TRACING THE OCCUPATIONAL INTEGRATION OF INTERNATIONALLY TRAINED MEDICAL DOCTORS OF AFRICAN DESCENT

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ABSTRACT

While Canadian schools are not producing enough medical doctors there is a surplus of immigrant medical doctors who are well equipped and eager to practice. Internationally trained medical doctors have increasingly experience difficulties in finding jobs that reflects their medical training and expertise. This research investigates the occupational integration of internationally trained medical doctors of African descent. Using snowball sampling and convenience sampling methods I interviewed 12 participants. Their experiences show why many internationally trained medical doctors end up in other fields after they try to practice medicine in Canada**.** Participants most often noted issues of lack of knowledge about the process, limited residency positions, lack of requirement consistency and lack of guidance. This study is expected to add to our understanding of internationally trained immigrant doctors' path to successful or different medical occupation and the effectiveness of policies and practices that aim to help these professionals.

Key words: internationally trained medical doctors; occupational integration; employment; African and Caribbean immigrants in Ontario.

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I first want to thank all the 12 participants who dedicated their time to participate in this study. All of my participants were helpful and without them this MRP would not have been possible. Some of them were interviewed after midnight, and others were interviewed during their commute to and from work. This research has really impacted me as a researcher. I want to dedicate this research for all internationally trained medical doctors who are still trying to make their way into the Canadian medical system and are hoping for a promising future. I also want to thank my supervisor Dr. John Shields from the Department of Politics and Public Administration**.** I am grateful that he has taken me under his wings for a year. His guidance and advice have helped shape my paper

Dedication

To the Canada-United States Fulbright Student Program for giving me the opportunity to not only conduct this research but also pursue a Canadian master's degree.

To my parents for their continuous support and to some of Bridgewater State University faculty members who guided me on this journey.

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Introduction

"To be honest, I really came in 2010. I spent some months here then went back to Haiti because I was in my last year of my medical school and I was working with the Haitian government to get my medical license. I went back and forth between Haiti and here. I come and spend some months then go back. I can say that I finally settled here in 2012. The thing is I was not really sure if I wanted to stay in Canada or if I want to stay in Haiti and practice medicine. I was going back and forth to see how the system is, how to get into the system, I was talking to other people at this place downtown Toronto. There was a little bit of uncertainty. What will I do? Uncertainty about the future because you never know what the future hold.

Since I already had my residency in Canada, I told myself I will need to make a choice. I had my paper in Canada as a permanent resident, I keep on going back and forth which costing me money. My two choices where stay in Haiti and practice medicine or stay in Canada and try to integrate myself into the system. I made up my mind to stay in Canada."

Dr. Jean

This quote exemplifies the uncertainty of every internationally trained professional when they move to Canada. It is not an easy road; these professionals know what they are leaving behind but they do not know what is awaiting them ahead. The immigration process itself is already a hard process and having to deal with the Canadian licensure process can come with a lot of psychological issues. The professional success of immigrants is one criterion to examine regarding whether their migration is a success or failure. Foreign trained immigrants are not fully aware of what they are getting themselves into. The information they get before they immigrated to Canada is not often what they end up experiencing. If they are not open minded and willing to explore other professions, they can get disappointed. As a regulated health profession, very few immigrants are able to practice medicine after they immigrate. For foreign trained medical doctors, it is not a given that they will be able to practice medicine as a doctor in Canada. There are immigrants who pass all the medical exams but they are not able to get a residency position meaning they will not be able to practice in Canada. There are also others who get a residency position but then for various reasons lose their placements. There is no secret formula that determines if a foreign trained medical doctor will successfully complete all the processes. This

is why some of these professionals go back and forth between Canada and their countries of origins. Some decide to migrate to another country where their professional reintegration is more easily attained. The United States is one of these top countries. As time passes by and these immigrant medical doctors continue to struggle to get into the Canadian medical system, they end up losing their professional identity. This happens when they are working in jobs that are not meaningful to them or if they perceived themselves as underemployed. The migration process clearly influences professional identity. Professional identity is defined as the collection of values, beliefs and experience that people use to describe themselves in a professional role (Zikic and Richardson, 2016). The inability to practice medicine restricts the meaning and the enactment of immigrants' professional identity.

Research does confirm that people experience career burnout when they believe that they are not doing meaningful work (Syed, 2008) The paradox is, they move from places where they were well known and highly regarded to another place where they are not. Like Dr. Jean said in his interview, people treat IMDs like they are nothing, ignoring the fact that they spent a lot of time in school in order to receive a medical degree**.** This is another major risk for internationally trained professionals. They witness their years of training and education going down the drain right before their eyes. They quickly realize who they can no longer be and what they can no longer do.

High-skilled migration has become the foundation for economic success for Western countries. Inevitably, this is leading to an increasingly international market place for labour. One of the biggest stumbling blocks for new immigrants in Canada is labour market integration. Prior to moving to Canada, immigrants have high expectations without knowing what is waiting for them. They were awarded points for their credentials that they will use once in their new country.

Once they arrived in Canada, however, too often they find out that they are not able to use their skills within their respective fields. There is a significant number of internationally trained medical doctors that find themselves in this situation. There is a disparity between the immigration admission criterion which allow their entry and those for actually securing appropriate employment (Somerville, 2018). Structural barriers are often noted as a cause that prevent immigrants from entering their profession. Unlike some other regulated occupations, the requirements to practice in the medical profession is extensive. One has to obtain accreditation, perform multiple tests by the Medical Council of Canada, and then secure a residency. Even then, employers ask them to provide evidence of Canadian work experience. As a result, some take jobs far below their skill-set, a problem known as "brain waste". Others are successfully integrated into their pre-migration occupation.

Canada depends on international health care professionals to fill the labour demand in the sector. This seems to be a contradiction because there is a poor professional integration of internationally trained heath care professionals yet the sector is dependent on those people. The need for these professionals will continue to increase as the country is dealing with an aging population. Despite the presence of internationally trained medical doctors, the shortage remains in part because so many are not able practice. The annual immigrant earnings deficit created by skill devaluation cost Canada, conservatively estimated, $3 to $4 Billion according to economists due to loss of productivity (Bhuiyan et al, 2015). Incorporating immigrant skills in the labour market is a priority for economic development.

I decided to focus on medical doctors because medicine is one of the professions that receives a large number of applications from internationally trained professionals (Cheng et al, 2013). The exact number of internationally trained medical professionals whose credentials are

not recognized is unknown. The devaluation of immigrants skilled is not only costly to the Canadian's economy. It has also a negative effect on the immigrants themselves.

My research questions are as followed: What are the determinants of successful and unsuccessful professional integration for internationally educated medical doctors of African descent? What improvements can be made in order to better integrate internationally trained medical doctors. Many studies have focused on the barriers that prevent internationally trained medical professionals from practicing in Canada. Little, however, is known about those who have been successful and those who have entered other occupations in the medical field. It is essential to identify the occupations and how internationally trained immigrant doctors utilize their valuable skills.

The paper will have three components that will be based on the story of the interviewees. In the first section, I will analyze what the participants find helpful and what was not helpful for their occupational integration. In the second section, I will discuss what the participants recommended. I define occupational integration as the successful participation of internationally trained medical doctors in the Canadian medical field as medical doctors.

Given that Canada is socially and financially committed to immigrants, particularly those who are skilled, this research provides a unique case. This research aims to inform in particular the provincial government given that healthcare is a provincial matter. In order to have a health care system that is efficient and succeeding, there needs to be an adequate number of doctors. If trained medical doctors are excluded from working in their field in conditions of great demand patients will be deprived of care.

The provincial government provides assistance to settlement services to help immigrant integrate in the labour market. In this work there should be more focus on the medical profession

in collaboration with the Ontario Medical Association (OMA) the professional body that represents physicians in Ontario. The OMA is responsible to advocate, support and represent not only practicing physicians, but also residents, and medical students. The OMA should extend it representation to cover the interests of foreign-trained medical professionals as well. This research will consequently be beneficial to the OMA in this regard.

