborlawtalk.com/showthread.php?t=67929)>15-2004> (Retrieved 02.11.08).

<sup>18</sup> In 2002, only 16.7 per cent of foreign medical graduates got into the training, according to statistics from the Canadian Information Centre for International Credentials. Only 83 of them landed one of the 1,260 internships available to medical postgraduates. Available: [http://www.metroimmcanada.com/attracting\\_skilled.htm](http://www.metroimmcanada.com/attracting_skilled.htm). Retrieved: March 22, 2008.

<sup>19</sup> “Doctor Shortages and the Integration of International Physicians: Opportunities and Solutions. 2001. (Conference hosted by Dr Carolyn Bennett, MP) Sponsored by *The Maytree Foundation*, 171 Bloor Street West, Suite 804, Toronto, Ontario M5S. [www.maytree.com](http://www.maytree.com)

<sup>20</sup> Field notes from – “Making the Mosaic Work.” 2004. *Second Annual Law and Diversity Conference* held at the University of Toronto, January.

<sup>21</sup> Report of the Task Force on Licensure of International Medical Graduates. 2004. *Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources*.

<sup>22</sup> Field notes from – “Making the Mosaic Work.” 2004. *Second Annual Law and Diversity Conference* held at the University of Toronto, January.

<sup>23</sup> Field notes from – “Making the Mosaic Work.” 2004. *Second Annual Law and Diversity Conference* held at the University of Toronto, January.

<sup>24</sup> Field notes from – “Making the Mosaic Work.” 2004. *Second Annual Law and Diversity Conference* held at the University of Toronto, January.

<sup>25</sup> See, for example, the Report of the Task Force on Licensure of International Medical Graduates. 2004. *Federal/Provincial/Territorial Advisory Committee on Health Delivery and Human Resources*. Feb. Available: [www.aipso.ca/Task%20Force%20Final%20Report](http://www.aipso.ca/Task%20Force%20Final%20Report.pdf) .pdf (accessed 02.11.08).

<sup>26</sup> See, for example, Cumming, Lee & Oreopolous, Access! *Task Force on Access to Professions and Trades in Ontario*, 1989, Queen's Printer for Ontario.

<sup>27</sup> Field notes from – “Making the Mosaic Work.” 2004. *Second Annual Law and Diversity Conference* held at the University of Toronto, January.

<sup>28</sup> Field notes from – Making the Mosaic Work.” 2004. *Second Annual Law and Diversity Conference* held at the University of Toronto, January.

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