Researcher Disclosure

This research is based on an issue that is personal to me. When my family immigrated to the United States from Haiti in 2010, my mother, a phlebotomist and nursing professor, brought all her certifications and degrees thinking it would be easy to get a job in her new country. She even had her documents translated into English by a Haitian lawyer. When she applied for her first phlebotomy job, she learned that her degree was not valid in the U.S. Though she had many years of experience, she needed to be licensed through a U.S program. Despite her skill-set, she decided her only option was to take a low skilled healthcare job like many other immigrants. My mother's story is not uncommon; there is often a gap between an immigrant's credentials and their job placement. If their education was formally assessed, immigrants could be more certain that their skills will be put to use, and employers would be more familiar with foreign credentials. Foreign credentials recognition is defined as "the process of verifying that the education, training and job experience obtained in another country are equal to the standards established for Canadian professionals" (Bourgeault & Grignon, 2013).

A current narrative surrounding U.S immigration, though, is that immigrants depress wages because they arrive without employable skills and thus are willing to work for less. In reality, there is no federal mechanism that assesses immigrants' credentials, leaving new arrivals with few employment options. With the introduction of the Reforming American Immigration

for Strong Employment (RAISE) Act, in July of 2017, which would reduce the number of immigrants to the U.S and create a merit-based immigration system, the issue of assessing immigrant credentials is more pressing than ever. This is an ideal time to learn about the experience of skilled immigrants in Canada as they experience many of the same problems as those coming to the US. The pressing problem I hope to address is that when many immigrants come to the Canada, they end up and stay in low-status and low-wage jobs, even when they have valuable education and skills. Given that they do not have any Canadian job experience or degrees, they have no other option than to take whatever job is available. I hope my research will inform policy makers to ensure that immigrants' skill do not go to waste.

Goals

My goal for this study is to learn about the experience of two different types of internationally trained medical doctors: those who have been successfully integrated in their pre-migration occupation and those who are not. By looking at these groups, I will examine various policies and practices that try to close the gap between immigrants' skills and their occupation in Canada. My particular interest in people of African descent derives from personal observation. Caribbean and African immigrants are more likely to be target of exclusion because of their race and ethnicity. They often get funneled toward particular low-skilled sectors of the labour market. Other races have better labour market experiences despite having equivalent skill levels and educational background with immigrants of African descent.

Operational Definition

The term "immigrants of African descent" as used in this paper refers to those who are from the continent of African and the Caribbean Islands. People from the Caribbean are very diverse, everyone identifies themselves with their specific ethnic ancestry. For instance, there are the Afro-Caribbean, Asian Caribbean, and Indo-Caribbean. For the purpose of this study, I am

focusing on the Afro-Caribbean, whose ancestry are linked to Africa. It is important to note that language will be a sub-theme of my research. Given that French and English are the official languages of Canada, I wanted to see if there is any variation between the experience of Francophone immigrants and the Anglophones. English-speaking countries tend to rank high on the "brain drain" because of the shared language with the United States and Canada, which are two countries that historically are high immigration nations. Although, I was not able to get an equal number of participants who are from French Speaking countries, their experiences were practically the same as those who were English speaking in my sample.

Research Approach

This research is based on qualitative research approach. Qualitative research focuses on generating meaning and understanding through rich descriptions (Collingridge, et al. 2008). Qualitative approach are exploratory in nature. It is useful for studying the occupational integration of immigrants because qualitative research focuses on the quality of experience. It tries to describe or understand the essence of human experiences that cannot be measured. My investigation aims to describe and understand immigrants' path to their pre-migration occupation.

Scope

When immigrating to Canada, many immigrants choose the province of Ontario as their destination. Employment opportunities is one of the reasons why people choose Ontario particularly the city of Toronto. Furthermore, Toronto is one of the most multicultural cities in the world, half of the population is foreign born. Therefore, my research is based on immigrants who reside in the Toronto and throughout the province of Ontario. My interviewees were limited to people who are foreign-born and received their medical degree before they came to Canada.

However, there was no restriction based on gender or age, though all respondents are adults. Research on discrimination always raise the issue of intersectional discrimination.

Intersectionality is the notion that multiple identities such as gender, race and ethnicity influence one's employment outcomes and experiences (Syed, 2008). In terms of settlement, I wanted to select only people who arrived to Canada within the past twelve years from 2007 to 2019. The rational for this selection is that the settlement process of immigrants is a long process. The process of practicing medicine in Canada itself can take more than five years for some people. However, I found one participant that has been in Canada for over thirty years. Because this study will contribute to existing research on internationally trained medical doctors, immigration streams was not one of my major themes. Nonetheless, the application process and the program of admission were asked.

Setting and Sample

My goal was to interview eight to ten immigrants of African descent who are medical doctors. I wanted to interview an equal number of immigrants who are practicing medicine and those who are not. Although this is a small sample size, according to Robinson (2014), this helps to intensively analyze each of the interviews. Also, the interviewees will not be subsumed as anonymous into a larger whole. I ended up interviewing twelve participants only two of which were women. Robinson (2014) mentioned that women are more likely to volunteer to participate in qualitative research compared to men. To my surprise, most of the people that I recruited were men. This likely reflects that there are more male than female medical doctors.

I did not have any already-existing relationships with any potential participants. Therefore, I advertised to find recruitments. I prepared flyers to distribute in various settlement agencies in Toronto, the Caribbean Student Association, the African Student Association and some Caribbean and African organizations outside of Ryerson University. To me, these were the

best way to recruit participants given the time limitation and my unfamiliarity with immigrants who are internally trained medical doctors. These organizations tend to serve as gatekeepers by helping to publicize the study. The only organization that I reached out to directly was the Black Physician Association of Ontario (BPAO).

The interviews were based on a combination of snowball sampling and convenience sampling methods. Snowball sampling or referral sampling entails asking participants for recommendation of individuals who are qualified for participations (Robinson, 2014). This method is found to be particularly effective when studying topics that are illegal in nature. The selection process in convenience sampling is based on participants that are easily available (DiCicco-Bloom & Crabtree, 2006). The participants were very eager to refer me to their previous classmates, friends and people in their network that fit the profile that I was looking for. I also got recommendation from Caribbean and African professors who I reached out to from University of Toronto and York University.

Data Collection and Organization

I used interview guides to conduct my interviews. The interview guides provided a framework to facilitate the conversations. The interview guides contain a list of main questions and specific probes to help the participants understand the intent of the questions. Interviews is one of the well-known strategies that is used to collect qualitative data (DiCicco-Bloom & Crabtree, 2006). Unlike other forms of data collection, interviews introduce a human dimension to existing data. The interviewees are able to share insights on an issue and leaving the investigators to interpret and analyze the data (DiCicco-Bloom & Crabtree, 2006). There was be a combination of both in-person and phone interviews. The drawback of interviews is that they are time-consuming because it involves multiple stages such as: setting-up the interviews,

transcribing, analyzing transcripts, etc (DiCicco-Bloom & Crabtree, 2006). I anticipated that some of the participants will not be able to meet with me in person due to their work schedule which is why I added the phone interview tool. One of the drawbacks of phone interviews is that I did not know who was on the other end of the phone. Meanwhile, with in-person interviews I only had to worry only about aural and visual privacy. The participants were not interviewed in their workplace or any public areas such as coffee shops or parks.

The interviews were semi-structured and audio recorded. I asked the participants questions that touch on themes such as medical licensure, professional support, personal difficulties, and employment. Semi-structured interviews use one interview guide for all respondents but give interviewees a lot of freedom to focus on things that matter to them. My interview questions led each discussion but participants had flexibility to bring up topics that were most important to them. The questions were broad to allow responses that are guided by participants based on what is most important to them. As they talk, I paid careful attention and probe for additional relevant details. DiCicco-Bloom and Crabtree (2006) stated that the quality of recorded interviews are influenced by issues such as weak batteries and background noise. To avoid these issues, I had extra batteries and a backup recorder on hand.

All the participants were informed about the aim of the study, what their participation entrails and any other information that helped them make an informed and consensual decision to participate. Additionally, they learned about their voluntary participation rights in the informed consent process. No one felt obliged or pressured to take part in this research. The consent form was provided on the day of the interview. For those that I interviewed over the phone, I read out the form to them. At the end of the form, the participants who decided to go forward with the

interview had to provide their signature to confirm consent. I did not find any participant who decided to withdraw after or during participation.

Robinson (2014) voiced that incentives stimulate recruitments because participants can be motivated to participate in order to gain the money. I did not provide any incentives to the participants; however, I gave a thank you card to everyone that I met. I could not find as many immigrant medical doctors from the Caribbean as I expected. I went to many Caribbean organizations as well as Little Jamaica, I learned that many of the medical doctors who came here as immigrants have either retired or attended Canadian medical school. This was intriguing because the Caribbean has emerged as a destination for Canadian medical students. Compared to other places in the world, the Caribbean region now has the highest density of medical students per capita (Morgan et al, 2017).

Data Analysis and Interpretation

Data analysis plays an important role in evaluating the quality of a study; it involves the process of sorting and classifying the data that have been collected (Daly, et al 2007). The analytical process includes analyzing the relevance of the theoretical concepts that are used in the study (Daly, et al 2007). The quality of the data influences the task of data analysis.

My data analysis is built on the theory of human capital. I follow a well-defined data analysis procedure. Because I am working with audio-data, I listened to the audiotape while reading the transcriptions to ensure accuracy during the interpretation. This allowed me to fully examine what was said and proceed to the process of coding. In order to create codes, it is essential to clearly understand in what context some statements were made (Green et al, 2007). To code my data, I started by making notes in the margins of my printed transcripts. The codes were illustrated by quotes from the interviews.

Validity, Reliability and Generalizability

I spoke directly to individuals who are or have dealt with the issue of occupational integration. They told me their own stories about their experience (whether positive or negative). The interviews were conducted in English, the language that we both understand without involving any interpreter. Given that I am studying a particular group of immigrants, I cannot say their experiences are similar to those of other immigrant communities. However, further research can be done on other immigrant groups using the same research questions.

Theoretical Framework

One of the theories I will be using to shape my paper is the human capital theory. According to this theory, immigrants' skills play an important role in their employment prospects (Syed, 2008). It implies the total investment in individuals' skills determine their productivity, the more skills investment the greater the enhancement of the labour market. Also, it suggests that employers are the primary factor determining the labour market outcomes of immigrants. The power to gain employment lies within the control of the immigrants based on their skills. For example, an investment on an individual skill translate into an investment in productivity and gainful employment (Syed, 2008). In general, scholars recognize that migration tends to transfer human resources from developing countries where they are underused to developed countries where they are not needed (at least for the most part at that skill level) (Syed, 2008). Research that utilizes the human capital theory to study immigrants work outcomes explain that it defines the career trajectories of skilled immigrants in the labour market of host countries (Syed, 2008).

Immigrant skills are not necessarily transferable across national borders as accreditation and recognition of foreign experience and qualification remain an issue in the labour market. Through this paper, I hope to show that immigrants' employment opportunities are not only determined by their skills but also by the occupational opportunities and their experiences in Canada. The labour market does not treat all potential workers equally based on their skills.

Evidence indicates even when immigrants' qualifications are recognized, employers are unwilling to hire them without work experience from the host country (Almeida, et al., 2015).

Literature Review

This literature review aims to:

1) Describe some of the challenges and barriers that immigrant medical doctors face when trying to enter their field of work;
2) Illustrate the effect of the underutilization of immigrants' skills; and
3) Provide a framework for my research.

Background

When Canada adopted the point system in 1967, restrictions based on race and nationality of applicants were eliminated. The racial make-up of immigrants changed from white Europeans to minorities from other parts of the world such as Africa, the Caribbean, Asia and South America. The economic rationale behind this policy is that economic migrants will not be a burden on the Canadian government and society. Rather economic immigrants will be an asset since they will contribute to the growth of the Canadian economy. Therefore, Canada ensures that immigrants who wish to become permanent residents under this stream are skilled members of its economic workforce. Canada's skill-based system is congruent with the country's quest for nation building which is done through the accumulation of human capital (She & Wotherspoon, 2013). Although Canada ended its overt discriminatory immigration practices, Canadian institutions often covertly exclude immigrants from fully integrating into the society. According to a study by Sommerville and Walsworth (2015) the interviewees said that the Canadian immigration system is misleading and seductive as qualified workers have negative labour market outcomes. Clearly, the non-recognition of foreign credentials is an immigration problem.

The labour market success of recent immigrants in Canada has been an aspect that many researchers have studied. Success can be defined in multiple ways. For example, Frank (2013) defines employment success as the rate at which immigrants obtain a job that matches their skills after immigrating to Canada. Others define employment success only by being employed. With Frank's idea of "job match", he points out that an individual can be working in a field of interest but they are not performing the same duties as their pre-migration occupation (Frank, 2013); that they are not being employed at their skill level. This means occupational integration studies should also examine if immigrants' job matches their skills and if they gained their desired employment. Job matches can also be determined by pre-migration arrangement.

It is important to note that there are two types of internationally trained medical doctors. There is one category which consist of those who left Canada to study medicine abroad, they are often referred to as CSAs or Canadians who Study Abroad. The other category are immigrants who come to Canada with their medical degree which was obtained elsewhere. The Canadian Resident Matching Service classify an International Medical Graduate as a person who obtained "their medical degree from a medical school that is not accredited by the Committee on Accreditation of Canadian Medical Schools (CACMS) or the Liaison Committee on Medical Education (LCME)". The Medical Council of Canada consider an IMG as an individual who graduated from Medical school outside of the U.S and Canada. Additionally, some agencies in Canada such as the College des Medecins du Quebec and the Canadian Resident Matching Service (CARMS) consider those who graduate from accredited US medical schools as Canadian Medical Graduates (CMGs) (Mowat, et al., 2017). This paper is only about immigrant medical doctors. One of difference between CSAs and immigrant medical doctors that studies have found

is that immigrants are less likely to gain Post-Graduate Medical Education (PGME) which is residency training than their counterparts (Kandar, et al., 2017).

The Problem: Causes and Prevalence of Skills Devaluation

Yasser (2000) notes that the evaluation of immigrants' skills is not based on human capital but rather their employability. In other words, the skills of immigrants are equivalent to their productiveness as workers. It has been argued that skill is a social construct and is ranked based on race, gender, educational status, and class (Yasser, 2000). The Immigration, Refugees, and Citizenship Canada's (IRCC) website says that Canada encourages immigrants to integrate and take an active role in Canada's "social, cultural, economic and political affairs" (Department of Canada). Meanwhile, the knowledge of immigrants is considered inferior compared to Canadian ones. There is a hierarchical ladder of skills whereas immigrants from developing countries face greater difficulties with their foreign credentials but those from other developed countries do not. Immigrants' credentials are judged based on the educational system of their country of origin because it also reflects the country's level of economic development (Banerjee & Lee, 2015). In the South Asian community, it is very common to find Medical doctors driving taxis (Banerjee & Lee, 2015). The acceptance and rejection of immigrant's knowledge create a difference between those who are desirable and those who are not desirable.

The war on talent is based on neoliberal model of immigration policies. In terms of immigration, neoliberalism is defined as "internalization of the power of dominant classes in advanced capitalist states, the consolidation of capital's structural power, market liberalization and the bringing about of favorable conditions for private sectors" (Dufour & Forcier, 2016). These policies help wealthy nations increase their flexibility and competitiveness. However, one of the outcomes is skilled immigrants from developing countries tend to be overeducated for

their jobs that they come to take on compared to native-born workers (Ellermann, 2019**).** This indicates a prevalence of occupation-mismatch. According to the neoliberalism approach, the unemployment of skilled immigrants in their perspective fields is caused by personal and cultural reasons (Shields, 2004).

The Brain drain is a real issue, as the mass exodus of high-skilled workers has contributed to the loss of skills in developing countries. The paradox is skilled immigrants leave a vacuum back home while they are concentrated in Canada and are not able to use their skills. For developing nations, high-skilled individuals are an asset and are part of a minority educated group. Dawson (20007) noted that the destination countries benefit from the accessibility of skilled workers, not contributing to the associated fees of the workers' training and education. The loss of African intellectuals is a big challenge for the continent because it is happening to multiple countries at the same time. Without skilled workers, it will be impossible for the countries in the south to have a thriving economy. The Toronto Globe and Mail argued that the brain drain represents the new slave trade where the supply is the best workers from poor countries. There is an estimate of 20,000 African health professionals who migrate annually (Kana, 2009). This group of workers includes pharmacists, nurses, medical doctors, and other healthcare practitioners. South Africa is the biggest source country of immigrant physicians who are practicing in Canada (York, 2015). Immigrants with higher level of education, not surprisingly, tend to be more dissatisfied and frustrated with their employment outcome than those with low level of education before migration (Caidi et al., 2014).

A growing literature suggests that visible minorities tend to experience racial discrimination in the labour market. This might explain why there is a high rate of migration return of Chinese and Indians from Canada to their home countries. Hence, return migration is

often considered as the outcome of an unsuccessful migration experience most often associated with the failure to secure skills appropriate employment (Li & Lo, 2015). Pekkala et al. (2016) observed that the dense cluster of skilled workers migrating can be a cause for unemployment. As an alternative to returning home, some immigrants innovate and open their own businesses. Even those who continue their education in Canada still encounter discrimination. The experiences of immigrants in the labour market reflects existing societal attitudes regarding differences. Employers value the credentials of Canadians obtained in Canada over those obtained by immigrants and in foreign countries. While Canada officially is committed to equality, fairness and justice that are democratic values, discrimination is a continuing reality that negatively effects many newcomers.

The failure rate of internationally trained healthcare professionals on professional certification exams is higher than the average of Canadian born (Neiterman, et al., 2018). In Appendix B, there is a list from the Office of the Fairness Commissioner that identifies the alternative careers for nurses who are not able to find jobs in their field. Bourgeault (2005) observes that during the 1970s almost one third of practicing physicians in Canada graduated from foreign medical schools. However, these numbers have dropped in subsequent years. Therefore, it is important to know what alternative occupations internationally trained medical doctors tend to go into. Appendix C has a list of organizations and authorities that participates in the occupational integration of internationally trained medical doctors in Ontario. They either provide credential evaluations or administer medical examinations or residency or postgraduate trainings.

In 2006, Ontario established the Office of the Fairness Commissioner (OFC) under the Fair Access to Regulated Profession Act. Regulated professions made up about twenty percent of

the jobs in Canada (Chen & Novak, 2012). The OFC evaluates the registration practices of regulated occupations and sets up clear licensing requirements (Banerjee & Lee, 2015). Appendix A, has a summary of the Fair Access to Regulated Professions Act which was passed in 2006. Although immigration is federally regulated, occupations are regulated at the provincial level (Banerjee & Lee, 2015). Based on findings, both the application process and the test are very important in order to successfully obtain a medical certification (Cheng et al, 2013). For the field of medicine, applicants have to perform a professional knowledge test and a language proficiency test (Cheng et al, 2013). Testing is used as a powerful decision-making tool to exclude or include internationally trained immigrants from their pre-migration profession (Cheng et al. 2012). The continuous experience of immigrants in regulated profession suggests that the OFC has been passive and has not proactively eradicate occupational barriers. Because new challenges continue to arise, the integration of internationally trained medical doctors remains low.

According to Bourgeault & Grignon (2013), professional bodies are motivated by political, social and economic factors. They control the supply of workers through professional licensing, standardized tests and mandatory professional training. They determine who is qualified to practice. In 1983, Larkin introduced the concept of occupational imperialism that implies "occupation-based monopolies aimed at conserving particular skills…" (Bourgeau & Grignon, 2013). One of the major problems facing internationally trained medical doctors is securing residency that is mandatory to obtain a medical license. Due to high competition, the majority of internationally trained medical doctors do not get a residency placement. According to a survey completed in 2011, only 6% of immigrants from international graduate of medical

programs were accepted into a residency program in Ontario (Bhuiyan et al, 2015). The rest are not able to find meaningful jobs.

Difficulty accessing good jobs, lead some immigrants back to school to obtain Canadian education. Cresse and Wiebe (2012) noted that this helps immigrants to gain institutional cultural capital, but afterwards many struggles to find more than survival jobs. Researchers and research participants often describe the jobs as "survival employment" which indicates a contrast between occupation and status prior to migration with present circumstances (Creese & Wiebe, 2012). In a gendered labour market, men often get manual jobs while women end up in care-giving occupations or cleaning (Creese & Wiebe, 2012). In those fields, employers do not require post-secondary education and "Canadian experience" (Creese & Wiebe, 2012).

One problem that remains is the definition of the Canadian experience, this notion is interpreted differently by each employer. It may mean exposure to Canadian culture in general or having work experience in Canada including precarious employment and volunteering (Ozair, 2012). Producing that experience can be exasperating and stressful for new immigrants. In 2013, the Ontario Human Rights Commission declared that the Canadian experience is a human right issue because it is discriminatory for those who are unable to attain it.

Unfortunately, there is no centralized Canadian office that is in charge of evaluating foreign credentials (Guo, 2009). Immigrants are left to navigate this complex and frustrating process on their own. They are usually less familiar with the labour market and have limited to no access to social support as well as networks that are available to native-born. Based on the nature of the evaluation, foreign trained immigrants may need access to more than one of the following organizations: educational institutions, professional bodies and provincial/territorial credential assessment services (Guo, 2009). The credential assessment and recognition of

immigrants vary across discipline and occupation (Albert, et al., 2013). Whichever organization that process the assessment determines the functionality of the credentials in obtaining a job. There is a difference between the assessment done by educational institution and professional body. Another limitation is the lack of credential assessment services in provinces besides Ontario, Alberta, Quebec, and British Columbia (Li & Basran, 1998). This translates into lack of national standards for the evaluation of foreign credentials.

When applying for immigration, immigrants are told by the federal government that their assessment will be useful to find employment and to get admission to universities and professional bodies (Chaze & George, 2012). For example, immigrants who come under the independent class and skilled worker category have to get re-assessed by professional bodies and educational bodies after being assessed by the Federal government. Chaze and George (2012) found that the professional organizations offer assessment service that is expensive and slow. However, the assessment done by professional bodies are more important because they determine both licensing and employment. The costs related to the assessment services are not something that unemployed newcomers can meet. Their immediate desire is to meet their daily living expenses. Hence, internationally trained immigrant professionals are less likely to get into regulated occupations than their Canadian-trained counterparts.

Practices

The type of support available for internationally trained professionals varies by profession. Most bridging programs are developed through the partnerships of government educational and professional stakeholders (Neiterman et al, 2018). They often started as pilot program then they become self-sustaining relying on student's tuition fees. The investment and popularity of bridging programs have grown in Canada. In Ontario, there are many bridge

training programs for immigrants. Bridging programs help internationally trained professionals to find employment that will use their skills and experiences. These programs provide tools for the immigrants to successfully transition into the labour market and try to reduce the employment unfairness. The majority of bridging programs are offered in Ontario (Bhuiyan et al, 2015). However, the bridging programs are competitive, they require additional assessments and examinations (Bhuiyan et al, 2015). Between the years of 2003 and 2013, the province of Ontario invested more than $240 million in bridging programs for 50,000 internationally trained individuals (Neiterman, et al, 2018). Based on evidence, participating in a bridging program shortened the time for workforce entry and the probability of getting employment. Participants learn the local culture of practice, build networks and improve their communication skills as well as their cultural competence.

Section 2: The Experiences of the Interviewees

In this section I focus on the participants' experience. I will list the factors they mentioned that they find useful and what they did not find useful for their integration into the Canadian labour market. Some of these factors include provincial programs, policies, and professional assistance. These factors were mentioned by those who are currently practicing medicine and those who do not. By focusing on the experiences of the participants, I want to demonstrate what are the most concerning aspects of the interviewee's professional integration.

Professional Support

The process of integration into the Canadian medical field is described as confusing, costly and difficult. It is a long and complex journey. There are no preparatory educational course or programs for licensing examinations. Many interviewees mentioned that they received support from other internationally trained medical doctors while preparing for various medical

exams. Seven out of twelve of the participants said that they took part in study groups to prepare for their exams. Advanced Medical Communications Academy (AMCA) Medical Council of Canada Exams Prep Center is the dominant organization that was mentioned for study groups. For the past 19 years, this organization have been helping internationally trained doctors to attain high test scores for their board exams. Though it started in Toronto, AMCA MED now provide courses in Ottawa, Edmonton, Saskatoon and Vancouver. There are also IMG support groups that are administered by some universities. For example, Dr. Chike who lived in Saskatchewan participated in the IMG support program at the University of Saskatchewan. Similarly, the University of Alberta has a similar initiative called Alberta International Medical Graduates Association.

Some of the participants mentioned the University of Toronto's Department of Family and Community Medicine (DFCM) annual conference in collaboration with Pri-Med Canada. These three days conference is open to both locally and internationally trained healthcare professionals including nurses, pharmacists and physicians. Although there is a fee of participation, internationally trained medical doctors and graduates who are not yet practicing in Canada receive discounts. Participants noted that this networking and exhibition conference is worthwhile. They discuss a lot of topics especially things that are very important for family doctors. They are various healthcare recruiting agencies from different provinces that attend this conference as well. One thing that is essential for Dr. Chike, the certificate of attendance he receive from the conference is used to renew his license back in Nigeria.

There are many benefits of participating in a study group including book recommendations, study strategies and information sharing. Knowing what to study and how to study are the main priorities for IMDs. Dr. Bukari explained that if IMDs try to get the materials

that Canadian medical students use to study, they will not have access to these materials because they are only for Canadian students. The way Dr. Bukari put it is by having access to these materials, IMDs would be able to study and be at the same level as Canadian medical students. Another problem that may arise by reaching out to Canadian medical students is ethics. If a student decide to give the materials to you, they will violate the school's ethics code. So, people are left alone to navigate things. These are the reasons why IMDs rely on study groups. Some IMDs are fortunate to have friends and colleagues who went through the process prior to them and share their materials with them without paying any fees. Even then, some do participate in study groups because as an IMD anything they can do to add to their knowledge is helpful. They find other IMGs that relate to them on a personal level and they all help each other out.

In general, the participants spoke highly of their experience participating in study groups. There was only one participant who complained about the ineffectiveness of support groups in the city of Montreal where she used to reside. According to Dr. Yvette, the support groups in Montreal are not as organized as Toronto. This is how she described her experience with various groups that she reached out to: "What happened is you will find them on the internet and when you reach out to see if they have an email, there is no answer. They never replied to any of the email that I have sent and the phone numbers were not working". Granted these organizations are trying to do something but they need better strategies to attract IMGs. If IMGs are not aware of the support groups that are available to them, they will not know they exist. This is the case in Montreal. Apart from basic information that is provided on the internet, most organizations are not publicized. Besides L' Association Medical du Quebec which is a medical organization that is well known, there are not that much support for IMGs. Dr. Yvette did mention that there are a few ethnic specific IMG groups such as Tunisian, Algerian, Congolese groups.

Apart from independent private groups that provide assistance to IMGs, there is Health Force Ontario that assist IMGs throughout their journey until they obtain their medical license. Health Force Ontario is an agency created in collaboration of the Ministries of the government of Ontario (i.e., the Ministry of Health and Long-term Care and the Ministry of Training, Colleges and Universities. The Access Centre for Internationally Educated Health Professionals is the specific program that is designated to provide information and guide IMGs who are in Ontario. It offers medical school interview preparation workshop, pathway to practice seminars and career workshops. Once an IMG registers with the Assess Center they are assigned an advisor. Dr. Ijeoma who spoke about her advisor mentioned that they meet once a week for one hour where she discuss her medical licensing path. Additionally, the advisor helps her edit her resume, cover letter and write referrals for her. In addition to services that are related to medical registration and licensure, the Access Centre held other types of information sessions. In these events, IMDs learn about bridging programs in order to help them get into other aspects of healthcare if they are not successful on the path to becoming a medal doctor. As well as other options may be available to them in other provinces. This is very important as many IMGs feel like it is impossible to get into the medical system, plus the province of Ontario is saturated which makes it more difficult for IMGs to get a residency position in Ontario.

There are also grassroots organizations that create programs to help IMGs in different capacities. One of the partner organization of the Toronto Region Immigrant Employment Council (TRIEC) is the International Medical Graduates Waste-Prevention Network (IMGWPN). This non-profit organization was created in 2011 to limit the waste of foreign trained healthcare talents in sub-qualifying jobs instead of leveraging the capacity these people have to give to the society. In 2013, this organization merged into a program under Community

Matters called the International Educated Professionals Program that Dr. Mukendi helped to create. They held meetings every Wednesdays offering mentorship and coaching to internationally trained medical doctors from various parts of the world. The goal of this organization is to help these immigrants find meaningful employment in the healthcare sector.

Peer networking does not only help internationally trained medical doctors during their licensing journey but also during their job search. For the participants who are independent licensed physicians, meaning that they can work independently without the supervision of other medical doctors, finding a clinic to work in depends on networking. Dr. Bandile and Dr. Chike who are both independent license physicians raised that they were able to find temporary or "locum" opportunities in clinics from their formal peers. Though the official way is to go to a hospital or clinics and request to be on their locum program, finding these opportunities through colleagues is the most efficient way.

Observership

Medical observerships is an opportunity for healthcare professionals to observe other medical professionals as they take care of patients in different healthcare settings. International medical doctors observerships are regulated under the Delegation of Controlled Acts of the College of Physicians and Surgeons of Ontario. According to this policy, under certain circumstances some acts can be performed by observers. The physicians in charge will know when and how these controlled acts can be completed. The law does not require one to have any licensure in order to act as an observer. The observerships expose IMGs to the Canadian medical culture and experience that they can be useful in their medical career. Out of the twelve interviewees, three have done observerships. Although it is non-paid, they were all advised that the observership will make their profile more appealing when they are applying for residency.

Some participants did more than one observership because they say the more observership experience they have the better their application will be. Besides being non-paid, some participants mentioned that their observerships were far from where they live so they end up spending a lot of money on transportation.

Throughout the interviews, I received both positive and negative feedbacks from the participants on whether or not observership do help IMDs. To begin, it is not easy to get an observership because most places do not offer formal observership. It is up to the IMDs to contact different facilities and initiate their interests to do an observership. All the participants who had an observership position got the opportunity based on referral either from friends, church members, or family members. Moreover, another concern that prevent licensed physicians to accept observers is ethics. Some physicians let observers collect the medical history of the patients and examine them. Though they do not have clinical contact with the patients, these tasks facilitate the physicians by allowing them to see more patients. At the same time, if anything goes wrong with the patients the physicians' license will be in jeopardy.

The greatest concern now with observerships is that they are not recognized anymore. Dr. Chike who now is a medical resident interviews residency applicants, discussed that medical schools do not recognized observership anymore because they are not clinical placements. Unlike clinical placements where the IMGs can gain clinical skills, observerships are meant to "observe a license physician". Because the IMG is just observing and not working, the physician that they assist cannot actually write a recommendation letter on their behalf that describes their clinical work. The program director at each medical school choose applicants for residency positions based on whom he or she regards to be the best qualified. Even though the qualifications of internationally trained medical doctors are recognized as proper degrees by the

Medical Council of Canada, they face systematic barriers from the medical schools. This is why the "matching" residency system has been criticized as being exclusive. Equally, employers in the healthcare industry are reluctant to hire them for entry level positions without any work experience in Canada. Hence, people like Dr. Ijeoma and many others use the observeship position as their "Canadian work experience".

Settlement Services

In 2005, the province of Ontario signed two intergovernmental agreements, the Canada-Ontario Immigration Agreement (COIA) and the Canada-Ontario-Toronto Memorandum of Understanding on Immigration and Settlement (MOU). Based on these agreements, all levels of government should work in collaboration on immigration issues such as selecting immigrants, resettling of refugees and the integration of all new comers (Sadiq, 2004). Settlement services are the first point of contact for newcomers. While services are provided for free, the types of services that are available for immigrants should be taken into considerations. Immigrants who seek settlement services are very diverse, ranging from professionals, highly skilled workers to refugees. The interviewees complained that the settlement services are not well equipped to meet their needs. For example, when it comes to internationally trained medical doctors, the settlement workers do not have any information that they can provide or do referrals. They do not have any programs that are designed for specialized immigrants like medical doctors. This reflects the notion of immigrants' self-reliance in settlement integration. When the interviewees went to seek help from settlement services they did not received advice or guidance on the best way to reintegrate with their degrees. Instead, they received general information about housing, language trainings, etc. This is illustrating that there indeed there are organizations that are dedicated to the integration of newcomers but there are some that are better than others in

providing the right quality and quantity of information. Getting useful information requires one to know the relevant professional association and specific needs of highly and especially skilled client groups.

Location Matters

Although all the interviewees reside in the province of Ontario, some have moved from other provinces such as Saskatchewan and Quebec. It was fascinating to hear the interviewees enumerating the benefits and challenges that IMD encounter in different provinces. They range from job opportunities, provincial programs and medical schools.

In terms of licensing, the province of Saskatchewan has the Saskatchewan International Physician Practice Assessment (SIPPA) program that empowers IMGs to practice medicine. This program assesses the readiness of IMGs that are family physicians to practice in Saskatchewan. The participants are issued an educational license for the duration of their assessment that is twelve weeks. They are placed in a community to complete their Clinical Field Assessment. Once the participants have successfully passed SIPPA they receive a provisional license. They are evaluated at the level of Canadian trained family physicians that are entering practice.

In the province of Quebec, there is a special program that help IMGs to get into residency. According to Dr. Yvette, these three months hospital training program is only for those who have applied to the Canadian Resident Matching Service (CARMS) and did not get a residency position. During this training, IMGs get expose to family medicine practice and are evaluated. Once the three months are over, the IMGs receive a certification that says whether or not they passed the program and a letter of participation. This program is very competitive, only those with high medical test scores are able to apply. People have found this program very

helpful because they later get into residency and the program is recognize by every medical university in Quebec.

Regardless of the opportunities mentioned above, the interviewees said that Ontario was the best province to reside in. Because the province has a large population, there are a lot of opportunities that IMGs can compete for. For example, the province of Saskatchewan has one medical school and there are four in the province of Quebec but in Ontario there are six. An IMG who lives in Ontario has more chance to find a residency position within one of the six medical schools compared to if they were living in Saskatchewan. There was something that distinguished the French speaking interviewees who have lived in Quebec versus the rest of the interviewees. The cultural difference that exist in Quebec does affect the professional integration of IMGs there. The interviewees found Quebec to be less open towards IMGs. Dr. Yvette said that she faces discrimination at her job. She mentioned that despite her expertise, people continue to view her as a "foreigner". This is what she has to say when asked what part of her job she did not like "I am a black skinned girl so they think that you are not competent enough although competency comes with experience." She receives this kind of feedback from both patients and coworkers.

Dr. Boukari, who used to practice medicine in France with his license from Burkina Faso also found Quebec to be a strange place. He supposes that the fear that Quebec has towards IMGs is due to their unfamiliarity with the medical practices of African and Caribbean countries. Unlike Canada, France which has been involved in Africa and the French speaking Caribbean countries for centuries, the Medical school curriculums are almost the same, it's just a duplication. There are a lot of collaborations and interchanges between France and its ex-colonies. Therefore, when an IMG from a French speaking country immigrate to France they

find less occupational barriers. This is how Dr. Boukari understands the situation of Quebec: "If Quebec had some colonies in Africa there wouldn't be any difference between us, they would have understood a lot of things." His statement demonstrates that in the province of Quebec internationally trained medical doctors need to demonstrate that they are safe and competent practitioners within the Canadian healthcare system.

Another difficulty IMGs in Quebec face is language barrier because all the tools and reintegration process for IMGs and IMDs are in English. For example, the books to study, etc. They translate a lot of things in French but the majority of things are still in English. So, for those who speak another language they must learn English first and then start their medical studies. The Canadian Medical Council try to adapt, like all the exams are administered both in English and in French but most of the guidelines and the books are written in English. Dr. Boukari believes that this is one of the reasons why it takes IMGs in Quebec longer time to integrate professionally. Like Shohamy and McNamara observed, the use of a specific language expresses a condition for belonging (Cheng et al. 2012).

Doctors Without Borders: A Saving Grace?

While it is difficult for internationally trained medical doctors to practice medicine in Canada, Doctors Without Borders represents a second option for those who decide to use their medical degrees outside of Canada. Doctors Without Borders recruit local medical doctors in Canada including those who are educated outside of the country in order to work in different MSF field work locations. MSF process is different than that of the Canadian Medical Council. International Medical doctors go through a validation process. Once the degree is validated, the selection is done by expertise that are needed. The expatriates have to abide with the medical

council requirement of the country where they work before they can start to do any type of clinical work.

Among all the participants, I interviewed one person who works at Medecins Sans Frontiere and this is his story:

> "I was working in the European MSF branch before I came here. So when I get accepted under the skill worker program to come here after a few months, that's when I switched to the Canadian branch. My licensure process was easy because I only had to take a few test and register with the College of Physicians and Surgeons. I did not finalize the whole process with the Canadian Medical Council. It was not useful for me to finish everything all at once. I only did the part that was require by MSF. Unless I decide to leave MSF one day and let's say go to work at Toronto General Hospital then I will need to complete everything."

Personal Circumstances

There are several circumstances that complicate the integration process of internationally trained medical doctors. In medicine if too much time takes place without clinical practice it can be challenging for IMDs as their skills will be viewed as having deteriorated. Medicine is more about practice then theory. Moreover, starting in January of 2018 the Medical Council of Canada made it official that after attempting four times to take the Medical Council of Canada Qualifying Examination (MCCQE) Part 1, people will not be eligible to take the test again. This is one of the tests that is required in order to obtain the Licentiate of the Medical Council of Canada (LMCC). While preparing for the exams a lot of internationally trained medical doctors have to work in order to support their family. This is where many get trapped.

The participants mentioned that work is a distraction that many internationally trained medical doctors cannot avoid. Working has negative influence on one's ability to take the test. Some of the participants wished that they did not worked when they came which would have helped them to just focus on studying for the exams. Others revealed that they were lucky

enough to have money from their country of origin to take care of their bills while preparing for the exams. Dr. Chike, unlike everyone else, received a loan from Windmill Micro lending formerly known as the Immigrant Access Fund. In recent years, microfinance has emerged as a social innovation to assist professional integration of skilled immigrants in Canada (Ngo and Kawaguchi, 2015). Having access to microloans have positive and lasting effects for participants.

Those with no economic safety net often cannot afford a prolonged period of integration. The focus of many newcomers when they land on their host country is usually settlement and providing to their families. Because of the needs of daily economic survival many end up in precarious labour and become disheartening about their hopes of practicing medicine in Canada. Such employment often includes long hours, stressful environments and sometimes heavy physical demands which make it hard to concentrate on study. Therefore, pursuing a medical licensing in Canada requires both financial and personal commitment. The longer one remains outside of their field of training, the likelihood of working in this professional area decreases.

Alternative Path

In Appendix C, there is a list of alternative careers for internationally trained nurses. Apart from the traditional medical profession, there are also other roles that internationally trained medical doctors held in which they are able to use their skills. Whether it is interacting with patients in different capacities or working with Canadian medical doctors, the participants mentioned that they are glad that they are still in the healthcare sector. Most of the jobs that are held by the participants are either at hospital settings or in pharmaceutical companies. Two of the most cited jobs were clinical researcher and health technology worker. Tapping into the human potential, skills and experience of internationally trained medical doctors helps to restore their

professional identity. This is crucial for those who cannot pursue another degree or certification in Canada. Alternative paths provide a way to put former skills into new usage. Career exploration allow international professionals to reflect or make sense of their careers and consider diverse options (Aten et al., 2016).

Clinical research is the study of human subjects that involves the experiment of multiple products in order to ensure efficacy and safety. This field of study take less than one year and at the end of the program a certificate is given to the participants. The interviewees mentioned that during the program they learn about subjects that they were already familiar with such as anatomy, human physiology, immunology and genetics. While working as clinical researchers, the interviewees performed urine tests, pregnancy test which are the closest things that they can do without a medical license. Some of them said that they wish their work were more clinically involved. Others complained that they are working with people who have the same knowledge as them but because they were not educated in Canada they feel that they are undervalued. This is how Dr. Bandile escribed her education compared to his colleagues who are Canadian trained medical doctors:

> "I found that the training that I had was very superior. In Africa, we do a lot of hands on work. So, some of the things that my colleagues didn't do, I have done them long time because of a lot of experience that I get in Africa. For instance, in place like Zimbabwe, when I was in obstetrics, we could do things such as c-section. In fact, it was part of our training. There were so many things to do so they allow us to get things done. It's a lot of clinical work because there are very few doctors. So you find that it's a lot but its hands on experience."

Because of the extensive clinical trainings, they have, international medical doctors who are from third world countries often commented that they have the enough skills to put into use. They are dedicated people who love their work as medical doctors, but the system is basically closing its doors. The system opens its door for them to come as immigrants but also closes its

door on them from practicing as doctors. They are placed at the "institutional periphery'' as Richardson and Zikic (2016) describes it.

Getting a Canadian degree is also an alternative option that some internationally trained medical doctors consider. At times, the degree maybe completely different from what they studied. For example, Dr. Bukari mentioned one of his friends decided to start up fresh and ended up becoming a psychiatrist after not being able to obtain a residency position. This seems like an attractive choice for those who came to Canada at a younger age. Some of the interviewees decided to get a master's in Public Health that is a branch of medicine. Public Health is a professional area of medicine. As public health students, the interviewees indicated that they were able to secure research coordinators jobs either at their university or with hospitals. Among those who ended up getting a residency position, some choose the public health track as their specialty. The overall benefits of working in a healthcare related job or getting a health-related degree is that it can help the internationally educated medical doctors to build their portfolio for medical residency. Portfolios are used by universities and colleges to assess the competencies of applicants and their preparedness to enter or re-enter an academic program (Albert et al., 2012). The portfolio offers both employers and university a well-created profile. The regulated bodies in Ontario require that a portfolio must have the following components: personal details, language skills, technical demonstration of competencies, formal and informal education as well as work experience (Albert et al., 2012). Some of the interviewees who have not proceed with their medical journey mentioned pursuing a master's degree in Public Health has one of their options.

Interestingly, some internationally trained medical doctors come to Canada and decide to pursue other careers. For example, two of the interviewees said that when they come they

voluntarily did not want to practice medicine. Both of these individuals are pleased with the path that they have taken. What is unique about Dr. Mukendi and Dr. Oba's stories is that they are helping other internationally trained doctors to find other paths. Dr. Oba does mentoring and public speaking for other IMGs who are interested in health technology or digital health. IMDs and IMGs from all over the world reach out to him through LinkedIn for mentorship. This is worth nothing because most people have a misconception that if they are not working at a clinic or hospital treating one patient after another then they are not practicing medicine. Dr. Oba said that is a fallacy, "That's one of the problems that is very pervasive in medical practice. Your knowledge as a medical doctor can be applied in several other domain so there is no other time than now where this has been more important because regardless there are so many people impacting healthcare delivery that are not clinicians". Without proper guidance from people who have complete domain expertise they will just continue to poke around in the dark. That is why people should look for other ways to apply their medical knowledge.

Dr. Mukendi on the other hand started his own business helping international medical doctors to find alternative paths. After he worked at a clinic with a couple of physicians in Calgary as a clinical aid, he realized practicing medicine was not the option that will make him the happiest. He started a staffing agency where he recruited other international medical doctors as clinical aids for a company in Edmonton. Although he moved to Ontario and this agency has been sold, Dr. Mukendi is satisfied when he hears from some of the internationally trained medical doctors he recruited that in the end find a residency position. Others who were discouraged about pursuing their medical license reconsider their decisions. Dr. Mukendi mentioned that he would not be able to impact the lives of these internationally trained medical doctors like he did if he was practicing medicine. The stories of Dr. Mukendi and Dr. Oba

demonstrate that some internationally trained medical doctors decide to go to other fields and use their skills in other capacities when they come to Canada.

Section 3: Recommendations Emerging From the Interviews

In this short section, I discuss the recommendations that the interviewees proposed. These recommendations are based on the interviewee's experience. It is important to consider the suggestions of internationally trained medical doctors as they have informed opinions on what should be done that is often left out from the literature. Giving the mounting critiques, Canadian governments at all levels and non-profit organizations have tried different ways to integrate internationally educated doctors. However, according to the interviewees a lot still needs to be done. These recommendations were made to other and future international medical doctors and to the governments as well as medical bodies.

A Need For Teaching Hospitals

As raised in Section 2 there are not enough medical schools in order for internationally trained medical doctors to get residency positions. Compared to the amount of IMDs that are waiting for postings and the number of IMDs that migrate to Canada each year, the residency positions available are inadequate. Some of the interviewees recommend that there needs to be more teaching hospitals. Teaching hospitals do not only serves as research institutes but they also work closely with medical schools to provide placement for medical students.

Moving To Another Province

Most provinces and territories have recruitment agencies that help bring international medical graduates to their jurisdictions (Campbell-Page et al., 2013). Although the integration process can be very difficult, some of the interviewees recommend that other international medical doctors should consider moving to other provinces. Every province has different

requirements, but they all have some similar basis for evaluation and accreditation of medical degrees. For some of the interviewees, they found more obstructions in the Ontario medical system than other province. The province of Saskatchewan was cited as a province that has easier path into medical practice. Among all the interviewees, two of them who are now practicing medicine moved from the province of Saskatchewan to Ontario and two of the ones who are yet to get into a residency said that they are considering to move to Saskatchewan with their family. Compared to Ontario, Saskatchewan has a smaller population and harsher climate and not many people are eager to move there. This may help explain why the medical bodies in Saskatchewan have more accessible requirements for medical qualification as a way of bring in more IMDs. This is the story of Dr. Badile who migrated from England to the province of Saskatchewan with a medical degree that he obtained from Zimbabwe. As he notes:

> "First, I wrote the college of physician in Saskatchewan I told them I got a medical degree from University of Birmingham England, do I qualified to come practice in Saskatchewan. They said send us your curriculum. I send them that then they looked at my qualifications, they reviewed my degree and they say your degree is recognize here you can register as a doctor if you come but you have to come for a personal interview first. I came to Saskatchewan because I know I could practice straight away. I couldn't come to Ontario because Ontario would not accept that. At that time you couldn't go straight and practice without doing extra exams. Meanwhile in Saskatchewan if you had a British degree that's all you needed, they accept your trainings and everything."

After practicing in Saskatchewan for nine years, Dr. Badile moved to Ontario where he then applied for a license using his work experience in Saskatchewan. In general, internationally trained medical doctors look for a province that has the least resistance that can allow him to obtain their medical license. This is where human agency plays an important role. Individuals contribute and influence their life circumstances. Their ability to make choices are not guided by anything but their own desires, needs and wish for fulfillment. From a sociological perspective, agency is represented as a micro level part of the migration experience. Even if all internationally

trained medical doctors in Canada are presented with the cost and benefits of moving to another province, their migration depends on their free will. Although the requirements to practice in the province of Ontario might be more difficult, some internationally trained medical doctors prefer to stay here because of other opportunities and life style.

Analysis and Conclusion

Medicine is a highly-regulated profession that is founded on knowledge-based credentials (Zikic and Richardson, 2016). There is a national and provincial need, given doctor shortages, to minimize training entry barriers and increase the number of internationally trained medical doctors in the Canadian health care system. According to Frank (2013), immigrants that had high-status occupations before their migration face more difficulties in finding their desired employment in their host country. The participants willingly shared their motivation to study medicine in the first place was their desire to provide care and to help others. They invested a great deal of time into developing their careers. In our interview sample their years of practice from their country of origin ranged from one to ten years.

In the Canadian health care system**,** family physicians that is the expertise of almost all of the participants, serve as gatekeepers to specialists (Wang et al 2008). Without a referral from a family doctor an individual cannot seek specialized services. Seven out of the 12 participants in this sample are working as or is a resident doctor. This is a very high rate compared to what we hear as the norm in such circumstances. Some are able to overcome the complex process of reintegration while others are still stuck in the process. Professional regulation in the field of health tend to be structural and drive by profound social, political and economic considerations (Bourgeault and Grignon, 2013). This is the primary explanation for those who fail to qualify as a medical doctor. The structural explanations for the underutilization of skilled immigrants

focuses on systemic inequalities linked to racism (Creese and Wiebe, 2009). Our interviewees did recount numerous instances where racial profiling occurred.

Around the world, medical education differs in their curriculum, educational standards and evaluation methods (Greg et al, 2013). The Canadian government tries to have universal occupational standards that can be utilized to evaluate applicants from different countries (Guo&Shan, 2013). Clearly, however, more needs to be done on this front.

There are skilled migrants who do not come directly from their home countries. Instead, they go to another foreign country that serves as a transition or stepping stone before they reach their intended country of destination. This process is described as "step-migration" or "transient migration," because migrants choose this option in order to gain more work experience (Ghosh, 2014). For instance, Ghosh found that many Indians have been in a "step country" before they come to Canada. While they are there, they apply for Canadian permanent residency. This suggest that high-skilled migrants are becoming increasingly mobile. Having prior international work experience or international education can give immigrants an advantage and additional cultural capital. Preference, however, is often given to those who had their experiences in "western countries" (Bailey & Kou, 2014).

As can be seen from the participants' profile, they were from different African and Caribbean countries. Though English is the first language of most of them, language is not considered to be an issue besides for studying. Some of the interviewees got other advance degrees in Europe to supplement their medical degree. When they come to Canada, they start at the same level as other internationally trained medical doctors. They all have to take the same tests and follow the same procedure. Our sample population had a high level of success in attaining their employment goals. While this is not a representative sample of internationally

trained medical doctors it does suggest that there are pathways to successful employment integration. However, their experiences also point to the host of obstacles that are placed in their pathways and the need for reform. Based on the data, we can conclude that the human capital theory can not predict the experiences of internationally trained medical doctors.

Appendix A

Fair Access to Regulated Professions Act, 2006 (abbreviated)

PART I

INTERPRETATION AND APPLICATION

Purpose of Act

The purpose of this Act is to help ensure that regulated professions and individuals applying for registration by regulated professions are governed by registration practices that are transparent, objective, impartial and fair.

PART II

FAIR REGISTRATION PRACTICES CODE: GENERAL DUTY

General duty

A regulated profession has a duty to provide registration practices that are transparent, objective, impartial and fair.

PART III

FAIR REGISTRATION PRACTICES CODE: SPECIFIC DUTIES

Information

A regulated profession shall provide information to individuals applying or intending to apply for registration by the regulated profession and, without limiting the generality of the foregoing, it shall provide,

(a) Information about its registration practices;

(b) Information about the amount of time that the registration process usually takes;

(c) Objective requirements for registration by the regulated profession together with a statement of which requirements may be satisfied through alternatives that are acceptable to the regulated profession; and

(d) A fee scale related to registrations.

Timely decisions, responses and reasons

A regulated profession shall,

(a) Ensure that it makes registration decisions within a reasonable time;

(b) Provide written responses to applicants within a reasonable time; and

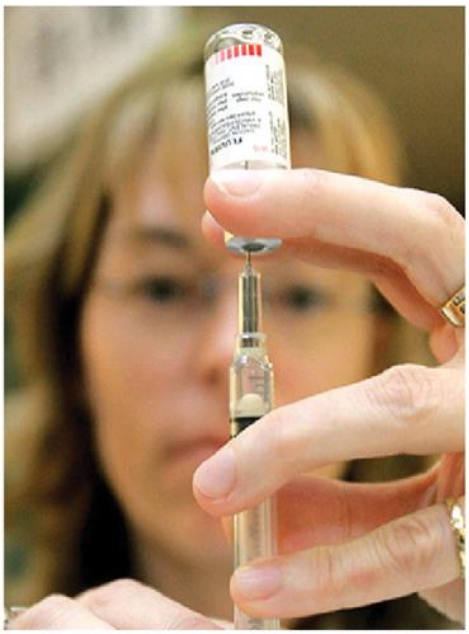
(c) Provide written reasons to applicants within a reasonable time in respect of all registration decisions and internal review or appeal decision.

Appendix B

DIFFERENT WORLDS

Top 10 alternative occupations for nurses unable to find work in their chosen field in Ontario, 2011:

Canadian born/educated	Foreign born/educated
1. Health care manager	1. Nurse aid/orderly
2. Head nurse	2. Homemaker/housekeeper
3. College instructor	3. Practical nurse
4. Health policy researcher	4. Babysitter/nanny
5. Nurse aid/orderly	5. Food service worker
6. Administrative officer	6. Retail salesperson
7. University professor	7. Cashier
8. Office clerk	8. Secretary
9. Retail salesperson	9. Cleaner
10. Homemaker/housekeeper	10. Labourer



SOURCE: OFFICE OF THE FAIRNESS COMMISSIONER, TORONTO

DARREN FRANCEY / POSTMEDIA NEWS

Appendix C

List of authorities for internationally trained medical doctors in Ontario

CICIMG-The Canadian Information Center for International Medical Graduates. It provides inclusive information regarding the steps to accreditation for each Canadian province.

Website: http://imgcanada.ca/

PCRC-The Physician Credentials Registry of Canada. It provides centralized repository for physicians' core medical credentials.

Website: http://www.pcrc.org.

RCPSC-The Royal College of Physicians and Surgeons of Canada. This national organization oversee the medical education of specialists in Canada.

Website: http://www.royalcollege.ca/rcsite/home-e

CFPC-The College of Family Physicians of Canada.

Website: https://www.cfpc.ca/Home/

CEHPEA- The Centre for the Evaluation of Health Professionals Educated Abroad. It serves as an evaluation centre.

Website: http://www.touchstoneinstitute.ca/

CaRMS- The Canadian Resident Matching Service. This organization provide matching services for entry into postgraduate medical training in Canada.

Website: https://www.carms.ca/

AIPSO- The Association of International Physicians and Surgeons of Ontario. It is the main organization of international medical doctors of Ontario.

Website: https://aipso.webs.com/

Appendix D

Interview Sample

1-What country do you come from? And how long have you been living in Canada?

2-Under what immigration program where you admitted into Canada?

3-What was the first city or province did you settled in when you came to Canada? (why?)

4-What is your professional education in your country of origin? Elsewhere?

5-What was your profession back home? How long did you work in that profession?

6-What motivated you to study medicine?

7-What was your aspiration for when you settled in Canada?

8-What is your current job/profession?
b) How long have you been working in this job?
c) How long did it take you to obtain this job? And how did you obtain it?

9-What other jobs have you been working in any other jobs since Canada?

10- Can you describe your experience navigating the Canadian labour market?

11- What part of your current job do you & not like? Why? (I am looking for job satisfaction)

12- Do you feel that you are using any of your medical skills and knowledge in your current job? If yes, in what way (s)?

13-Were you adequately informed about the assessment requirements for registration in the medical field either prior to immigration or after migrating to Canada?

14- What were the challenges that you encountered when you were searching for job in your field?
b) What helped? Who helped? How did they helped?

15-Are you aware of any educational training or program that is available to newcomers?
b) If yes, how did you find out?
c) Have you participated in any of these programs/trainings? what is the name?
d) From your personal experience, did the program (s) meet your need?

16- What improvement(s) would you advise the Canadian organizations to make in their efforts to integrate medical doctors?

17-If you had an opportunity to go back to time, what would you do differently regarding your experience?
18- Is there anything you would like to add or ask?

Participants Profile

Participants	Sex	Country of origin	Date arrived in Canada	Current job
Dr. Bukari	Male	Burkina Faso	2007	Medical doctor
Dr. Leroy	Male	Jamaica	2010	PGY-5 (medical resident)
Dr. Ijeoama	Female	Nigeria	2018	Unemployed/non-paid observership
Dr. Ade	Male	Nigeria	2006	Medical doctor
Dr. Bandile	Male	South Africa	1980	Medical doctor
Dr. Nana	Male	Nigeria	2011	Medical doctor
Dr. Kouadio	Male	Ivory Coast	2017	Security guard
Dr. Chike	Male	Nigeria	2011	Independent Family physician/ PGY-4 (medical resident in Public Health)
Dr. Oba	Male	Nigeria	2017	Health informaticist
Dr. Mukendi	Male	Democratic Republic of Congo (DRC)	2008	Pharmaceuticals Sale Associate
Dr. Yvette	Female	Haiti	2010	PGY-2(medical resident)
Dr. Jean	Male	Haiti	2012	Medical Information Specialist

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